Exploring Contraceptive Service Delivery on the Thailand-Burma Border

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Introduction and Context

Historical tensions have long existed between Thailand and Burma, due to colonialist rule that dates back to the end of World War II in 1945, and the self-determination of Burma, a former British Colony. Four years after the war, in 1949, an ethnic minority, the Karen Armed Forces, led a coup that resulted in direct military control of the government. Over time this has led to instability along the Thailand-Burma border and has reverberated into the early part of the twenty first century. This has been demonstrated by elections in 2010 that were regarded by the international community as important steps toward democracy, however the violent protests produced a human rights crisis[1-2,12-13]. As a result of this ongoing instability in Burma's military and political systems a large portion of Burma's population has fled into Thailand for refuge. In 1988 the military seized power, democracy activists disappeared and thousands fled or were forced to go into hiding. Many thousands of migrants and refugees moved rapidly to the Thai-Burma border, seeking safety and protection. A steady flow of refugees and migrants from Burma (renamed Myanmar as of 1989 and recognized globally in 2010) into Tak Province, Thailand has occurred over the last 60 years. An estimated 100 000 Burmese refugees entered Thailand in 2010, and have been termed 'Internally Displaced Populations' (IDPs)[1-2,12-13].

Throughout Eastern Burma and Western Thailand, IDPs face many challenges to their survival, including food security issues (destruction of agricultural fields), forced labor, forced relocation, physical attacks by soldiers/authorities, and landmines. It is indicative in the literature that nearly eighty percent of women in Burma have never used contraceptives[2]. As a result women in Burma are facing a vicious cycle of low contraceptive use resulting in unplanned pregnancies and effectively causing unsafe abortions and a high maternal mortality rate. This cycle seen throughout the Thai-Burma border has a significant impact on the health care systems and potentially could even be worsening the problem of reproductive health care access. This structured literature review will explore issues related to contraceptive service delivery along the Thailand-Burma border[1-2,12-13].

Research Question

This structured review of the literature seeks to address the question 'What barriers do women living along the Thailand-Burma border face when trying to access contraception?'.

Material and Methods

A structured literature review was conducted using content sought in the databases MEDLINE, CINHAL and EMBASE. These databases were selected as due to their relevancy and appropriateness for the research question. Key words included contraceptives OR contraception, women, Myanmar OR Burma, Thailand and barrier*. Set limits included: Human studies, articles published in English, and articles published within the last 30 years. The preliminary search yielded 62 articles collectively from the three databases, which was reduced to 41 after removing duplicates. Articles were prioritized based on inclusion criteria defined by titles and abstract content. There were an additional 12 articles excluded after having read the abstracts. The researchers independently assessed the 31 remaining articles for full text relevancy. An additional 10 articles were omitted for they did not satisfy the inclusion criteria. Reasons for exclusion included location were not along the Thailand-Burma border; focus was on a disease, and did not discuss barriers to access. An additional 5 studies were included after reviewing bibliographies of the included articles, resulting in 24 articles as the final product. The researcher suspects that the addition-

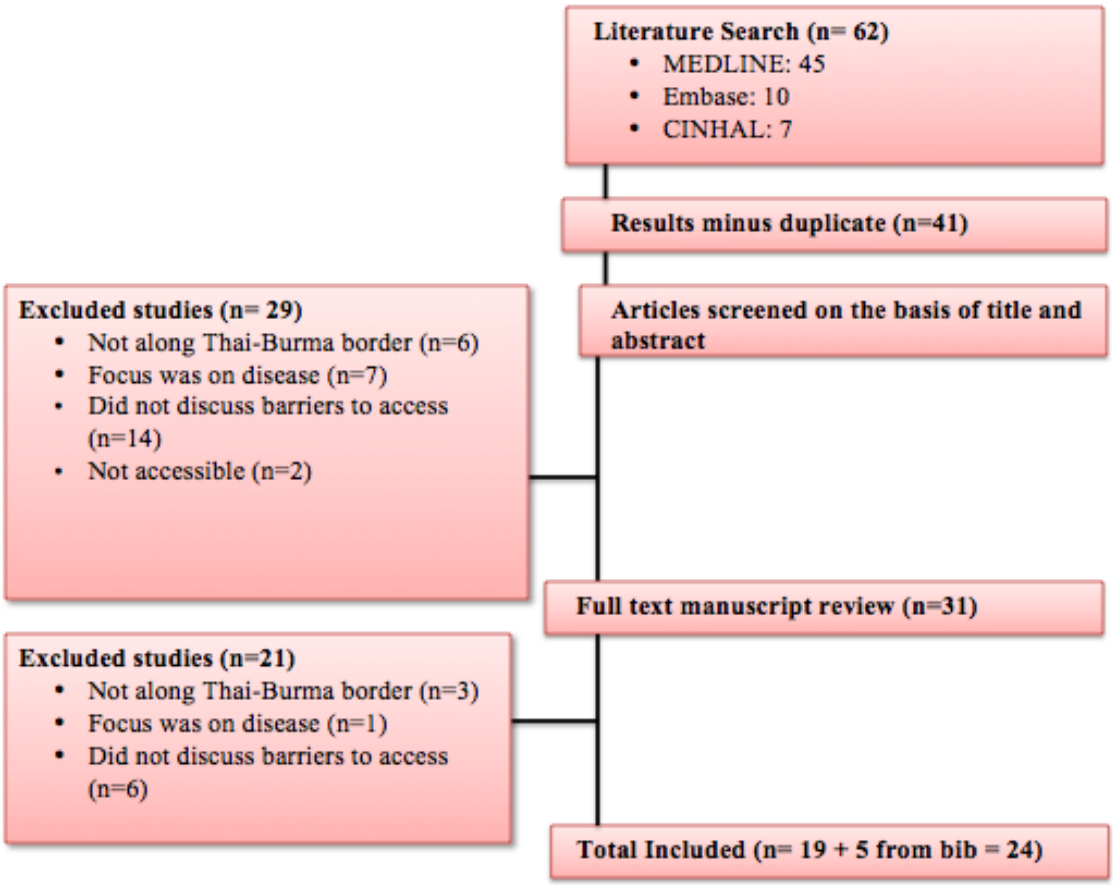

Figure 1. Review Profile and Study Selection Process.

al 5 studies retrieved from reviewing bibliographies were not captured in the initial search because the search terms and screening process may have been too narrow to capture all of the relevant articles.

Data Analysis

The qualitative content analysis used a thematic data analysis approach using inductive reasoning. NVivo, a qualitative software analysis program was used for coding and analysis involved standard steps in thematic analysis, where the coding categories were derived inductively from the literature using a constant comparative method. This allowed the researcher to not only stimulate original insights but also allowed apparent differences between categories to be made. In order to ensure reliability of coding categories, the research defined them in ways that are internally as homogeneous as possible and externally as heterogeneous as possible. In addition, the research developed and used a coding manual, which consisted of category names, definitions and basic rules for assigning codes. Due to the nature of the constant comparative method, the coding manual evolved through the data analysis process. After all the data was coded, the researcher rechecked the coding to ensure consistency. This helped to ensure that the coders' understanding of the categories did not change over time.

Results

Following the content analysis, five major barriers were expressed throughout the articles evaluated; these barriers include: legal, geographical, security, educational and socio-demographic. Table 1 represents a starting place for delineation.

Legal Barriers

Induced abortion is legal in Thailand and the laws surrounding abortion are viewed as less restrictive, however there is noteworthy inequality for Burmese women who live in Thailand and seek reproductive health care. The literature indicates that one of the reasons for this is their illegal status in the country [2-4].The situation is even bleaker in Burma where abortions are only legal to save the life of a woman[3]. This is due to the Burmese government's pro-natalist views and their desire to increase their

Table 1: Major themes and their defining characteristics

Theme	Characteristics	Reference
Legal	- Abortion laws - Illegal residency status - Government pro-natalist views	2-4
Geographical	- Limited services and private clinics in rural - Varying religious beliefs	5,4,10,11
Security	- Travel distance and time - Risks of travel (e.g. rape, landmines or deportation)	5,10,12,13
Education & Socio-Demographic	- Misinformation - Lack of awareness - Untrained staff - Marital status	4,13-15

birth rates in order to have a larger population[5]. As a result of these laws that govern both Burma and Thailand, many face appreciable barriers to accessing contraceptives. This is most notable in Burma, where government health center do not offer information nor contraceptive products because of the government's pro-natalist view.

Geographical Barriers

In essence, it was discovered that rural areas have limited services and areas along the borders are significantly poorly served as these areas lack private clinics[5], which as previously mentioned is one of the main ways to access contraceptives in Burma.

Migrant workers were often able to access contraceptives as well as women living in camps. However, most often these women do not access the products do to their religious and or cultural beliefs[2,6,7]. Many women and NGO's expressed that the location from which women receive contraceptives can impact their choice of the contraceptive used. Pharmacies in Burma do not carry emergency contraceptives (ECPs) as a result of government regulations however Thailand pharmacies do carry said product with no prescription needed[2]. In both locations women expressed a strong dislike towards receiving their contraception from pharmacies as they felt there was a lack of privacy and women were embarrassed[8].

Mobile Health Units that travel throughout Burma were said to carry very little contraceptives as their main concern was for malaria and other life-saving medications[2,9]. As a result of limited space, contraception therefore has taken a back seat. And although it was indicated that while some mobile health units are willing to pack specific contraceptives if women express a desire, most women feel a strong discomfort asking for the products[9]. Another issue regarding mobile health units was while they do travel extensive distances, they are often hesitant or unwilling to travel into conflict areas due to the significant threats it would pose, and as a result women in these areas are unable to access the contraceptives even if they did make a recommendation[2].

Private Clinics are relatively common in Burma and are one of the only ways in which Burmese women can receive contraceptives. However, a significant down side are the elevated costs associated with using these clinics[4,10,11].

Security Barriers

An elevated portion of women are required to travel in order to receive the proper contraceptives they need, however, traveling throughout the Thai-Burma border presents appreciable risks such as rape, landmines, and confiscation[5,12]. Women expressed that travelling for a contraceptive method that is needed every 3 months or less is not practi-

cal and those who were aware of the IUD found it to be a more positive option because it cuts down on cost and travel time[12].

Migrant women living in Thailand also fear traveling long distances, as it requires public transportation. Not only is transportation an expensive cost in Burma, it is also presents dangers being deported. Women explained that they could be deported if they don't have proper papers (ie. work permit) and often public transit gets stopped numerous times to check people for these therefore the risks do not outweigh the benefit in this case[5,10,13].

Educational Barriers and Socio-demographic Barriers

Women living along the Thai-Burma border expressed numerous times that misinformation and lack of awareness were of substantial barriers for them to receive the contraceptives needed. As it stands, there is no evidence-based knowledge (pinnacle of the research hierarchy) on various contraceptives and their uses. This is correlational with staff being not trained on the products and the various uses, pros and cons for various contraceptive methods. In addition, women expressed language to be a barrier at times, namely for migrants who do not speak or read Thai[4,13,14].

Furthermore, a large proportion of women were unaware that some contraceptives could be used in the prevention of diseases. Similarly, adolescent girls who have expressed that they are engaging in sexual activity as young as 13 years of age (with the average being around 18)[15] were not receiving education on sex and sexual anatomy. As a result, these young women either stated not using contraceptives or were misusing contraceptives[5,10,13].

Marital status was an additional barrier that women along the Thai-Burma border face. Culturally there are negative attitudes towards young unmarried women using contraceptives, as it is a group of products viewed as only to be used by married couples or adult women[13,15].

Discussion and Conclusion

This review sought to discover what barriers exist for women along the Thai-Burma border who seek contraceptives; six main barriers were discovered.

Work is being done by various NGO's and the United Nations to improve access to contraceptives however little to no work is being done to decrease the rights violations of these women[5]. It is my belief that if efforts were additionally focused here women would face significantly less barriers and would eventually be able to have the access to contraceptives that they need and deserve. An additional area of focus is educating workers in both Burma and Thailand, along with women, men and adolescents on the importance of contraceptive use. Education is needed to change the societal view and to make reproductive health a priority. Similarly, training tailored to conflict areas is needed, as knowledge is different and low in crisis areas.

Work needs to be done on a local and global scale to improve the situation for women in the Thailand-Burma border. There is still a serious requirement for political, and policy overhauls in order to properly train and equip frontline health workers. This should begin with education-based programs to eliminate the stigmatization surrounding the issue.

As with any research, limitations were identified in this study. The articles obtained were limited to those accessible through the University of Ottawa Search+ databases. Additionally, only studies published in English were used. The publication date ranged from 1985-November 2015, thus providing a 20-year span. This creates a limitation because data published outside this time period was rejected. Also, some selected articles published within this time span, conducted their research many years prior to publication. This time range creates the potential for outdated data. In addition, data from certain studies had potential biases affecting results. More specifically, there were studies that used self-reported questionnaires as the main sources of data, creating the potential for response bias. An additional limitation is that the research was conducted only in English.

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