

Women's Commission for Refugee Women and Children Thai-Burma Border Assessment Annotated Bibliography

Refugees living in camps: studies and reports

American Refugee Committee, *Reproductive Health Project Report. Nu-Poh Camp, Umphang District, Tak Province, Thailand, February 10-April 15, 1997, April 1997.*

This is a report by ARC's international health advisor about the RH assistance provided during the February-April 1997 emergency phase at Nu-Poh Camp on the Thai-Burmese border. The report documents the findings of the initial reproductive health (RH) Needs Assessment; the development of the second draft of STD Guidelines for Refugees on the Thailand/Burma Border; a one-day RH Awareness Course for 79 health workers; a five-day Health Worker Training Course for 14 maternal and child health (MCH) staff; the planning and gearing up of ongoing RH services; and the implementation of the Minimum Initial Service Package (MISP). Implementation of the MISP included identification of trained midwives and traditional birth attendants (TBAs); training and enforcement of universal precautions; training about gender-based violence (GBV) and emergency contraception; identification of a long-term RH Coordinator; procurement and provision of safe delivery kits; ordering of UNICEF TBA and midwife kits; establishment of a basic community health surveillance system, including RH indicators for maternal and infant mortality; establishment of an emergency system for referral of obstetric complications; condoms and other contraceptives made available; equipment and supplies for emergency obstetrics made available and manual vacuum aspiration (MVA) kits ordered. As a result, all components of the MISP were implemented at Nu Poh camp; however, although condoms were made available they were not accessed due to cultural constraints: condom use in the Karen community is believed to promote promiscuity among unmarried people. In addition, comprehensive RH services were planned; safe delivery and referral systems were established; health staff were trained on safe delivery, family planning and sexually transmitted diseases (STDs); and a surveillance and monitoring system was developed. Finally, recommendations for future actions included continued trainings for health staff, use of pictorials for staff and clients' education and a mass information, education and communication (IEC) campaign on family planning.

Centers for Disease Control and Prevention, Division of Reproductive Health, Malteser Germany, American Refugee Committee and Médecins Sans Frontières, *An Assessment of Reproductive Health Issues Among Karen and Burmese Refugees Living in Thailand, August 2002.*

This cross-sectional research study was conducted in Mae Kong Kha, Umpiem Mai and Mae La camps on the Thai-Burma border representing a total camp population of 70,480. Study objectives were to document unmet need for family planning; assess knowledge, attitude and practice (KAP) of HIV/AIDS; estimate the prevalence and magnitude of GBV; and provide data to inform RH care services. Subjects were 549 randomly selected Karen and Burmese married women of reproductive age. Family planning prevalence was 45%, with the majority using injectable contraceptives obtained from the refugee health center. Twenty-one percent of women stated that they had a tubal ligation. A conservative estimate of the unmet need for family planning was 7%. Knowledge of HIV/AIDS was 87%, resulting from the inputs of a community health education program. Only 5% of women had made a change in their behavior, such as adopting the use of condoms, that would prevent HIV transmission and 33% said they thought they had "little" to a "good" chance of acquiring HIV. Sixty-seven percent stated their intention to get an HIV/AIDS test. The prevalence of domestic violence, including verbal, physical or sexual abuse, was 20%, and 17% of those women had sustained a physical injury. All women stated that their husbands did not have the right to abuse them. The women preferred that the refugee community, rather than the health care center, address domestic violence issues. The study findings allowed the health staff to plan to identify women who could be at risk of frequent pregnancy; develop ideas for further outreach to the community on HIV/AIDS education and possibly train counselors to perform comprehensive HIV testing; and use the data to confirm violence as a community problem that needs to be addressed through prevention activities focusing on domestic violence.

Centers for Disease Control and Prevention, Division of Reproductive Health and American Refugee Committee, *An Assessment of Reproductive Health Issues Among Karen and Burmese Refugees Living in Thailand*, August 2002.

This study analyzes specific results from Umpiem Mai camp which were taken from a larger, three-camp study of the same name conducted on the Thai-Burma border (see above). Interviews were completed with 118 Karen and Burmese married women of reproductive age. Inadequately spaced multiple pregnancies and GBV were found to be the two main health problems facing Karen and Burmese refugee women of reproductive age. In addition, the study highlighted a lack of understanding regarding female sterilization and GBV. Results from Umpiem Mai camp included: a 43% use of contraceptives at the time of the study; Depo-provera was the most commonly used contraceptive, followed by female sterilization; knowledge of HIV/AIDS was 99%; 56% of women reported at least one incident of domestic violence and one-quarter of women surveyed reported violence by other perpetrators. The majority of women reporting domestic violence or violence by another perpetrator preferred to share this information with a friend or family member. This study highlights the urgent need to remove barriers to RH care (e.g., improving access to family planning services and prevention and management of GBV) so that women can avail themselves of these life-saving services.

International Rescue Committee, *April – December 2000; Final Report, Reproductive and Child Health, Mae Hong Son Province*, February 2001.

The final narrative report by IRC-Thailand on program status and activities in the Karenni refugee camps (site I/II) in Mae Hong Son province. The report provides a brief situation update on the continued conflict within Burma resulting in a steady rate of more than 1,500 refugees per month crossing into Thailand and notes a number of incidents within Thailand that has contributed to the decline of the Thai government and media's support of the refugees. The report provides RH information, including contraceptive prevalence rate (CPR) rate of 29.4%, no maternal deaths, 96.1% of deliveries attended by a trained birth attendant and ante-natal care (ANC) coverage of pregnant women at 100%. The main problem encountered by the program was the camp leaders' concern that condom usage would lead to an increased level of sexual activity among unmarried youth.

International Rescue Committee, *Karenni Refugee Camps, Mae Hong Son, Thailand: Annual Health Statistics Report 2002*, March 2003.

This report provides detailed statistics on the Karenni population residing in Ban Kwai and Ban Tractor (Camp 2), Ban Mai Nai Soi and Ban Mae Surin (camps 3 and 5, respectively). The report furnishes an overview of the population growth and movement from 1995 to 2002; a comparison of the camp population with local population; Thailand and Burma health statistics; morbidity and mortality causes and rates; and reproductive health statistics. The report noted a maternal mortality ratio of 130 per 100,000 live births (Thailand 44 and Burma 230) and an overall CPR of 25.3 percent. Three-quarters of deliveries were assisted by MCH workers and one-quarter were referred to Thai hospitals

International Rescue Committee and Burmese Border Program, *Knowledge of HIV/AIDS among Karenni Refugees in Thailand: Results of the 1996 Knowledge, Attitude and Practice Survey*, February 1997.

This KAP survey, conducted in five Karenni camps in Mae Hong Son province, found that of the 344 survey respondents, 66 percent had never heard of HIV or AIDS and only 10 of the 117 people who had heard of AIDS had entirely correct information. The study concluded that newly arrived refugees were much less likely to have knowledge about HIV/AIDS; educational materials were needed for illiterate and semi-literate people; and accurate information about HIV/AIDS was needed, especially emphasizing transmission via unprotected sexual intercourse. The study also notes that there appears to be a zero-to-low prevalence of HIV among refugee population, but the refugees are at high risk given their location.

International Rescue Committee and the Department of Community Medicine, Faculty of Medicine Chiang Mai University, *A Final Report of Knowledge, Attitudes and Practices: Health Information Survey in Karenni Camps, Mae Hong Son, Thailand*, 2001.

This study is a repeat of a previous KAP survey conducted in 1999 (see below) in three camps in Mae Hong Son province — Ban Kwai, Ban Mai Nai Soi and Ban Mae Surin camps — among a total population of 18,398. Among other general health information reported, the survey demonstrated that the refugees had fewer opportunities to access HIV/AIDS health education messages than in 1999, but the overall

knowledge about HIV among those who had received the information had improved from two years earlier. Recognition among the population about services available at the MCH clinic had improved significantly from the previous survey. However, more than half of the respondents, particularly men, still were not aware that family planning services were available at the MCH clinic and half of those who knew about family planning services had never used a contraceptive method. Recommendations included removing barriers to accepting contraception, improving male involvement in the MCH program and continuing health personnel training.

International Rescue Committee and the Institute for Population and Social Research at Mahidol University, *Knowledge, Attitude and Practices: Health Information Survey in Karenni Camps, Mae Hong Son*, April 2000.

This study was undertaken in December 1999 in three mainly Karenni camps in Mae Hong Son province among a survey population of 504 men (196) and women (308) between the ages of 15 and 49 years, representing a total camp population of 16,506. About a third of respondents had ever attended school, women were more likely to have attended school and among those who had attended school, 57 percent had primary education and 35 percent had secondary or higher education. Eighty-two percent of respondents were married with two children or more, about one-third had more than five children and about half wanted a total of four children. Respondents were aware of a number of services available at the MCH clinic but less than half knew that family planning services could be obtained there. Sixty-two percent of respondents had received information about HIV/AIDS, most from community health educators (81%), and more than 80% of people who had heard of HIV/AIDS knew that it could be transmitted sexually, by blood transfusion, from mother to child or through needle-sharing. However, a significantly smaller number knew ways to prevent contracting HIV. A little more than half of married respondents were aware of a contraceptive method, 61 percent believed family planning to be useful, only 29 percent of respondents were currently using a family planning method, and more than half reported never having used contraception. Recommendations include: provide literacy classes and income generation activities for the camp population; explore the reasons for the lack of demand for family planning services (cultural or religious constraints or unsure that children will survive); promote family planning methods so women can space their births and maintain their health; involve men in RH activities; and continue to target new camp members for health education.

Karen Refugee Committee, *Evaluation of INGO and Karen Organizations in 5 Camps*, December 2002.

This 2002 study, carried out in five camps — Mae La, Umpiem Mai, Nu Po, Mae Khong Kha and Mae Ra Ma Luang — is the only one in the region that evaluates the work of the local and international NGOs and demonstrates a valuable form of community participation. The findings showed appreciation for NGOs that have made an effort to involve and inform the community in their work. The evaluation allowed community leaders to express their opposition to sex education offered to youth and condom distribution to unmarried people. The survey also raised a concern that refugees may not clearly understand that sterilization is a permanent contraceptive method.

Khin, Yuzana, *Assessing Adolescent Reproductive Health in the Karenni Refugee Community, Mae Hong Son, Thailand*, May 2002.

This study assessed knowledge, attitudes, beliefs and behaviors of the Karenni refugee population about adolescent RH, focusing on unprotected intercourse, safe motherhood, STI/HIV/AIDS and violence against women. The study was conducted in Camp 2 (Ban Kwai and Ban Tractor) and Ban Mai Nai Soi. This student thesis also provides a background literature review on adolescent RH, the experience of refugee youth, history on the refugee RH movement and RH issues for adolescent refugees. Participants included adolescents (who made up 9 of the 33 focus groups), religious leaders, parents, youth groups, medical staff, teachers, leaders, members of the Karenni Women's Organization and IRC staff. Barriers to accessing RH included shyness, the perception that RH was only for married couples and lack of same-sex providers. Education level, marital status and religious affiliations were important determinants of RH knowledge and behaviors. Causes of violence against women included alcohol abuse, financial problems and stress. The author recommended that IRC develop youth-friendly RH information and services.

Lambert, Caroline and Pickering, Sharon, *Domestic Violence on the Thai-Burma Border: International Human Rights Implications*, Forced Migration Review, May 2003.

This article focuses on domestic violence against women living in camps, highlighting both the potential and the limitations of human rights standards in bringing change to women's lives. In particular, the article emphasizes the lack of recourse Burmese refugee women have to hold any state actor accountable at the national level for human rights violations and notes that even in the camps women lack representation on camp committees which are the de facto state actors at the local level providing food, health care and education.

Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T, October 2002.

This report documents the findings of an independent consultant's evaluation of PPAT's RH projects in Mae La and Umpiem Mai camps and offers recommendations for the future. PPAT's RH services were found to be accessible, efficient and friendly. In regard to outreach services, PPAT has provided training courses for women, men and youth on a range of RH issues. It is recommended that GBV be added to training courses as key informants noted cases of rape of Karen women by Burmese soldiers or by intimate partners. Men participating in PPAT's RH trainings realized the importance of birth spacing but continued to desire large families and most would not accompany their wives to the PPAT clinics, demonstrating the need to target younger men who showed particular interest in gaining further information on topics such as HIV/AIDS. The main project constraints noted were the need for an onsite physician and more attention to diagnosing and treating STIs. It was still essential to increase understanding among the Karen of the importance of providing education to adolescents about RH and to dispell the myth that providing them with condoms would lead to promiscuity among youth. In addition, GBV should be added to training curriculums and addressed more openly in the camp to show support for survivors and to aid prevention activities. Sexually transmitted infections (STI) prevention, diagnosis and management needs to be improved, continued staff training is required, and program monitoring and evaluation of family planning program should be increased. The consultant found that the project was not ready to be turned over to the camp staff and still required support from PPAT and the Thai-Karen staff. The project has also served Thai residents living near the camp and has thus initiated a new project to address the needs of the local community as well.

Planned Parenthood Association of Thailand (PPAT), *Baseline Survey on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention Among the Refugees in Mae-La Camp, Tak Province, December 1999*.

This baseline survey of 931 women 15-45 years old, youth and men was conducted prior to the project design phase of PPAT's RH and family planning program in Mae La refugee camp. The study explored the respondents' socioeconomic history and status and their knowledge about RH, including maternal and child health, family planning (not including emergency contraception), STI/HIV/AIDS and cancer, and sought respondent suggestions for addressing RH. Key findings indicate that 78 percent of households have four or more members while nearly one-third have seven or more members. Just over one-quarter of women, one-third of men and one-half of youth have had primary school education. Approximately five percent of men and women and ten percent of youth have had secondary school education.

More than three-quarters of women, men and youth agreed on the use of contraceptive methods for child spacing and more than half of men and women reported that they did not want more children, while only 23 percent of women were reportedly using contraceptives. Knowledge about contraceptive methods varied between women and men, with women more aware of sterilization, injections and pills, and men more aware of condoms, pills, injections and tubal ligation, respectively. Approximately 20 percent of women knew of a married woman who had an abortion, while nine percent of youth had heard of unmarried youth having abortions. More than half of women and men and two-thirds of youth were not aware of the dangers of unsafe abortion. In addition, more than half of respondents have some knowledge of HIV and its prevention, particularly that it is transmitted sexually; however, there is some misunderstanding. For example, eight to ten percent of respondents thought that masturbation can lead to HIV/AIDS. Seventy percent of women and 60 percent of youth did not know about STIs. Seventy percent of respondents said that community leaders should be involved in planning PPAT activities (subsequently the community expressed much appreciation for this); Karen language should be the working language of the project; refugees tend not to use contraception because of their desire for more children; and income-generating activities are needed in the camps.

Planned Parenthood Association of Thailand, *Focus Groups on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention among the Refugees in Mae-la camp, Tak Province, January 2000.*

PPAT conducted focus groups among 106 respondents, including youth, community and religious leaders, and married and unmarried men and women of Buddhist, Christian and Islamic background, each addressing a range of issues such as family planning, ANC and safe delivery, cancer prevention and treatment, STIs/HIV/AIDS, RH media dissemination and youth issues. The focus groups revealed that young people know where to access contraception but need to improve their overall knowledge of family planning. Community leaders support family planning activities, while there was varying support for family planning among religious leaders. Men and women not using family planning were less knowledgeable about contraceptive methods than current users of family planning and also had experienced negative side effects and heard rumors that using contraception could prove fatal. Islamic men and women who used contraception did so discreetly because they said it conflicted with their tradition. All respondents stated the value of antenatal care and the importance of women delivering at an equipped health center. Different groups noted that it is difficult for some women to walk to the hospital, some women are ashamed to be seen by a doctor, and the cost of services can be an obstacle to accessing services. Due to these barriers, some women continue to deliver at home with the help of neighbors. There was varying knowledge of cancer prevention and treatment among all groups and the cost of services was an issue. Young men were more knowledgeable than young women about STIs; however, all young respondents were aware that using a condom prevents transmission of HIV/AIDS. Many of the focus groups respondents were familiar with HIV/AIDS and had seen people infected with HIV. Some respondents noted that those who "party in town" and do not use condoms may return to the camp infected. The groups provided a variety of ideas for supporting youth activities in the camp. Young people themselves stated that, "They have no definite role." All groups mentioned the effectiveness of video tapes in Burmese and Karen or simple posters as effective methods of spreading information in the camp.

Planned Parenthood Association of Thailand, *Reproductive Health and Family Planning Services for the Karen Refugees from Myanmar Union in Tak Province, December 1999-2001, December 2001.*

This summary report describes PPAT's RH project plan for Mae La and Umpiem Mai refugee camps, survey results from an RH assessment undertaken among Mae La camp residents in December 1999 (noted earlier in this bibliography) and a summary of activities carried out in the first year of this 3-year project. PPAT project objectives are to provide general RH and STI/HIV prevention information, family planning information and services, pap smears, breast cancer screening, postpartum care, STI treatment, counseling and medical advice, HIV testing, and RH information and services to adolescents through peer education and counseling services. First year project results note establishment of clinical services, conducting of trainings on various topics, including male involvement and adolescent RH, participation of community leaders in RH activities, support to women's subcommittee and conducting of home visits to provide family planning services, among other activities.

People living in refugee-like circumstances and migrants: studies and reports

ALTSEAN, *Abused Bargaining Chips. Women's Report Card, March 2003.*

This concise summary of the situation of women of Burma, including those within and outside its borders, from mid-2001 to January 2003, reveals how the ruling Burmese military regime manipulates its representation to the international community while inflicting and condoning massive human rights violations against women and girls. The report describes the status of women and politics in Burma, addresses gender-based violence, trafficking, forced labor, health, including reproductive health, education, as well as the particular vulnerabilities of women displaced outside its borders. Rape of women, primarily perpetrated by members of the Burmese military, is reportedly endemic and often accompanied by further violence and torture, such as beating, suffocation, mutilation and murder. Other gender-based violence, such as sexual exploitation and molestation, is also widespread, while women are forced into silence for fear of further retribution by authorities.

The authors report that between 220,000 and 400,000 people are currently living with HIV/AIDS in Burma, while multiple factors, such as lack of women's awareness about HIV/AIDS, high mobility, sex

work, low contraception use and trafficking to name some, put women in Burma at increased risk of HIV/AIDS. Programs to inform and educate women about HIV/AIDS are constrained by both political (information restriction) and cultural barriers that only condone sex among married women, limiting education and information to them.

Women's access to health care in Burma is reported as woefully inadequate and of vital concern for internally displaced persons and migrant workers. The authors cite an April 2001 UNICEF report that shows that more than one-third of women in Burma do not have access to reproductive health services and these incomplete services are limited to maternal care. Despite this focus, they report that UN research shows, maternal mortality (580 per 100,000 live births) and perinatal mortality rates, particularly among adolescents (46-67 per 1,000 live births) are high. The authors report that 50 percent of townships in Burma lack birth spacing and contraception services. In addition, they report that there are 750,000 illegal abortions per year in Burma and complications from the result of unsafe abortions contribute to approximately 50 percent of maternal deaths in Burma. The authors also report the significant problem of unsafe abortion among women from Burma in Thailand. Citing research by Suzanne Belton in one clinic in Tak Province, Thailand, that serves a beneficiary population of approximately 150,000 people from Burma, the clinic provided post-abortion care services to address complications of unsafe abortion for 457 Burmese women in 2001. Belton further suggests the number in the area is likely higher, given that most women deliver, as well as perform abortions, at home, with midwives or abortionists. The authors emphasize the clear and urgent need for women's access to good quality birth spacing services, including as an essential component of post abortion care.

The report provides both specific and general recommendations for governments, particularly the Burmese State Peace and Development Council, United Nations organizations, nongovernmental organizations, donors and others, along with suggested action steps for readers.

Asian Research Center for Migration (ARCM), *Cross-border Migration and HIV Vulnerability in the Thai-Myanmar Border Sangkhlaburi and Ranong*, March 2000.

This comprehensive report of quantitative and qualitative studies was undertaken, as explicitly stated by its authors, among voluntary migrants in Sangkhlaburi district in Kanchanaburi province and Muang District, Ranong province. The studies in this report are a component of a larger research study by the Asian Research Center for Migration (ARCM) in eight sites along Thailand's borders with Burma, Cambodia and Malaysia. The two additional sites on the Thai-Burma border are Mae Sot, Tak province and Mae Sai, Chiangrai province. The purpose of the research, initiated in December 1998 with survey data collection in Sangkhlaburi in March 1999 and in Muang district in April 1999, is to provide local, national and international service providers, policy makers, donors and others with contextual information about migrant's living situations and pre-migration, migration and post-migration patterns in these areas, migratory processes and migrants' knowledge, attitudes and practices about HIV/AIDS. The overall aim is to identify the migrant populations' vulnerability to HIV/AIDS and improve HIV prevention programs designed for migrant populations in these areas. The report is included in this bibliography because of its direct relevance to forced migrant populations and the difficulties in distinguishing people that have decided to leave extremely harsh living conditions due to economic destitution or human rights abuses owing to political repression, from people who electively cross a border to pursue economic opportunities.

Sangkhlaburi and Muang sites were selected based on the high level of cross-border traffic and existing information about HIV/AIDS transmission in these areas. The basis of the research is a structured questionnaire supplemented with qualitative research. A knowledge, attitude and practice (KAP) questionnaire included 327 respondents in Sangkhlaburi and 436 respondents in Muang of reproductive age with purposive selection of respondents' gender and occupation (with the exception of transportation workers, military, police and government officials) to complement the proportional ratio of national data for migrant laborers in Thailand, which is just over two-thirds male and one-third female. The report includes a brief literature review and background information, such as a local geography, people, culture, trade and economy, migrant travel routes, health services and HIV/AIDS situation in each of the study sites. In addition, the report details, summarizes and compares site-specific findings. It also offers specific and general recommendations to guide local and national strategic planning and policy development.

ARCM reports that there are 20,000 migrants, primarily Mon (43 percent) and Karen (36 percent) with some Burmese (16 percent), comprising almost twice the local Thai population (11,606) in Sangkhlaburi district. Approximately 50 percent are registered migrants and the majority have lived in the district with their families, availing themselves of Thai services, including school for their children, for more than five years and do not plan to return to Burma. The authors point out that migrants in Sangkhlaburi have somewhat close cultural similarities with the Thai population and are perhaps more welcomed by Thais in this area because of this. The overwhelming majority (75.5 percent) of respondents indicated that they cross the border to Thailand to seek employment, while 8.4 percent reported that they were escaping war. Migrants are employed primarily in agriculture (58 percent) but also find work as laborers, maids, fishermen and construction workers. While women represent 39 percent of migrant workers, they also travel to Thailand and live with their husbands and families without gainful income.

The authors report that migrant women's combined lower socio-economic status and limited knowledge of HIV/AIDS increase their vulnerability to HIV/AIDS. Researchers learned that knowledge of HIV/AIDS is low and there are great uncertainties about HIV/AIDS, particularly among migrants with lower incomes who are often employed in agriculture and the fishery industry. There are also widespread misperceptions about HIV/AIDS predisposing migrants to stigmatize persons living with HIV/AIDS (PLWHAs). Commercial sex work (CSW) is not common in the district and when it does occur, it primarily involves indirect sex workers (women who may or may not receive cash for sex but receive benefits in other forms and are often employed in the commercial entertainment versus brothels) and clientele, such as Thai uniformed men and officials, traders, truckers, wealthy residents and, rarely, migrants. However, 22 percent of migrants engage in casual sex and condoms are infrequently (12.5 percent) used. Injecting drug use was reported by 3.4 percent of respondents with more than 50 percent sharing needles. These behavior patterns lead the authors to conclude that there is a slow but certain HIV transmission in this population. The majority (88 percent) of respondents are aware of health services and access government health facilities as well as the Christian missionary hospital.

The authors report that at the time of this study there were 77,500 primarily Burmese (57.7 percent) migrants but also Mon, Tavoy and Karen, just several thousand more than the local Thai population, in Muang District of Ranong. Nearly half of the migrant population has lived in Ranong for more than three years and unlike Sangkhlaburi district, almost all intend to return home after they have saved a sufficient amount of money. The authors indicate that unlike Sangkhlaburi, cultural differences between Thais and Burmese may result in less favorable attitudes toward migrants in this area, including by authorities. Children are not officially allowed to attend Thai schools and public health services are not well accessed. The migrants in Ranong tend to live in Burmese communities when their employment allows for it and are therefore more isolated from Thai communities. Just over one-third of migrants in Ranong have jobs in fishing or related activities while others work in the service industry, agriculture, manufacturing, construction and sex work. Migrant women in Ranong represent a similar (38 percent) proportion of migrant workers as Sangkhlaburi district, and are employed in a variety of settings, including commercial sex work and nightclubs.

As with Sanghlaburi district, a number of women have also traveled to Thailand with their husbands and families and are not employed. Researchers learned that migrant women in Ranong also had low knowledge about HIV/AIDS and combined with their poor socioeconomic status, are at increased vulnerability to HIV. Unlike Sangkhlaburi, Ranong has a flourishing sex industry, despite the Thai government's closure of brothels in the early 1990s. Moreover, researchers found that migrants engage in variety of sexual relationships, including with regular partners, casual partners and CSWs. Condom use was found to be very low and only used regularly 60 percent of the time in CSW, 30 percent of the time during casual sex and only 2 percent of the time with regular partners. Respondents to the study indicated that the main reason condoms were not used was due to condom costs and lack of availability.

World Vision Thailand (WVT) initiated HIV/AIDS awareness in Ranong in the early 1990s and has been largely successful with increasing knowledge about HIV/AIDS among CSWs and fishermen; however, their work was not found to result in significant safe sex behavior changes among these migrants. In addition, ACRM researchers report that there are approximately 500, mostly Burmese, indirect sex workers who engage with Burmese, Thai and foreign clientele, who drink alcohol and frequent the

entertainment venues where they work. ACRM researchers conclude that there is both rapid and slow transmission of HIV in Ranong, with rapid transmission occurring among CSWs, their clientele and injecting drug users, as well as a slower HIV transmission occurring in the population through unsafe sex among casual and regular partners. In addition, the authors report that misperceptions about HIV/AIDS are also widespread in Ranong, increasing the HIV vulnerability in the community and promoting stigmatization of PLWHA. Finally health services were reported to be difficult to access and only pursued as a last option due to migrants' illegal status, costs and language barriers combined with a lack of funding at the district hospital to encourage migrants to avail themselves of preventive services. While WVT does provide primary health care (PHC) services at its clinic, its beneficiary population only represents approximately 20 percent of the migrant population in Muang district.

ARCM's specific recommendations include workshops organized at the local level in both Sangkhlaburi and Ranong. They suggest that the workshops should include representatives from the migrant population; police, immigration, health, labor and social service officials; and civil society groups and NGOs to discuss the findings and recommendations of this study. The authors also suggest the workshops provide an opportunity to plan for the development of local working committees to improve health services for the migrant populations. The local working committees should comprise members of similar representation as the workshops and have the capacity to fundraise with a view toward public and private-sector partnerships, while receiving support from the provincial and national level. The authors also recommend that the Thai public health service address some of the known barriers to migrants' access to health care by developing creative financing schemes, hiring interpreters to address language barriers, coordinating activities with NGOs and involving the private sector. The ARCM authors also recommend in general, employer/private sector involvement in addressing the health and human rights of migrants. To prevent further stigmatization of high-risk groups, the authors suggest focusing on high-risk behaviors and targeting several high-risk populations in the same site. Finally, a specific recommendation is put forth for a national-level committee to develop strategic planning for migrants and provide technical and fundraising support to improve health services for migrants.

ARCM's general recommendations include: improving migrant's legal status; creating an enabling environment to improve migrants health by working with local immigration, military and border police; developing monitoring and evaluation systems for HIV/AIDS programs; improving public health services for migrants; addressing the needs of vulnerable Thai populations on the border; implementing cross-border mass media campaigns; and advocacy initiatives by local and national committees to raise awareness in support of migrants' health and well-being.

Back Pack Health Worker Team, *Reproductive Health Survey*, 2002.

The Back Pack Health Worker Team (BPHWT) provides health care to IDPs living in rural conflict areas of the Burmese border region. They conducted an RH survey of 1,169 women among this population between June and December 2002 to learn about knowledge, practices, attitudes and resources related to the RH of the IDP women. The findings include: the average IDP woman has 4-5 pregnancies in her life and 3 living children, with her first pregnancy by the age of 20; only 35 percent were aware of the importance of ANC; 79.2 percent cannot recognize the warning signs of pregnancy; just 16.5 percent deliver with skilled attendants and 77.7 percent deliver at home with traditional birth attendants (TBAs). Nearly two-thirds of women initiated breastfeeding within the first hour after delivery with their most recent pregnancy.

Most of the IDP women are illiterate and unable to count; they are unaware of their ovulation cycles and only 17.3% know about three or more methods of birth control. Forty-one percent of women in this study reported that they do not want more children and the majority of them (59.8 percent) reported not using contraceptives for the following reasons: breastfeeding (21.9 percent), fear of side effects (15.3 percent), prohibitive costs of methods (10.4 percent), husband's objection ((7.3 percent), religion (5. percent) among others. The birth control pill (8.9 percent) and Depo-provera (10.4 percent) were the most common currently used birth control methods.

The report shows that early marriage and adolescent pregnancy is common, with over two-thirds of youth married by 20 years of age and more than a fifth of girls having reported their first pregnancy by 18 years

of age. Approximately one-third of women reported at least one spontaneous abortion. Ten percent of women reported induced abortions, with 18 percent not responding to the question or stating they did not know. While just over one-third of abortions were performed by TBAs, an additional one-third of women said they did not know who performed the abortion and 17 percent were reportedly self-induced. Discussion of RH issues is generally taboo, although one-third of women agreed that unmarried youth should receive information about family planning before marriage.

Belton, S. and C. Maung. *Fertility and abortion: Burmese women's health on the Thai-Burma border*. Forced Migration Review www.fmr.org Issue 19, January 2004.

See <http://www.fmreview.org/FMRpdfs/FMR19/FMR1917.pdf>

This article presents the findings and conclusions about fertility and abortion among Burmese women living in Thailand as documented and undocumented migrant workers who live in refugee-like circumstances on the Thai-Burma border. Conducted from 2001-2002, the research methodology involved a retrospective medical record review of 185 Burmese women who attended the Burmese-run Mae Tao Outpatient Clinic for the complications of abortion in Thailand near the Burma border. In addition, a record review of 31 women with serious post-abortion complications who were admitted to the local Thai hospital as inpatients was conducted. Semi-structured interviews with 43 women receiving post-abortion care in Burmese and Thai health facilities were collected. Traditional and modern health workers, spouses and community members also contributed to complete the analysis of fertility and abortion in this site.

Among the key findings by the researchers are that most women in the study are married, two-thirds have children and one-third have had five or more pregnancies. In addition, abortion and menstrual regulation are considered traditional birth control by most women and lay midwives, although it is illegal in Burma and Thailand unless the women's life is in danger. Thai law is slightly more liberal in that if a woman can prove she has survived incest or rape she may request a legal abortion, but for Burmese women who live on the margins of Thai society this is impossible. Some women seek abortions because they are fearful of losing their jobs and feel forced by husbands and employers, while others cite domestic violence as influencing their decision. Women in this study were found to self-induce abortions (at least 25 percent) or seek an untrained abortionist to end their pregnancies with international and Burmese medicines. Drinking ginger and whiskey, inserting objects such as sticks in the uterus and intense pelvic pummeling are common methods used to induce an abortion. While women at the Mae Tao Clinic receiving post-abortion care (PAC) are offered temporary and permanent contraceptive methods, women receiving PAC at the Thai referral hospital are not offered temporary contraception education or methods, though some women were found to have been offered tubal ligations.

The authors conclude that good quality family planning and contraceptive services are acceptable to Burmese women and recommend that the Thai government implement community outreach programs to migrant workers and others living in refugee-like circumstances. In addition, public health facilities should place Burmese workers in public health facilities to improve communication with Burmese PAC inpatients and ensure that they are offered counseling, education and range of modern contraceptive methods.

Belton, Suzanne, *The Roses Stink From Here! Female Labour and Fertility on the Thai Burma Border*, International Association for the Study of Forced Migration, Panel: Idea in Progress, Sub theme: Forced migration and human rights, Chiang Mai, January 5-6, University of Oxford, Refugee Studies Centre, 2003.

This unpublished conference paper highlights the human rights abuses, including gender-based violence, experienced by Burmese women in Burma and Thailand and the lack of culturally acceptable and accessible health services for Burmese migrant women, including those living in refugee-like circumstances in Mae Sot, Thailand. The research focuses on fertility, unwanted pregnancies and unsafe abortions. The author shares findings from research conducted at the Mae Tao Clinic and Mae Sot hospital from 2001-2002 and annotated above in the article, *Fertility and abortion: Burmese women's health on the Thai-Burma border* published by the author in Forced Migration Review number 19 in January 2004.

Qualitative findings from the research are shared in this paper through multiple vignettes that provide insight to the extreme hardships in the daily lives of the women. The short stories vividly describe the

social and economic human rights abuses faced by Burmese women in Thailand in relation to their limited reproductive decisions and subsequent poor health outcomes. Many women described the dire economic situation in Burma that compelled them to cross the border to work in Thailand often in exploitative circumstances with minimum wages, while others describe exploitation and abuse by the government of Burma such as excessive taxes and forced labor. Some vignettes reveal Burmese women's lack of awareness and knowledge about reproductive health, particularly family planning, and the dangers of unsafe abortion, as well as barriers to accessing health care in Thailand.

Belton, Suzanne, *Unsafe Abortion and its Prevention: Who cares?* Health Messenger. March: 46-53, 2003. This article addresses the economic, legal, social and religious influences that surround the issue of unsafe abortion among Burmese women in Thailand. It begins with a story about 32-year-old Ma Win Kyaw, a Buddhist woman from Karen State, who suffers from the consequences of an unsafe abortion. The story highlights the pressures that Thai employers and husbands have placed on women who are found to be pregnant if they desire to maintain their employment. Ma Win Kyaw uses the herbal medicine Kathy Pan, commonly purchased by woman as a de facto contraceptive or abortifacient at the local market, despite its unknown efficacy. Without result from the use of Kathy Pan, Ma Win Kyaw returns to the market and is directed by a woman there to see an old woman (*aporgee*) who can help her. The old woman induces an abortion by inserting two bent sticks from a tree into Ma Win Kyaw's uterus. Later Ma Win Kyaw, suffering from pain, fever and heavy bleeding, is transported by her husband on the back of a bicycle to a clinic where she is treated for an induced inevitable septic abortion. The author points out that Burmese women, risking their life and fertility, often seek to end their pregnancy due to their economic circumstances. The article includes statistics from the Mae Tao Clinic in Thailand which show that the number of Burmese women receiving post-abortion care remains relatively stable, at around 500 each year, but is still a considerable burden of disease. While approximately three-quarters of the women treated at the Clinic were suffering from complications of spontaneous abortion, one-quarter of the women were treated following induced abortion. The author shares that there are reportedly some 20 different non-modern methods of contraception, primarily used by Karen, and 5 different modern methods of known contraceptives, with some of them on sale in the local market.

Belton, Suzanne (as Ma Suu San), *Lady's Love Powder. Burma — Women's Voices for Change*. Thanakha Team. Bangkok, ALTSEAN, 2002.

This brief article calls attention to commercial products, particularly Lady's Love Powder, which can be found in the local market in Burma in a package with a semi-nude provocative photo of an Asian woman on its cover, that, according to the English version of the instructions, could mislead women into believing they are treating a vaginal infection or preventing pregnancy, though the author notes the Burmese instructions do not include this claim. This product and another one, called Kathy Pan, advertised on Burmese television, commonly taken to ostensibly regulate menstruation, are discussed in relation to the problem of sexually transmitted infections among Burmese women, the magnitude of unwanted pregnancies, unsafe abortions and the subsequent complications resulting in significant morbidity and mortality among Burmese women in Burma and Thailand. The author notes that the abject poverty of Burmese women in Thailand and the Burma border area and their lack of resources to purchase effective modern contraception contributes to poor reproductive health outcomes.

Beyrer, John, Unpublished report, *The Health and Humanitarian Situation of Burmese Populations Along the Thai-Burma Border: A Report on Current Status*, Johns Hopkins University School of Hygiene and Public Health, 1999.

This report focuses on the health and humanitarian situation among Burmese populations living in Tak Province, Mae Hong Son and Chiang Mai provinces on the Thai-Burma border in 1999. The author calls attention to the growing and changing demographics of the population of migrant workers and refugees without official status in Thailand in comparison to the established and stable camp populations in Thailand, as well as IDPs in Burma. Unofficially, the Thai Ministry of Interior acknowledged that up to 1.2 million Burmese migrants were living in Thailand in 1998 and registered Burmese migrants represented less than a quarter of the population at the time. The author reports that while little is known about the numbers of IDPs in the Naga Hill, Chin States, Arakan and Central Burma, the number of IDPs in the Thai-Burma area was estimated to have grown to 400,000. The author further states that while the influx of migrants and others living in refugee-like circumstances in the mid-1990s was primarily young Karen

and Shan fleeing SPDC conflict from their respective States in Burma, in the late 1990s extended migrant families were now fleeing from human rights abuses and exploitation, such as forced labor, excessive taxation, corruption and loss of land and livelihoods in the SPDC-controlled cease-fire areas of Moulmein and Thaton in Mon State, Irrawaddy Divisions, Bassien and Arakan.

The author describes the health and humanitarian challenges for this growing population as staggering, with humanitarian needs that cross all sectors, including protection, shelter, water and sanitation, food and nutrition, education and health. Migrants who found full- or part-time employment in Thailand were primarily laboring long hours for survival wages in factories and agricultural settings while living in overcrowded, unsanitary and exploitative conditions at the work site in order to prevent arrest, imprisonment, excessive fines and or deportation, due to their illegal status. The author identified the major health problems for this population to be childhood illnesses, gender-based violence, with many young women fearful of rape, harassment and unable to refuse the sexual advances of employers, as well as unsafe abortion due to a lack of family planning. The author reports that the major health problems among IDP populations include malaria, diarrheal diseases, obstetric emergencies and war injuries such as from land mines. In addition, apart from the backpack health worker teams of indigenous health workers providing cross-border assistance from Thailand, IDP populations on the border area are not receiving aid.

The author states that while early approaches to care were once focused on outreach to young people involved in the armed struggle, the current needs in Thailand are focused more on health, including reproductive health issues among destitute families struggling to survive in manufacturing and agricultural settings. Policy options to aid the plight of the migrants and IDPs recommended by the author include: exerting pressure on Thai authorities to halt, as well as, to hold Thai authorities accountable for, widespread exploitation and abuse of Burmese migrants, including gender-based violence of Burmese women and girls; in collaboration with Thai authorities, increase overall aid to migrant workers and their families; and expand and support cross border programs implemented by indigenous health workers.

CARE International, *Border Areas HIV/AIDS Prevention (BAHAP): Activities and Outputs of the Border Areas HIV/AIDS Prevention Project*, March 2001.

This is the final summary report of a project that took place from 1997-2000 in the border areas between Cambodia, Laos, Thailand and Vietnam. The project aim was to reduce the spread of HIV/AIDS and STDs among both mobile and host populations in these border areas by reducing risk behaviors through attitudinal and behavior change and the reduction of contextual risk factors common in border areas. Strategic objectives of the project included developing rapid assessments tools, implementing pilot HIV/AIDS/STD projects, strengthening local capacity to implement HIV/AIDS/STD prevention programs and developing project models for working in border areas. This report includes: a description of project activities; findings from site assessments; identified target groups and project interventions to address STD/HIV/AIDS attitude and behavior changes; specific initiatives to mitigate the impact of contextual risk factors; capacity building outcomes; model approaches for implementing HIV/AIDS/STD prevention programs; and identified project successes, constraints and lessons learned. Key BAHAP activities included use of peer and community educators, condom promotion and distribution, development of a large number of information, education and communication (IEC) materials in local languages, special events, public campaigns and cross-border meetings and events.

Project sites in Thailand were Chiang Kong district in Chiang Rai province and Klong Kai district in Trad province. The site assessment in Chiang Kong led to the selection of youth as the primary target group. Undertaking a youth group networking strategy, project facilitators identified youth leaders and conducted life skills trainings. Members of an in-school youth group called "Kee Mieng" emerged as a lead group within the network and subsequently implemented community outreach activities, primarily through drama, to peers, community members and cross-border in Laos. Another major activity emerging from the Youth Network was a group of Condom Youth Volunteers who undertook condom distribution. In Klong Yai, a planned HIV/AIDS/STD prevention IEC campaign with undocumented Cambodian migrants was abandoned due to the migrants' lack of participation in pre-event planning, reportedly related to fear surrounding their illegal status. Small participatory learning outreach sessions were deemed more successful in affecting attitudes.

Among the author's lessons learned and recommendations are to: strengthen local partnerships and capacity at border areas before building regional involvement; expand project life to 4-5 years; seek creative solutions to language barriers; obtain adequate funding not only for project activities but information sharing between sites and countries, identify clear target groups and their specific risk behaviors; collect existing knowledge and conduct in-depth baseline studies instead of site assessments; and partner with gatekeepers such as employers, immigration officials and brothel owners who are extremely important in reaching populations such as seafarers and sex workers.

The BAHAP team produced 27 reports and research publications. Many cross-border interventions have continued after the project ended.

CARE Thailand/Raks Thai Foundation, *Migrant Workers and HIV/AIDS Vulnerability Study Thailand*, September 1999.

The report of a study conducted with Burmese migrant workers in Samutsakorn and Samutprakarn provinces, Cambodian workers in Trad province and the general border situation in Chiang Kong District, Chiang Rai province. CARE Thailand/Raks Thai Foundation undertook this participatory research, collecting extensive quantitative and qualitative information, in the first of two phases of an AIDS prevention program among mobile populations in Thailand. Phase two involved the development of interventions to improve awareness and behaviors to prevent the transmission of HIV/AIDS among mobile populations. Researchers collected secondary data, conducted key information interviews, group discussions and a non-random self-administered questionnaire from August to October 1998. Recognizing particular challenges with language differences among migrants, the CARE Thailand research team employed three Burmese staff to develop the study tools and strategy. Other challenges researchers encountered during the study period included: the sensitivity of the sexual content for respondents; the sharp decline in the economy reducing the number of migrant workers; crackdowns by immigration and police and illegal migrants' fear of arrest; and lack of privacy for private meeting places due to migrants' overcrowded living arrangements. Most migrants sought work in Thailand for economic reasons, while some reported fleeing forced voluntary labor for the government.

One Burmese migrant study site was among approximately 23,000 migrants in two settings, Talud Kung (Prawn Market) and Wat Hong (Hong Temple), in Mahachai Tumbol, Muang District in Samutsakorn province, located on the Gulf of Siam just southwest of Bangkok. The other study site was among 3,000 migrants working in the seafaring industry in Sapan Pla and Wat Samut Jehi in Samutprakarn province, southeast of Bangkok.

The study showed that migrants in Samutsakorn and Samutprakarn are a diverse group of Mon, Burman, Kayin or Pa-O ethnicity from both urban and rural areas of Burma. The researchers note that Migrant's origin and language could affect migrants' access to HIV/AIDS prevention and care activities. For example, some ethnic groups may not understand Burmese and most migrants do not understand Thai unless they have been in the country for many years. The majority of migrants had at least primary level education, with the majority also reporting higher levels of schooling. The self-reported illiteracy rate of 7-13 percent in Samutsakorn and Samutprakarn, respectively, was higher among women (15 percent) than men (4 percent). Over 50 percent of the population was single or separated from their spouse. Focus group participants reported traveling to and from Myanmar for special events or holidays with the assistance of agents to negotiate border patrols. The majority of the respondents were aware that gonorrhea, syphilis and HIV/AIDS were sexually transmitted infections (STIs). Further, many understood other major modes of HIV/AIDS transmission, such as sharing needles; however, the researchers identified significant misconceptions, such as a belief that HIV/AIDS could be transmitted by sharing clothing or by mosquito bites and from a toilet. Migrants reported receiving information about HIV/AIDS primarily from Myanmar and less in Thailand, and that no agency was providing health education to them. The majority of migrant workers reported that people who have sex with commercial sex workers, multiple partners and intravenous drug users are more likely to get HIV/AIDS. However, less than 50 percent of respondents believed they could get HIV/AIDS while only 11-17 percent believed they could get HIV/AIDS from their spouses or boyfriends/girlfriends. Less than one-third of respondents reported ever using a condom before, and most had used condoms to prevent STIs while fewer (7 percent) of female

respondents reported using condoms for contraception. Most reported that condoms were not used because they diminished feeling; however, others reported they were unable to obtain condoms.

Risky behaviors identified by the researchers include sexual relations with commercial sex workers, multiple partners, with 20 percent of respondents in Samutsakorn reporting they had sex with more than one partner in the previous three month period, youth freedom and lack of control over their relationships, lack of social constraints over use of brothels in Thailand and Myanmar, very limited condom use among marital partners. The researchers also learned that migrants use a hierarchy of health-seeking behavior, often beginning with traditional practitioners, friends and peers, as well as obtaining drugs from local pharmacies. If these are not successful, the migrants will seek care next from private clinics and hospitals, accessing the government hospital as a last resort. Generally, migrants exhaust less expensive care first and cite language barriers, costs and fear of arrest as reasons for this approach.

The authors summarize the vulnerabilities of migrant populations to HIV/AIDS to include: language and health care access barriers; illegal status; misconceptions about HIV/AIDS; negative attitudes about condom use and limited access to condoms; the young age of men and separation of spouses including among seafarers long at sea; ease of access to commercial sex workers. The authors conclude that there is a need to develop culturally appropriate information and education in relevant local languages targeted to migrant workers and suggest that this could be integrated with a broader package of reproductive health services with referral mechanisms that link community services to relevant government services. The researchers further recommend increasing migrants' access to treatment for STIs; establishing community-based networks of volunteers, including youth networks with HIV/AIDS education and condom promotion and distribution schemes. Finally, the authors recommend that future research should focus on effective information messages for target groups such as youth or women; and in-depth research on migrants' use of brothels and STI/HIV infections among youth.

Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, Mahidol University, 2000.

This report addresses the issue of undocumented migration from Myanmar to Thailand. The number of people involved in that migration flow comprise one of the largest migration groups in South-East Asia; the study estimates that as many as five million migrants have moved within Myanmar and out of the country in the previous 10 years. The study, conducted in 1998 by the Institute for Population and Social Research at Mahidol University, provides the sociocultural, political and economic context in Thailand and Burma, and the structural, relational and individual constraints that migrants face in Thailand, to focus on the life experiences of female migrants in terms of sexuality, reproductive health and violence.

The research was implemented in Chiang Mai, Samutsakorn and Ranong provinces among 15- to 50-year-old women and men who left Burma anytime from 1988 to 1998 and did not possess a Thai identification card. Data was collected in two phases, beginning with formative research that included observations, in-depth interviews and focus group discussions among 147 participants. The qualitative assessments were followed by a quantitative survey of 418 participants living and working in fish processing, sawmills and plantations in Ranong and an additional 409 participants working in small factories, construction and the service industry in Chiangmai. Researchers were unable to collect quantitative data from the study site in Mahachai district, Samutsakorn province for security reasons.

The study indicates that while most migrants were landowners and held jobs in Burma, due to extreme economic hardship, political violence and threats to their security which participants viewed as interconnected, they crossed the border and planned to stay in Thailand, despite their anticipated difficulties, a lack of economic gain and exposure to further human rights abuses. Most migrants were illiterate or had attended less than four years of formal schooling with significant regional variations and gender disparities. Once in Thailand, migrants tended to stay in the same province, although construction workers in Ranong moved frequently within the province for their work. Moreover, migrants, particularly women and girls, were by and large confined to their overcrowded unsanitary living quarters out of fear of arrest.

The major health problems identified included malaria, maternal and infant mortality, injuries, diarrhea, skin rashes and depression. Complications from pregnancy and childbirth were regarded as serious among the vast majority of participants. Respondents also rarely heard about contraception in Burma and acknowledged a general lack of understanding about sexuality and reproductive health overall. While more migrants had used contraception in Thailand than in Burma, the study showed that migrants had a significant interest in specific methods of contraception as well as a considerable problem of unsafe abortions. Study findings also revealed that participants lacked knowledge about STIs and the words in the local language to describe signs and symptoms of STIs. The overwhelming majority of migrants had heard of AIDS but only 60 percent could report the correct transmission routes and most did not understand the difference between HIV and AIDS or that a person with HIV could be asymptomatic. The findings further indicate that participants viewed AIDS as a disease limited to sex workers and, by association, condoms represent promiscuity. The most significant impact on migrants' decisions to access health care included the constraints of their illegal and financial status and language abilities, creating a further dependency on their relationship with employers. These constraints also negatively affected migrants' interaction with Thai nationals and their assimilation into Thai society.

Social norms were reported to change significantly among migrants due to the influence of urban life and dissolution of social networks in Burma. However, gender disparities with regard to sexuality were strong, with acceptance of premarital sexual activity, including among sex workers, for boys, and powerful sociocultural values attached to girls' virginity before marriage. Approximately three-quarters of migrants had ever married, most before the age of 20 and were living with their spouse and had an average of two children. Women and girls are reported to face gender inequities and increased vulnerabilities, with less pay for the same work as well as a bias in the Thai system that provides husbands of employed women and girls with a Thai work permit that does not include registration of their families. Single migrant girls and women in Thailand sought marriage for protection from violence such as theft, rape and murder.

The authors recommend that the Thai government work with the international community and the Burmese government to tackle the root causes of migration from Burma to Thailand. Specifically, the ASEAN countries should engage East Asian countries such as Japan and China to support democracy and human rights with economic development in Burma, while protecting its natural resources and the environment. Progress made by the Thai government in the late 1990s at the bilateral level in ASEAN meetings should be followed by a solid plan to ensure undocumented migrants' rights. In addition, the authors recommend that policies and strategic plans are established at both the central and provincial levels with provincial committees comprised of a broad spectrum of civil society representatives to: ensure that migrant workers receive work permits with registration of their families; appropriate public health and disease control policies are developed and implemented; and that the migrant community is informed of relevant migrant policies and procedures in their local language. In addition, the authors recommend that a system is established, such as through an Office of Migrant Workers, with support of NGOs, to protect migrant rights. The authors cite the particular situation of Shan refugees fleeing gross human rights abuses and call on the Thai government to recognize and provide them with humanitarian assistance as they do other refugees in Thailand. In addition, they recommend the Thai government register all newborns and children under 15 years and work with migrant employers to improve the living conditions of migrant workers and their families.

The report suggests training migrant volunteers to provide community health care, conducting appropriately designed health, including reproductive health, education and related education materials in local languages and cost-sharing among stakeholders of migrant health expenses. The authors find that collaboration between governmental, nongovernmental organization and other community groups is essential to ensure comprehensive policies and interventions to provide better management of migrants, including health care. Recommendations for additional research include strategies for an effective migrant health system with a migrant health database used by the MOH to develop and implement relevant policies, additional study on migrants health beliefs and practices, particularly with regard to STIs, HIV/AIDS, safe motherhood, and migrants' access to quality health care.

Doctors of the World, Unpublished Report, *Field Mission to Thailand-Burma Border Concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001*, July 2001.

Report of a field visit by DOW-US to investigate the health and human rights needs of Burmese migrants in Thailand. Citing the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, which affirm basic human rights, including for illegal migrants, and for whom Thailand is a party, as the human rights framework of this assessment, the authors provide an overview of the health and human rights implications of migration from Burma to Thailand and document the particular situation of migrants in Mahachai, Ranong, Mae Sot and Chiang Mai. The assessment highlights the key push and pull factors contributing to the migration of an estimated 1.2 million, primarily ethnic minorities, from Shan, Karen and Mon States in Burma to Thailand, their priority health and human rights problems and initiatives to address them.

Political repression, forced displacement and labor, trafficking, economic survival and a lack of national support for the public sector in health and education in Burma compel migrants to cross the border in search of work to meet their survival needs. The pull factors in Thailand are opportunities for low paying, menial, "dirty" jobs in factories, seafaring, as day laborers in construction and agriculture and service workers in restaurants, private homes and the sex industry. While about 10 to 20 percent of migrants are able to obtain legal status and the benefits of the Thai Health system, if, they are able to pay for the cost of insurance, the overwhelming majority, approximately one million migrants, are illegal, putting their security and health in continuous jeopardy.

The report discusses both the significant challenges migrant's face to access health care, and the obstacles organization's encounter, to provide it. Following its assessment, DOW prioritized reproductive health as the number one need among migrants with the most significant impact on their health. Specifically DOW reported, priority programs should address family planning, STI/HIV/AIDS prevention and treatment including prevention of MTCT and condom distribution, safe motherhood services, violence prevention, safe post-abortion care, immunization of pregnant women, infants and children.

DOW suggests strategies to improve services for migrants, including strengthening their access to primary health care to reduce the burden on Thai MOPH tertiary care services and improving migrant education and community outreach through mobile clinics. It is further suggested that organizations that undertake programs to assist migrants work closely with both the ethnic minority groups and the Thai public health system to improve coordination.

Institute of Asian Studies, *Migration and HIV/AIDS in the Greater Mekhong Subregion: An Emphasis on Thailand-Myanmar Border Migration*.

This presentation provides an overview of population mobility and HIV/AIDS in the GMS, with particular attention to the Burmese emigration to Thailand. It includes HIV/AIDS data for 2000 and notes that border regions are not always "hot spots" for the spread of HIV.

International Rescue Committee, *Preliminary Needs Assessment of Migrant Communities Residing Along the Thailand-Burma Border*, June 2001.

This report, prepared by IRC Mae Hong Son, of an assessment of the health and education situation of different Burmese migrant communities living and working in or around small farms, Thai villages or satellite villages and factory and construction sites in Mae Hong Son, Mae Sot and Sanklaburi districts from December 2000 to April 2001. The author reports that migrants living in farming communities in both Mae Hong Son and Mae Sot appeared to have the least access to both health services and education compared to migrants working in construction or factories although this also depended on the owner and particular site. Burmese migrant barriers to health and education are reported to include economic insecurity, language differences, low level of education and literacy, poor health knowledge, restrictions on movement and fear of arrest. None of the NGOs working with migrants that were identified during the course of this investigation provided comprehensive primary health care, but offered vertical, topic-specific programs (e.g., HIV awareness, malaria and TB prevention).

The majority of migrants living and working on small farms and in factories and construction sites did not have access to latrines and potable drinking water. Conversely, migrants living in or near Thai villages or satellite villages tended to have much better access to latrines and potable water. Less than two-thirds of

children under five received vaccinations and only 49.8 percent of 161 children ages 5-15 years old were attending school.

Although the author notes there are a number of organizations both local and international working in these areas there is lack of coordination and collaboration among them and with the local government agencies.

Mae Sot Hospital, Community Health Promotion Unit, *Household Survey of 14 Migrant Communities in Mae Sot Municipality*, October – November, 2002.

These survey results provide insight into the demographics and lives of migrants in the Mae Sot area, including population, gender breakdown, age, education level, occupation, religion, income, childhood immunization status, antenatal visits, family planning, household water and sanitation. The average number of persons per household is five and more than one-half (58.6 percent) of respondents reported a monthly income less than 4,000 baht or approximately \$10.00 US dollars. 23.1 percent had not received any education, while more than 50 percent had four years or less of education. Women of reproductive age make up 29.3 percent of these communities and 64.7 percent of women are married or living with a partner. The majority (86.4 percent) of women had their last pregnancy in Thailand and more than one-third (37.4 percent) had never had an antenatal visit. Condoms are the most commonly used contraceptive method, at 38.1 percent, followed by pills (34.9 percent) and tubal ligation (23.2 percent). Less than 50 percent of children under five years of age completed childhood vaccinations per the recommended schedule.

Mae Tao Clinic, *Mae Tao Clinic Annual Report 2003*, September 2004.

This comprehensive report provides an overview of the health and social services provided by the Mae Tao Clinic for a “catchment” population of approximately 150,000 ethnic Burmese in Thailand and Burma in 2003. Clinic staff support includes six physicians, 86 intern health workers, 150 medical, administrative and logistics staff, as well as some 20-40 volunteer periodic international staff. The report describes a Clinic beneficiary population that endures or has fled economic despair and gross human rights abuses in Burma, and the ongoing struggle among forced migrants in Thailand. The health status of the population the Clinic assists is detailed in health surveillance reports.

Clinic health workers conducted nearly 83,000 patient consultations, representing an increase of 40 percent from 2002. Services included: outpatient and inpatient care including surgical care, blood transfusion services; reproductive and child health care; eye care; prosthetics support; and public health through migrant community outreach programs including for adolescents. In addition to services provided at its main facilities in Mae Sot, health services are also extended to the internally displaced through the Back Pack Health Worker Teams (BPHWTs) and two satellite clinics in Burma. The report also discusses the Clinic’s extensive health worker training programs and social and education services including support for a nursery and a migrant school for children.

In addition to managing the significant increase in service delivery in all departments and the ongoing challenges of malaria treatment and control, the report details significant developments at the Mae Tao Clinic in 2003. For examples, the Clinic improved its health information system to promote better data collection, and established a communicable disease surveillance program in collaboration with the Ministry of Public Health. The Clinic also implemented a new birth registration system in collaboration with the Thai Lawyers Association. In addition, several projects aimed at preventing and managing HIV/AIDS were established, such as voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT) services, improved blood transfusion services and new care and support projects for persons living with AIDS. The Clinic has also continued to expand attention to monitoring and evaluation of quality of care within all departments at the Clinic, building on the *Reproductive Health Quality Improvement Project* initiated in April 2001. Clinic staff have also undertaken advocacy and information sharing through presentations locally and at national, regional and international levels. Moreover, the Clinic reports extensive health worker training programs, including a new internship program with the Mae Sot District Hospital, fostering skills training for its staff and improved patient care for Burmese patients at the hospital. The Clinic also offers its own internship program for approximately 10-20 health workers from other ethnic groups and organizations.

In addition to growth and developments in 2003, the report highlights a need for support for antiretroviral therapy to mothers involved in the PMTCT program and for all persons living with AIDS. The authors also identify the need to address the burgeoning hospice and chronic care needs of patients at the Clinic due to the increased caseload of end-stage AIDS patients and other patients with long-term illnesses or conditions, such as amputees. Some chronic care needs also reportedly reflect the lack of social support for the elderly and infirm who are often too ill to travel home. Other social service costs that increasingly challenge the Clinic are the patient care costs for transportation and security and funeral and cremation expenses. The Clinic is seeking to launch its extensive traditional birth attendant (TBA) training program as an independent project with a designated coordinator and health information, management and monitoring and evaluation systems.

The authors report that the Mae Tao Clinic's plans for 2004 include upgrading the waste water management system at the Clinic and implementing a new training program for representatives of eight ethnic communities in order to improve health services and foster a more uniform approach to health care in the internally displaced areas of Burma.

Reproductive health-related services and indicators in this report show that the number of women who delivered at the Clinic increased by 57 percent since 2002 and that antenatal care includes the prevention and treatment of anemia, malaria, tetanus, voluntary counseling and testing for HIV, hepatitis B and syphilis. Among women who agreed to test, 1.43 percent were positive for HIV, 8.52 percent were positive for hepatitis B and 2.49 percent of pregnant women were positive for syphilis.

The report shows that the Clinic provides comprehensive basic emergency obstetric and gynecological care. The authors report that post-abortion care represented 10 percent of all obstetric and gynecological patients treated at the Clinic and 26 percent of patients treated in the Clinic's RH inpatient department. In addition, the authors report that the increased numbers of emergency obstetric care admissions managed at the Clinic in 2003, versus through referral to the Mae Sot district hospital, reflects the increased capacity of the Clinic's RH staff to treat emergency obstetric care patients since 2001. The authors attribute this significant achievement to the combined influences of two related projects implemented over the past several years, including one to avert maternal death and disability and the other to improve, monitor and evaluate the quality of RH care, as well as increased collaboration between the RH and general medical services departments at the Clinic.

The report shows that 6,469 clients visited the Clinic's family program with almost 18 percent of them adolescents. Depo-provera is the most commonly used method of contraception, followed by condoms, contraceptive pills and sterilization. The Clinic's staff is also working collaboratively with other local organizations to address adolescent RH in the community and on programs to address male involvement in RH, particularly with regards to family planning, safe sex and domestic violence.

Mae Tao Clinic, *Baseline Assessment: Improving Reproductive Health Services Among Forced Migrants*, May 2002

This report describes the assessment activities conducted at the Mae Tao Clinic to initiate its Reproductive Health Services Quality Improvement Project in 2001. The Clinic's RH staff identified three areas for monitoring and evaluation, in order to improve service quality: systems management; health worker knowledge and skill; and client knowledge, attitudes and behaviors. Baseline data was gathered using three instruments: facility audit to collect information about systems; an observation checklist, to determine health worker skill; and client exit interview, to ascertain client knowledge, attitudes and behaviors. The facility audit results led to plans for upgrading the facility and buying new equipment and supplies, revising patient records and register books, developing job descriptions and improving the system for ordering and supplying adequate amounts of medications, equipment and supplies. Areas for improvement resulting from use of the observation checklist included: better use of IEC materials; encourage clients to ask questions; better hand washing practices; screen for risk factors for obstetric complications; improve care for obstetric cases, such as helping the client plan for ANC and delivery; strengthen health promotion, such as discussion of safe sex, malaria prevention, etc.; and discussion of side effects and effectiveness of contraceptive methods. The client exit interviews showed that clients are

lacking knowledge about transmission, prevention and symptoms of STI/HIV/AIDS and signs of obstetric complications. The Clinic staff developed plans to improve on all the areas found lacking, including to distribute more health materials and broadcast health messages about these topics.

Mae Tao Clinic, Karen Women's Organization and Social Action for Women, *Promotion of Adolescent Reproductive Health for Displaced Burmese Girls in Thailand: Adolescent Reproductive Health Survey*, Final Report, September 4, 2002.

This is a report of activities implemented by the Mae Tao Clinic, the Karen Women's Organization (KWO) and the Social Action for Women (SAW) with support from the Women's Commission for Refugee Women and Children on a 2001 project titled: Promotion of Adolescent RH for Displaced Girls in Thailand. The objectives were: 1) to promote awareness of adolescent health needs among the displaced Burmese community; 2) to train adolescent girls to gain knowledge, skills and confidence in taking care of their own RH; 3) to encourage adolescent girls to organize supportive groups among themselves; 4) to encourage community-based women's organizations to support, protect and promote adolescent health needs; and 5) to train Mae Tao Clinic RH staff and women's organizations in promoting adolescent health. A survey was conducted among 102 youth in Umpiem Mai camp and among 101 migrant workers in the Mae Sot area to develop an adolescent-focused curriculum. Results showed that 40 percent of respondents could get condoms, with two-thirds indicating they could get them at the clinic, but half said condoms should not be used by unmarried couples. Most youth surveyed knew about HIV (90 percent) and also had a high level of knowledge about forms of birth control such as the pill, condom and Depo-Provera. Survey results were used to develop a curriculum and train 14 master trainers who subsequently trained 187 adolescents age 13-20 years in reproductive health. The local organizations reported improved capacity building in developing and implementing surveys and data analysis. The groups recommend that future effort is needed to encourage the adolescents trained to form their own support groups.

Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*. February 2003.

The Director and the Monitoring and Evaluation Coordinator for the Mae Tao Clinic report on the social and political context of forced migrants living in Burma and Thailand and promoting and protecting reproductive health rights in these circumstances. The authors report that the ongoing civil war in Burma, compounded by gross human rights abuses inflicted by the ruthless military regime, isolation of ethnic minorities, silence on political dialogue, struggle for daily survival in a climate of fear, lack of opportunities for education and the generalized breakdown of civil society, is manifested in psychological and social problems among people from the IDP areas of Burma. People are experiencing symptoms of chronic depression, such as apathy, chronic fatigue, sense of hopelessness about the future and elevated levels of aggression. In Thailand, where more than one million migrants are also living in fear without their families and communities and struggling to survive, second marriages, casual sex and early sex among teenagers are common, as are the symptoms of depression and gender-based violence. Moreover, the authors report that people are increasingly turning to substance abuse to cope.

This paper also discusses access, utilization and quality of health services in the IDP areas of Burma and among forced migrants in Thailand, with a particular focus on reproductive health. In the IDP areas of Burma, where there are no government services, the limited care that is available, is provided through the valiant efforts of 245 Back Pack Health Workers comprised of three medical assistants and deployed in teams of three including one trained to supervise traditional birth attendants, often the only person available to assist pregnant women. The generally unskilled TBAs are reported to engage in dangerous traditional practices such as pushing on women's abdomens during delivery and cutting umbilical cords with non-sterile blades. The work of the BPHW teams is constrained by Burmese military attacks and risks of landmine injuries as well as a lack of medicines and supplies due to limited donor support.

In Thailand, while there are national public health services available, and a new health insurance scheme implemented in 2001 allows registered migrants to access primary health care for 30 baht, the majority of migrants are not registered, largely due to the unaffordable cost of registration, while others are not aware of the health insurance benefit with registration. Those who are not registered face risk of arrest and deportation when they travel to health facilities. In addition, the authors explain that migrant workers are

often either not allowed or cannot afford to take time off work to seek care. The Mae Tao Clinic, established in 1989 in Tak Province, Thailand, provides services free of charge to a beneficiary population of approximately 150,000-2000,000 ethnic Burmese in the province and to IDPs in Burma who cross the border in search of care. The authors report that more than 30,000 ethnic Burmese availed themselves of these culturally appropriate services in 2001.

Among the key reproductive health issues identified by the authors in both Burma and Thailand are safe motherhood and the unmet need for family planning, reflected in emergency obstetric care needs, particularly complications from unsafe abortion. The authors also state that while contraceptive prevalence rates (CPRs) in the IDP areas are unknown, high infant and child mortality rates as reported in the BPHWT survey are a disincentive to modern contraceptive use, as well as the common misconception that contraceptives cause infertility. Further, limits in contraceptive choice and lack of consistent supplies due to security issues also constrain the use of modern contraceptive methods for birth spacing. Other RH problems noted at the Mae Tao Clinic and identified by the authors include steadily increasing STIs, including HIV, adolescent pregnancies and gender-based violence.

The authors report that while widespread human rights abuses inflicted on ethnic Burmese in Burma and Thailand significantly contribute to both RH problems and access to care, there are opportunities to improve reproductive health rights including: “strengthening existing referral systems and establishing referral centers; developing partnerships and coordinating services; developing health curriculum; addressing orphan care, adoption, and birth registration; creating guidelines for service delivery in the IDP areas; creating a monitoring and evaluation system; strengthening health information systems; and coordinating reproductive health training programs.” The authors also recommend addressing less sensitive RH issues first; approaching community development from the family level; raising community awareness about RH rights; taking a multi-sectoral approach and involving youth, men and women’s groups in RH programs, strengthening networks with NGOs and INGOs, implementing outreach programs in the community and improving data collection and documentation.

They point out that local political will is shifting towards ensuring the survival of women and future generations, but ask if this shift is occurring fast enough to save women’s lives.

Meyers, J., Friedlander E., *Emergency Obstetric Care: Critical Need among Populations Affected by Conflict*, Reproductive Health Response in Conflict Consortium, March 2004.

This report documents the availability of emergency obstetric care services and planned interventions for refugees and internally displaced persons in nine countries, including two projects on the Thailand Burma border, from 2001-2002. One project, administered by the American Refugee Committee, focuses on refugees from Burma living in Umpiem Mai, Nu Po and Ban Don Yang camps in Tak province, Thailand. The second project, administered by the Women’s Commission for Refugee Women and Children, focuses on migrants, IDPs and others living in refugee-like circumstances from Burma, receiving care at the Mae Tao Clinic in Tak province. Both project assessments include reports of a significant amount of unwanted pregnancy and unsafe induced abortion among the beneficiary populations, with limited skills of health workers to provide basic emergency obstetric care (EmOC), including post-abortion care. In addition, both sites report insufficient supplies and equipment including manual vacuum aspiration (MVA) kits at camp, clinic and referral facilities. The planned interventions included training refugee health workers in basic emergency obstetric skills, including onsite clinical training at the referral hospital and providing infrastructure support, equipment and supplies at camp, clinic and referral facilities.

A second report documenting the project outcomes and highlighting creative and innovative interventions, strategies and lessons learned to guide future EmOC programming will be available in 2004.

Nang Lao Liang Won, *Guidelines on Strategies and Responses to the Needs of Burmese Migrant Women in Thailand*, Asia Pacific Forum on Women, Law and Development, January, 1999.

This handbook documents the specific needs of Burmese women working in Thailand and offers practical guidelines for government and nongovernmental organizations to respond to them. The author identifies the following four overarching principles of response: involvement of migrant women throughout the process; acknowledgment of migrant women’s rights as human rights, sensitivity to time, situation and

content; and accessibility (ensuring that all programs can be accessible to migrant women). The author also discusses key push and pull factors leading to the influx of migrant women and girls from Burma. Among the push factors are the ongoing civil war between the Burmese military and the ethnic groups resulting in gross human rights abuses by the military junta, including its specific Four Cut Strategies of systematic forced relocation designed to weaken the ethnic minorities. In addition, the author reports that ethnic Burmese women suffer from forced labor, extortion, land confiscation and the economic calamity from inflation and government spending on the war in Burma.

In collaboration with local organizations, the author conducted qualitative research among ethnic Burmese women from Burmese, Shan, Akka and Mon ethnic groups at their place of employment, including factory and construction sites, massage parlors and brothels, restaurants and dormitories in Chiang Mai, Mae Sai, Mahachai and Samutsakorn provinces. The author notes that among the limitations of the study are that Burmese women are particularly sensitive to activities involved in research methods, e.g., strangers, questions, note taking, cameras and tape recorders. The researchers' findings showed that women are subject to extrajudicial killings, rape, compulsory portage and other labor, as well as forced to be sex slaves for State Peace and Development Council representatives. Women are drawn to Thailand by relatively increased security and the labor market demand for jobs considered 3-D jobs, i.e., dirty, difficult and dangerous, in Thailand. The guidelines include an extensive list of problems endured by migrant women, including language barriers, cultural differences, poor living conditions, exploitive working conditions, inequality in payment, difficulty with communications to and from home, poor health, limited access to healthcare, risk of arrest, detention and deportation, false documentation, police malfeasance, deception and exploitation, debt bondage, all forms of violence, gender issues and lack of sex education and effects on children.

A comprehensive list of needs and strategies to address the needs are also provided by the author and include: skills training; cultural orientation; improving living and working conditions; reinforcing existing laws on labor; communication skills; information, education and communication about basic health care and access to health services; assisting women and children when arrested; improving documentation, for example, work permits; addressing police corruption and misconduct; protection from agents, brokers and procurers; addressing all forms of gender-based violence; sex education; addressing the rights of children and activities for youth. Finally, the guidelines include a chapter on the effects of Thailand's economic collapse on migrants and practical tools in the appendices, such as an example of an application for a work permit and a list of agencies working with migrants in Thailand.

Ministry of Public Health, Unpublished document. *Public Health Problems Among Myanmar Migrants in Mae Sot District, Tak Province*, 2000.

This paper describes the structure of the district health care referral system along with key health data, mostly for 1999-2000. In 2000, health services were provided in 26 health centers, 15 private clinics, 3 malarial clinics, the 310-bed Mae Sot General Hospital and one 120-bed private hospital. According to the Ministry of Public Health (MOPH), healthcare, with the exception of care provided at the four malarial clinics, and prevention activities, such as immunizations, provided free of charge to Burmese patients, increased 26 percent from 1999 to 2000, with approximately 30 percent of Burmese patients receiving care free of charge. This paper also includes information on communicable disease cases, treatment results of TB and leprosy, MCH. Malaria represents the overwhelming majority of communicable disease cases (97 percent) among Burmese treated in the district and the case fatality rate was higher for Burmese (3.7 percent) than Thais (0.8 percent). Data showing the HIV prevalence rate from 1996 to 2000 among commercial sex workers (CSWs) from Burma indicates the HIV prevalence rate peaked at 28.1 percent in 1999 and decreased to 17.8 percent in 2000. Most of the CSWs in Mae Sot were reportedly from Burma. The HIV prevalence rate among pregnant women from Thailand and Burma was comparable in 2000 at 1.4 percent and 1.8 percent respectively. Nearly one-fifth of newborns delivered by Burmese women were low birth weight in 1999 and 2000, approximately twice the percentage of Thai infants born in both years. Between July 1998 and June 1999, the MOPH in Mae Sot district implemented a mobile immunization campaign targeted at migrant children 0—14 years in 13 communities of Mae Sot district. Prior to starting its campaign, vaccination coverage among Burmese migrants for childhood illnesses was extremely low. For example, only seven percent of Burmese children one to two years of age had received measles vaccine. Mae Sot District public health authorities also conducted a

contraception use and abortion history study among married migrant women in June 2000 and found that just over half of women (53.7 percent) were current contraceptive users and the most popular methods were pills and injectables. Among contraception users, factory workers had the highest contraception use at 71.1 percent and women working in agriculture had the lowest at 43.2 percent. The study also revealed that 18.7 percent of married women from Burma reported having had spontaneous abortions while 2.9 percent admitted to illegal induced abortions suggesting to researchers, that some women with spontaneous abortions were unwilling to report illegal induced abortions. Married Burmese women who had illegal abortions were less likely to have had a primary education and were more likely to be working in agriculture than a factory.

Ministry of Public Health, Division of Disease Control and the World Health Organization, *Summary Report of the Meeting on Development of Health Collaboration along Thailand-Myanmar Border Area*, Ranong, March 27-28, 2003.

The objectives of this meeting were to share information on the border health situation and activities of organizations working along the Thai-Burma border, and to develop tools and mechanisms for increasing health access among the cross-border population and coordination among organizations working in the border areas. Participants took part in one of four discussion groups. Some of the key recommendations include: 1) Health Coordination Mechanisms Along the Border: a national level coordination mechanism should be developed and existing provincial meetings continue; capacity building is needed at the provincial health level. 2) Utilization of Health Volunteers to Improve Health Access Among the Migrant Population: volunteers are important for a number of health activities and they should be trained and supervised; temporary status of migrant health volunteers should be considered. 3) Development of a Standardized Medical Record Book to Increase Health Access Among Migrants: a basic and easy to understand medical record book is needed in Thai and Myanmar languages. English is optional; the same format should be used border-wide and the Ministry of Public Health should be the main distributor. 4) Standardized Data Collection: all stakeholders need to commit to standardized data collection via a simple and effective system, and the Ministry of Public Health and the Border Health Program of WHO should disseminate the information.

National Health and Education Committee and Burma Medical Association, *Report on Health Conference (Burma)*, October 4-7, 2000.

The objectives of this health conference were to understand policies and programming of different ethnic health departments by reviewing the current health situation of IDPs, refugees and migrants and design policy guidelines and strategies for all health organizations on the Burmese borders in order to adopt a leadership role when political change comes to Burma. In addition the conference aimed to learn from the experiences of other countries whose nations have undergone the fall of dictatorship and reconstruction in order to be more aware of the challenges and obstacles post-dictatorship in Burma. The report includes presentations addressing the range of health issues intended by the objectives, including presentations from South Africa, Cambodia and the Philippines.

Mullany, L.C., Maung, C. and Beyrer, C. *HIV/AIDS Knowledge, Attitudes and Practices Among Burmese Migrant Factory Workers in Tak Province*, Thailand, AIDS CARE (2003), Vol. 15, No.1, pp. 63-70.

This article documents the knowledge, attitudes and practices (KAP) about HIV risk factors, prevention and transmission conducted among 725 Burmese migrant factory workers in a non-randomized study in eight factories in Tak Province, Thailand, in July 2000. The study, carried out in collaboration with the National Health and Education Committee, Burma Medical Association and the Thai Ministry of Public Health, showed limited knowledge among the migrant factory workers about the prevention and transmission of HIV, including high levels of misconception about how HIV/AIDS is spread, particularly among women. Only 12 percent of young migrant factory workers were aware that HIV is not transmitted by casual contact and nearly half of men and two-thirds of women believed that contraceptive pills could protect them from HIV/AIDS, while slightly more than one-quarter of respondents were aware that a blood test could determine HIV infection status. In addition, the findings showed significant gender differences in HIV/AIDS KAPs, with only 15 percent of females ever having seen a condom compared to 60 percent of males and 1.4 percent of females ever having used condoms compared to 12.1 percent of males. Among males who had used condoms, more than 50 percent purchased them from tea and betel nut shops and pharmacies. Fifty-four percent of respondents did not know where to obtain condoms. The

authors attribute the limited HIV/AIDS knowledge among Burmese migrant factory workers to lack of access to the successful Thai HIV/AIDS campaigns and, more fundamentally, the ongoing human rights abuses by the oppressive Burmese regime, including the lack of public education and health services for the ethnic minorities in the internally displaced areas on the eastern border of Burma.

NGO Network for Migrant Workers and Their Families, Thai Lawyers Council, Raks Thai Foundation and the Faculty of Law at Thammasat University, *Conference on Migrant Workers: Accessibility to Health and Health Promotion, April 30, 2002.*

“They come seeking opportunity, but most find only hardship” describes the situation of migrant workers in Thailand. This conference was a result of the efforts by a network of NGOs involved in migrant issues to bridge the gap in information sharing among the number of local-level, small-scale health projects working to address the health needs of migrant workers and their families and to find solutions to issues affecting the health and well-being of the migrant worker community. The purpose of the conference was three-fold: 1) increase implementers understanding about policies that affect the ability of migrant workers to access health services; 2) share implementers’ experiences to generate ideas for practical solutions at the ground level; and 3) brainstorm with relevant organizations to formulate policy recommendations to provide migrant workers and their families better access to health services. The conference was opened by the Thai parliament’s labor committee chair. University law students provided information on migrant workers’ rights and several implementing health agencies presented on a range of health issues. Working groups, composed of UN agencies, government and NGO representatives, discussed topics related to implementation as well as policy decisions. The conference highlighted the problem of the year-to-year changes in the Thai government’s policies toward migrant workers that limit migrant workers and their families’ access to health services and result in confusion among government and NGO agencies and varied implementation of the policies. Recent advancements have been seen as a positive step in the Thai government’s policies and access to health services by migrant workers; however, many structural barriers to utilization of health services remain within the system. Language was noted as the greatest obstacle to migrant workers’ access to health services as information on where and how to access services and the right to health services is not provided in migrant workers’ own language. This problem is exacerbated by the lack of translators preventing clear communication in the health delivery setting.

Ohnmar M.D., *Assessment of Sexual Behaviors in Two Myanmar Migrant Populations in Ranong: Fishermen and Sex Workers*, Master of Science Thesis in Epidemiology, Prince of Songkla University, 2000.

This study conducted in 1999 provides the result of in-depth quantitative and qualitative research into sexual behaviors among 639 migrant fishermen and commercial sex workers (CSWs) specifically related to factors associated with the use of condoms and HIV/AIDS in Ranong province, Thailand. The researcher seeks to answer questions about migrant fishermen’s and CSWs’ knowledge of HIV/AIDS, attitudes and practices surrounding condom use and to determine if there is a relationship to migrants’ length of stay in Thailand, awareness about safe sex and their illegal status. This thesis includes: a global and regional overview of sexually transmitted infections and HIV; demographic information about the situation of approximately 100,000-150,000 migrants in Ranong, including their employment sectors and access to health services; literature review; study description and methodology, research findings and conclusions with discussion about the findings. Among the main reasons the researcher decided to undertake the study are the increasing HIV problem in Myanmar, previous studies indicating high HIV infection among migrant CSWs and migrant fisherman from Myanmar in Ranong, and because of Thai provincial health department interest in strategies to address migrant problems including the control of HIV/AIDS in Ranong. The author cites the limited presence of NGOs working in STI prevention in Ranong with the exception of World Vision Foundation Thailand which initiated HIV/AIDS programs in 1992, but only reach a beneficiary population of approximately 15,000 migrants.

The findings indicate that migrants, primarily from Tavoy, Tanintharyi Division and Mon state, as well as Karen and Rakhine States, came to Thailand in the years following the political upheaval in Myanmar in 1988 to increase their income. Migrants are living in squalid conditions and males are mainly working in the fishing-related industry as well as rubber plantations, sawmills and forestry. Female migrants from Myanmar also work in the fishing industry and rubber plantations, while an estimated 300-400 work as direct or indirect CSWs with customers of whom the majority are from Myanmar. Direct CSWs work in brothels or houses and accept all clients for pay. Indirect CSWs work in shops where alcohol is sold and

do not consistently accept clients or take money for sex. Ranong province sentinel surveillance data in June 1999 indicates that HIV prevalence among both direct and indirect CSWs was 26.65 percent.

In this study, condom use was low among CSWs (12.4 percent consistent use) and fishermen (40 percent always use with CSWs). The main reasons for lack of condom use by CSWs were: having sex with a boyfriend, though a boyfriend is loosely defined and some CSW have many boyfriends; under the influence of alcohol or drugs during sex; and discomfort from condoms with prolonged intercourse. Where condoms were available, in some but not all brothels, the poor quality of the condoms and dislike for the particular type of condoms available, were also described as barriers to condom use. The researcher found that a significant and alarming number (25 percent) of migrant men in this study manipulated their penis to enhance sex by self-administering or seeking an untrained person to perform oil injections and or place marbles or "golly" (bead) under the skin of the penis resulting in enlarged penis and complications such as necrosis and erectile dysfunction. CSWs also reported than an extraordinarily enlarged penis caused difficulties with condom use and breakage as well as painful sexual intercourse resulting in some substance use by CSWs to relieve the pain. CSWs who used condoms revealed successful negotiation skills, to prevent unsafe sex. While almost all study participants had heard of HIV, most had a very limited understanding and few fishermen had ever attended any AIDS education sessions. While more CSWs had attended health education sessions, their perceived vulnerability to HIV/AIDS was low. In addition, CSWs often use over-the-counter medications or soap for vaginal hygiene believing this would prevent or treat sexually transmitted infections. The author recommends culturally appropriate effective information, education and communication (IEC) strategies addressing the severity of HIV, condom wearing methods and avoidance of penis injections and other manipulations. In addition an IEC strategy should include successful negotiation methods used by CSWs for condom use, avoidance of over the counter substances that falsely reassure CSWs they are preventing or treating STIs buttressed by legislation to address such quackery, and legal restrictions on trafficking and use of narcotics

Physicians for Human Rights, *No Status: Migration, Trafficking and Exploitation of Women in Thailand, Health and HIV/AIDS Risks for Burmese and Hill Tribe Women and Girls*, June 2004.

This report documents a qualitative assessment on the human rights violations committed against Burmese migrant and Thailand hill tribe women and girls in Thailand. Interviews were conducted with women who had experienced human rights violations and with a range NGOs, researchers, policy makers and government officials. Trafficked Burmese migrants were primarily interviewed in Thailand once they had reached the town of Mae Sot. Despite Thailand's acclaimed HIV prevention program, the government's lack of human rights protection has resulted in an increased risk of HIV infection among women from both groups due to their experiences of discrimination, trafficking, unsafe migration, denial of health care, and labor and sexual exploitation. Due to the lack of health care prevention and treatment services available to these women and girls, contraction of HIV without any treatment means they will likely develop AIDS and eventually face an early death. In addition, they are at higher risk of unintended pregnancy and unsafe abortion. Physicians for Human Rights (PHR) points to the lack of full legal status and gender-based discrimination as underlying factors making women and girls vulnerable to these human rights violations. PHR also argues that without specifically targeting these communities, Thailand guarantees that its HIV/AIDS problem will continue.

PHR also highlights the inadequacies of the registration system, which is the only way that migrants may safely and affordably access health services within Thailand's public health system. The number of workers with legal status has declined due to a number of barriers to registration, including the changing of the system's eligibility and application regulations, increased restrictions over the past three years, work permits being linked to place of employment and the exclusion of many migrant jobs from the registry. Furthermore, women who do obtain work permits still find themselves exposed to unscrupulous employers and harassment by law enforcement authorities and are particularly vulnerable to exploitation given their low-skilled and low-paying jobs. Women and girls trafficked into the sex industry face additional abuses including beatings, sexual assault and unsafe sex practices by traffickers, owners of commercial sex establishments, clients, police and immigration officials. This study also provides evidence of the constant harassment of women and girls by the police which may result in detention, arrest, extortion and violence. Some of these same women facing harassment serve as staff and

volunteers of NGO and ethnic organizations, which are working to improve the situation for trafficking victims, migrants and Burmese refugees in Thailand.

PHR provides numerous recommendations, some of which are highlighted here. The Thai government should provide access to a range of reproductive health services, including HIV/AIDS programs with free condom distribution, family planning and prenatal care as well as translation of all relevant health information into ethnic minority languages and provision of interpretation at all health services. The U.S. government, as well as international donors and organizations, is requested to pressure the Thai government to advance the implementation of HIV/AIDS programming to mobile and migrant populations. The U.S. administration is also requested to not limit the Thai government's ability to manufacture or import generic HIV/AIDS drugs, push the Thai government on implementing a comprehensive anti-trafficking plan and improve the treatment of Burmese migrants. PHR recommends to the State Peace and Development Council of Burma that it halt its overall campaign of terror against ethnic minority populations of Burma, including the use of rape as a weapon of war against the Shan and Karen ethnic minorities.

Pim Koetsawang, *In Search of Sunlight: Burmese Migrant Workers in Thailand*, Bangkok, Orchid Press, 2001.

The author has lived amongst and visited such people, both along the Thai/Burma border and in migrant communities close to Bangkok. She has documented their stories and their plight, and presents a harrowing picture of a powerless group caught between two evils, merely seeking to eke out a living under adverse conditions. The book exposes the maltreatment such people receive and explains their plight and motivations for making the move. (This entry has not been reviewed by report authors but is listed as a resource; description provided by publisher.)

Shan Human Rights Foundation, *Charting the Exodus from Shan State: Patterns of Shan refugee flow into northern Chiang Mai province of Thailand, 1997-2002*.

This document provides data to support the claim that the Shans arriving into northern Thailand should be recognized as genuine refugees rather than economic migrants. The data is based on interviews with 66,868 Shans arriving in Fang District of northern Chiang Mai province between June 1997 and December 2002. The data shows that almost all the new arrivals came from 12 townships in Central Shan State where the Burmese military carried out a mass forced relocation program since March 1996 and where the regime's troops have been perpetrating systematic human rights abuses against civilian populations. The evidence demonstrates that refugee flows increased directly after large-scale massacres were committed by the regime's troops, refugee flows are much higher than the annual influx of Shan migrant workers into Fang prior to 1996, there is no seasonal pattern to the inflows as would be expected of agricultural workers, and that people are traveling as families while in the past migrant workers would typically be adult men between the age of 20 and 40 years. The SHRF estimates that 230,000 Shan refugees have arrived in Thailand since 1996.

Sullivan, T., Maung, C. Sophia, N. DRAFT *Using Evidence to Improve Reproductive Health quality along the Thailand-Burma Border*, February 2004.

This article summarizes the major objectives and results of the *Reproductive Health Quality Improvement Project* implemented from 2001 to 2003 at the Mae Tao Clinic and is authored by the Michigan Population Fellow based at the Clinic for two years to provide technical support on the project, the Clinic's director and senior medic in reproductive health. The project's aim was to both improve reproductive health services and build the capacity of the Clinic's local staff to monitor and evaluate reproductive health services. The objectives included improving the Clinic's readiness to provide services with well-functioning supply systems for essential materials, medications and equipment; improving the knowledge and skill of health care providers and improving client satisfaction, knowledge, attitudes and behaviors. Evaluation findings showed that quality of care improved for several components of service delivery, such as increased information and materials were provided to clients receiving reproductive health services and increased client knowledge about STI/HIV/AIDS symptoms and prevention methods. In addition, an increased number of new hand washing stands increased health workers hand-washing practices. However, there were some contradictory findings on interpersonal relations between the provider and client. An observation check-list used by project researchers revealed improvements in both the family planning and antenatal departments in the item "provider sees client in private," but clients themselves did

not rate privacy as high nor was there an improvement over time in this item. Another item showed a decrease in clients' belief that they were treated with respect, which may have been related to the study instruments, but nevertheless, the authors suggest there is room for improvement in these areas. Among the key lessons learned in the project, was the importance of a participatory approach to engage and motivate staff to improve quality of reproductive health care. In addition, the Clinic staff learned that improving service facility readiness contributed to improved quality of care and client outcomes. The reproductive team also learned how to use Clinic data to improve programming and advocate for reproductive health services for people living in refugee-like circumstances at local and international levels. Some challenges facing the project were the lack of familiarity and difficulty translating monitoring and evaluation concepts and terminology in the local language as well as the time constraints of the project duration.

Women's Commission for Refugee Women and Children, *Nowhere to Run: Ethnic Burmese Living in Refugee-like Circumstances in Thailand*, February 2000.

This paper reports on the progress of a collaboration, which began in 1998, between the Women's Commission and the Mae Tao Clinic based in Tak province, Thailand providing health and social services to Burmese living in refugee-like circumstances in Thailand, migrant workers and internally displaced people from Burma. Project efforts included: training of health workers, provision of women's health care, programs aimed at reducing STIs/HIV infection and unwanted pregnancy among migrant factory and sex workers, development and support of women's networks, and the development and distribution of public health information materials. Complications from abortion is one of the priority reproductive health problems addressed at the clinic, In 1999 alone, 277 women presented at the clinic with abortion complications; 23 percent of these were young women under the age of 20. Despite the difficulty in ascertaining how many abortions are spontaneous versus induced, it is known that one in five women presenting at the clinic with complications of unsafe abortion have had at least one previous abortion. Obstetric emergencies and landmine injuries requiring blood transfusion are the major reproductive health problems that Back Pack Health Worker Team members face in their work tending to the health needs of IDPs living in remote border areas of Burma. The emergency obstetric skills of the medics working with the IDPs are limited and HIV/AIDS testing is not available at the referral clinics in this area of Burma. Eighteen percent of the 356 women who came to the clinic to deliver were considered emergency obstetric cases and referred to Mae Sot hospital; no maternal deaths were reported in the past year. A concern was raised that the hospital was performing a high number of cesarean sections in order to accommodate physicians' schedules. The number of family planning users has increased annually with a 50 percent increase seen in the past year. The most popular form of contraception was Depo-provera (47%), followed by condoms (33%), contraceptive pills (19%) and voluntary sterilization (4%). In 1999, 25 percent of the total 1,276 contraceptive users were adolescents. The total HIV-positive lab test rate at the clinic was 2.5 percent with a higher rate of positive results found among emergency obstetric patients at 4.2 percent. The clinic did not document rape cases but did note that 2.2 percent of all patients at the clinic sought care as a result of injuries, including domestic violence. In addition, the Karen Women's Organization, a local group addressing the psycho-social, economic and health problems of women, identified domestic violence as the most important problem for women caused by husband's drug use, drug-trafficking involvement and general economic constraints which lead some women to become sexually involved with Thai soldiers. Outcomes of the project included integration of reproductive health care to the Mae Tao Clinic's training programs, new donor support for two projects, one focusing on emergency obstetric care and the other on monitoring and evaluation of the reproductive health project. A plan for future activities, including identification of other funding sources, completes this report.

Burma/Myanmar Reports

Belak, B. *Gathering Strength Women from Burma on their Rights*, Chiang Mai, Images Asia, 2002.

This book covers a range of issues related to women in Burma, including CEDAW, violence against women, women's health, education for women and girls, migration and trafficking of women and girls and women's political participation. (This entry has not been reviewed by report authors but is listed as a resource; description provided by publisher.)

Global IDP Project, *A Global Overview of Internal Displacement by the End of 2002*, February 2003.

The section on internal displacement in Asia and the Pacific highlights the impact that the global war on terrorism since September 2001 has had on IDPs in Asia: tightening of asylum policies in western countries and the undermining of the protection of vulnerable groups like IDPs due to counter-terrorist operations. The report notes that, as in several other Asian countries, fighting between secessionist movements and the ruling state has been the major cause of displacement in Burma, resulting in many IDPs in Burma hiding in inhospitable jungle territory without access to sufficient food or health care. The lack of effort by governments, such as the Burmese military regime, to recognize or address the problem of displacement in their countries is rooted in geo-strategic and political considerations rather than a lack of resources. Finally, the lack of any regional mechanisms to deal with internal displacement in Asia and the refusal of regional bodies such as the Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC) to interfere in domestic issues leaves the issue of internal displacement in Burma unaddressed.

Htay, Thein Thein, et al, *A Strategy for Advancing Reproductive Health in Myanmar*, Asia-Pacific Population Journal, December 2000.

With Burmese government approval, the WHO's strategic approach to contraceptive introduction in Burma was utilized to conduct a contraceptive method mix assessment including RH components as necessary links to the introduction of a birth spacing program as well as links to adolescent RH, reproductive tract infections and abortion. Subsequently, an RH needs assessment was conducted with UNFPA in 1998 (listed later in this bibliography) and RH pilot activities, based on the recommendations of both assessments, have begun. The report notes a large unmet need for contraception resulting in a high number of abortions, despite the fact that abortion is illegal in Myanmar, and contributing to the country's high maternal mortality rate. A 1992 hospital-based study cited found that abortion complications accounted for almost 40 percent of maternal deaths and a 1997 study estimated one-third of pregnancies end in abortion. Report authors suggest introducing long-term methods of contraception such as voluntary sterilization and IUD, emergency contraception to reduce abortions and vacuum aspiration to improve the management of unsafe abortion. Other recommendations include developing an IEC strategy for and involving men in birth spacing programs, improving access to birth-spacing services (only 15 percent of the population had access at the time of the study) and broadening RH services to address reproductive tract infections. It was also suggested that the program response must be strengthened to address the RH needs of the adolescent population. The paper describes the positive impact of the assessment process itself on increasing awareness of RH issues, improving collaboration between groups working on RH, empowering Department of Health staff and, ultimately, convincing decision makers of the need to strengthen the country's RH program.

International Crisis Group, *Myanmar Backgrounder: Ethnic Minority Politics*, ICG Asia Report No. 52, 7 May 2003.

This report describes in detail the background political situation of the various Burmese ethnic minority groups and is crucial reading for gaining insight into the fundamental issues at play today. The history of the insurgent groups is complex due to the mutation of the groups themselves and their changing alliances primarily against, but at times in cooperation with, the central government. The report highlights the fact that these communities contain few people with the education and experience relevant to political, social affairs, negotiation and organization. Many of their political organizations are directed by soldiers, who also lack the necessary experience to effectively lead their groups toward a better life for their communities and the country as a whole.

Karen Women's Organization, *Shattering Silences: Karen Women speak out about the Burmese Military Regime's use of Rape as a Strategy of War in Karen State*, April 2004.

This report documents 125 cases of sexual violence committed by the Burmese military regime in Karen state from 1988 to 2004. There are no known cases where legal action has been taken against perpetrators. The 125 case studies provide a description of the attacks, including location, time and date as well as the human rights violations, perpetrators and consequences suffered by the rape survivor. The cases were documented by the Karen Women's Organization (KWO), witnesses or survivors of the rape in Burma, and Karen men and women residing in refugee camps in Thailand. Despite the widespread and systematic rape of Karen women, it has been difficult to document cases because: 1) displacement of Karen villages since 1975 has made record keeping nearly impossible; 2) many rape survivors live in

areas controlled by the military and fear further abuse if they speak out; 3) rape is seen as a shameful experience among ethnic groups and survivors fear stigma within their community; and 4) women do not want to be reminded of their painful experience. KWO asks that other researchers use the case studies in this report to avoid having women retell their distressing experiences.

This report focuses on the atrocities being committed against Karen women by the State Peace and Development Council (SPDC), formerly known as the State Law and Order Restoration Council (SLORC). It follows other reports noted in this bibliography documenting the rape of Shan women in the joint 2002 report by the Shan Women's Action Network and the Shan Human Rights Foundation, *License to Rape* and Refugee International's 2003 report *No Safe Place: Burma's Army and the Rape of Ethnic Women*, which provides evidence of abuses against Karen, Mon, Karenni and Tavoyan women. The KWO investigated the patterns of rapes committed against the Karen women by SLORC/SPDC soldiers and the impact on the women and their families. Military officers committed half of the rapes; 40 percent were gang rape; and in almost a third of the cases women were killed after being raped. The report uses a human rights framework citing relevant human rights doctrines to hold the Burmese regime accountable to the international community. Beyond rape, the report also provides evidence of other abuses against Karen women, including beating, mutilation, torture, murder, forced labor and denial of basic rights. The KWO underlines the fact that the rapes are part of a larger strategy by the Burmese regime aimed at terrorizing the Karen people and destroying their culture. The KWO also demonstrates that women suffer the greatest burden of these systematic attacks as they are oppressed on the basis of their gender as well as their ethnicity. Sexual violence has continued into 2004 despite the declared ceasefire negotiations between the regime and the Karen National Union raising concerns for the safety of any refugees who may be repatriated prematurely.

The report also provides a number of recommendations to the SPDC, the states of Burma, the United Nations and the Royal Thai Government (RTG), some of which are highlighted here. The SPDC is requested to cease all human rights violations against the Karen people and to withdraw its troops from occupied areas, while other Burmese states are asked to support these appeals. The KWO recommends that UNHCR prioritize the processing of rape survivors and support community-based organizations assisting these women and that the RTG ensures that rape survivors feeling to Thailand have access to physical and mental health support systems.

Migrant Action Program, et al., *Deportation of Burmese Migrants and HIV Testing*, July 2002. Accessed May 2003 at [www.http://december18th.net/paper52Burma.htm](http://december18th.net/paper52Burma.htm)

An information sheet and recommendations developed by a group of organizations that work with Burmese migrants on the Thai-Burma border reports that 3,000 migrants deported from Mae Sot, Thailand to Myawaddy, Burma have undergone mandatory HIV testing. Twenty migrants testing HIV-positive were separated from their families and communities and sent to a Rangoon hospital. The report notes the violation of the UN HIV Principles and Guidelines adopted by both Thailand and Burma and the false assumption by the Burmese government that HIV is foreign disease being brought into the country from external sources. Recommendations are listed for ending these abuses and the document is signed by nine local organizations, of which MAP is the contact group.

Ministry of Health Union of Myanmar and United Nations Population Fund, *A Reproductive Health Needs Assessment in Myanmar*, Yangon, 1999.

This RH needs assessment was conducted in 1998, with particular interest in contraceptive use and unmet need for birth spacing; induced abortion, maternal mortality and morbidity and emergency obstetric care; prevention and diagnosis of RTI/HIV/AIDS; and adolescent RH.

Various health statistics were cited: MMR was estimated from 140/100,000 (MOH 1993) to 580/100,000 live births (IUNICEF, 1998); abortion-related maternal deaths were reported to be 38.3 percent (Krasu, 1992) to 60 percent (YCW, 1994); CPR was reported as 22 percent (UNFPA/UNDP, 1993-96) to 32 percent (MOIP, 1998); TFR was estimated at 2.7 to 2.9 (1997, 1991); and the percentage of pregnant women testing HIV positive was 1.9 percent in 1997. In regard to services, approximately 35 percent of the population does not have access to any kind of public sector primary health care services.

Adolescents are noted as a population of concern that has few services available to them which are needed to prevent unwanted pregnancies and transmission of STIs. The assessment team highlighted

various cross-cutting issues that must be addressed to achieve integrated RH services and an improvement of RH status among the population. Recommendations include: increase community involvement and knowledge of RH issues; improve the quality of care for RH, particularly ante-natal care and the management of obstetrical complications; establish partnerships between the public and private sectors to reach a larger population as maternal health care is largely provided by the public sector, while the private sector provides most other RH services. In addition, the costs of commodities and services must be reduced to increase care-seeking behavior and greater awareness of RH risks to women, such as STI/HIV exposure, and the lack of access to birth spacing methods must be better understood by both the community and the health care system.

National Coalition Government of the Union of Burma, *Memo on Humanitarian Policy Initiative for Burma*. August 2002.

This policy statement from the NCGUB intends to guide the international community in responding to the deteriorating humanitarian conditions in Burma in a way that ensures a contribution to positive changes in Burma and supports the process of democratization. This memo includes the January 2002 recommendations made by the Strategic Coordination Committee of the Burmese democracy and ethnic movements in exile. The memo also: recommends an informal consultative mechanism between the NLD and the SPDC; asserts that monitoring mechanisms be in place to ensure transparency, accountability and non-discrimination; encourages sustainability via the development of competent community-based, local NGOs; and recommends increasing cross-border humanitarian efforts for IDPs in remote areas of Burma. The document notes that the SPDC has signed the Convention on the Rights of the Child (CRC) and CEDAW; thus humanitarian agencies can use these instruments to advocate for the rights of women and children in Burma. The memo also calls for the international community to explore ways of delivering humanitarian aid directly to those in need, without political interference, and simultaneously contributing to the protection and promotion of human rights and addressing the root causes of the humanitarian crisis. Finally, the memo cites the UN Working Group on Human Development statement that defense spending, as a percentage of GDP, is twice as high as it is on health and education.

National Coalition Government of the Union of Burma (Border Office), *Internally Displaced Persons Situation in Burma*, January 2003.

This report provides an overview of the circumstances surrounding IDPs in Burma, reviewing the main causes and patterns of displacement, the situation of food scarcity imposed upon the ethnic minority groups by the SPDC forces and population figures of the distribution of IDPs within Burma. The report states that an estimated 2.2 million had fled from Burma to Thailand, Bangladesh, India and China, while 2 million were internally displaced inside Burma. Burmese refugees residing in camps in Thailand number 150,000, with another 300,000 to 500,000 living in border areas as non-registered migrants and some 400,000 registered with the Thai government as official migrants. The report also highlights the fact that international NGOs are not permitted access to the displaced within Burma, evidenced by the almost complete lack of any official humanitarian aid by international NGOs inside Burma, aside from the BBC which provides food to three camps in Mon State. A frightening step-by-step description of the process of cleansing insurgent elements from the local population is provided. The process starts with the launch of a military offensive against a village, proceeds with forced labor for portering and construction of military roads and bases in addition to ongoing extortion of money and goods from villagers, and ends with the execution of village elders if any demands are met with resistance.

Refugees International, *No Safe Place: Burma's Army and the Rape of Ethnic Women*, Apple and Martin, April 2003.

No Safe Place is difficult to read to the end, as it is painstakingly descriptive in its detail reporting the brutality of the Burmese army's systematic rape and abuse of women from Burma's ethnic minorities. The purpose of the report is to "support and build on the movement and activity generated by SWAN and to expand the scope of understanding regarding the brutal phenomenon of rape in Burma to include a broader profile of ethnic nationalities." (*License to Rape* reports on violence against Shan women, listed next in this bibliography). *No Safe Place* includes personal stories told by women themselves who have been raped and have witnessed the rape of others. From 26 interviews, RI learned of 43 cases of rape or attempted rape against women from five different ethnic groups, with 23 confirmed by eyewitness testimony or physical evidence. RI makes a direct connection between rape and migration; women flee

Burma because they have been raped or to escape being raped and women in flight are often victims of rape. Rape and sexual violence by the Burmese army is a widespread practice; women tell of rape during flight, incarceration in military camps, during forced labor and while farming. RI was unable to verify any case of rape being prosecuted. Most victims were afraid to report abuses for fear of retaliation and some who did step forward indeed were killed. RI also observes that rape has been a practice of the SPDC for at least 50 years aims of which are "Burmanization" and subjugation of the population. The issue is taboo among the Burmese people: women are seen as "unclean," men feel impotent to protect their families, and communities are reminded they are oppressed by their country's own military. The SPDC has refuted the reports of rape against ethnic women and despite the number of international human rights instruments to which it is obligated to comply, no action is expected to be taken to cease the widespread violence against women.

Shan Human Rights Foundation and Shan Women's Action Network (SWAN), *License to Rape: The Burmese military regime's use of sexual violence in the ongoing war in Shan State, Burma, May 2002.*

License to Rape is the first major published report recording the atrocities of sexual violence employed as a weapon of war by the Burmese army against women of ethnic nationalities in Burma. The report documents 173 incidents of rape and other forms of sexual violence, involving 625 girls and women, perpetrated by soldiers from 52 different battalions of the Burmese army in the Shan state from 1996 to 2001. Officers committed 83 percent of the rapes, a quarter of the rapes resulted in death, 61 percent were gang-rapes and only one rape was prosecuted, with most complainants typically being fined, detained, tortured or killed by the military. The report catalogs the incidents and case studies, provides maps of forcibly relocated villages and names perpetrators. It also includes descriptions of the Shan culture and the increased militarization of the Shan state by the Burmese army resulting in persistent human rights abuses in the region and increased vulnerability of girls and women to rape and other forms of sexual abuse. In addition, the report explores the consequences faced by rape survivors who are often shunned by their families and communities or flee to Thailand where, due to their illegal status, they have no access to humanitarian aid, may be deported or are often further victimized by trafficking or other forms of exploitation. Sexual violence is also analyzed through human rights instruments as torture, an element of genocide, a crime against humanity and a war crime. This report led to a fact-finding mission by Refugees International and its report, *No Safe Place* (listed earlier in this bibliography), and brought the issue of rape in Burma to the attention of the international community.

UNAIDS, *Epidemiological Fact Sheets Myanmar; 2002 Update.* Accessed May 2003 at www.unaids.org

The UNAIDS website updates epidemiological information about HIV/AIDS by country each year. Where data is available (e.g., via sentinel surveillance, etc.), it is incorporated into the fact sheets, and where it is not available estimates about the local epidemic are made. HIV infection among injecting drug users (IDUs) is more than 50 percent, the prevalence rate among female sex workers (FSWs) indicates about a quarter of the population is HIV positive, HIV among the military has increased to 1.4 percent, and ANC testing rates have stabilized at approximately 2 percent. Although HIV patterns in Myanmar are similar to neighboring Thailand, HIV infection rates in Thailand seem to have peaked among many populations whereas Myanmar's rates are still seen to be increasing. In addition, Myanmar is not taking as strong an approach to implement condom use as Thailand did in its "100% condom campaign," showing only an increase to 50 percent by 2000 of consistent condom use among FSWS.

UNAIDS, *Country Profile: Myanmar, December 2003 Update,* accessed January 9, 2004 at http://www.unaids.org/nationalresponse/print_html.asp

The UNAIDS 2003 update describes Myanmar as "on the brink of one of the most serious epidemics in Asia," emphasizing that it is the only one of the three Asian countries most affected by the epidemic to have rising HIV infection rates. Current prevalence rate among 15- to 49-year-olds is 1.1 to 2.2 percent in the urban areas, indicating a generalized epidemic, with lower rates in the rural regions.

UNFPA, *Myanmar Report, 2001. United Nations Population Fund Proposed Projects and Programs.*

This UNFPA program proposal requests "special assistance" to Myanmar for 2002-2005 for preventing HIV/AIDS and other STIs, reducing high levels of maternal mortality through RH information and services and the provision of RH commodities, including condoms and contraceptives. The report cites a MMR of 580 deaths per 100,000 live births (WHO, UNICEF), a total fertility rate of 2.8 with possible geographic

variations, a CPR of only 29 percent, and an unmet need for family planning among married women of 20 percent which would be expected to be higher among unmarried women. The report estimates that one-third of pregnancies end in abortion and unsafe abortions account for half of maternal deaths. Adolescents are a population of concern due to a 2 percent HIV prevalence rate, women under 20 comprising 8 percent of maternal deaths and the vulnerability of out-of-school youth to unwanted pregnancies and STIs, calling for a more targeted approach to the younger population.

U.S. Committee for Refugees, *World Refugee Survey: Burma*, 2003.

Despite the difficulty in accessing IDPs in Burma, USCR estimates that between 600,000 and 1 million Burmese were internally displaced at the end of 2002. Over half a million Burmese refugees and asylum seekers were living in neighboring countries, including 335,000 in Thailand, and hundreds of thousands of Burmese were living in bordering countries in refugee-like circumstances, with about a quarter of a million in Thailand. Thailand only recognizes those refugees fleeing direct fighting, not human rights abuses, but refouled 600 to 700 Burmese fleeing fighting between the Burmese military and an ethnic rebel group. The Burmese Border Consortium reported that 2002 was the worst year for human rights abuses in Burma since 1997. Religious persecution was another tool used by the Burmese regime against some ethnic minority groups such as the Rohingya (Muslim) and Chin (mostly Christian). Interestingly, the Burmese military cited terrorism as a reason for its persecution of the Rohingya. The major causes behind internal displacement continue to be forced relocation and forced labor resulting in a range of human rights abuses and often death. USCR notes that the reports from Refugees International and the Shan human rights groups concerning the rape of ethnic minority women by the Burmese military had resulted in the US State Department urging the Burmese regime to undertake a full investigation. UN agencies and international NGOs continue to be denied access to IDPs in Burma, although some activities by organizations working in the country may indirectly benefit the IDP population. In October 2002, UNHCR met with SPDC officials to discuss a presence in the country if repatriation becomes possible.

UNHCR, *Country Operations Plan, Myanmar*, 2004. Accessed January 9, 2004 at <http://www.unhcr.ch/cgi-bin/texis/vtx/home/opendoc.pdf>

UNHCR endeavors to gain access to the areas in Myanmar from which the 110,000 refugees in Thailand have come. If cease-fire agreements are reached between the SPDC and fighting factions along the eastern border, the voluntary return of some Karen, Karenni and Mon refugees could be possible. The Special Rapporteur of the Human Rights Commission made a strong call for UNHCR's access to Myanmar's eastern border and involvement in the peace and reconciliation process. UNHCR cites three program goals: 1) promote the sustainable reintegration of 80,000 vulnerable returnees to prevent renewed flight; 2) monitor the voluntary repatriation, protection and reintegration of returnees; and 3) raise awareness among Myanmar government officials on refugee and humanitarian law and build the capacity of Myanmar's Human Rights Committee. In addition, the situation of the 235,000 returnees from Bangladesh to Northern Rakhine State in Myanmar and the 19,000 refugees remaining in camps in Bangladesh is discussed.

Women's League of Burma, *Breaking the Silence*, paper submitted to the forty-sixth session of the Commission on the Status of Women, March 4-15, 2002.

Established in 1999, the Women's League of Burma comprises 11 Burmese women's organizations of different ethnic backgrounds and works for the empowerment, advancement and participation of women in all spheres of society. The intent of this paper is to highlight some of the root causes of poverty and environmental degradation in Burma, and to show how this has affected women. Included are descriptions of how women have organized themselves in order to survive and move toward gender equality in working for political and social change. Based on interviews with Burmese women who have experienced the impact of state policies and recently left Burma, the paper explores the root causes of poverty and environmental degradation including the Burmese military regime's anti-insurgency policies, "open door" natural resources policy, and exploitative and irresponsible agriculture and development policies.

The authors describe underpinnings of traditional social and cultural values that support a patriarchal society as the basis from which ongoing gender-based violence and women's rights to education and health care are further denied. They also report that in the face of economic hardships in Burma and in

the limited situations where education is available and affordable, families will choose their sons over their daughters to attend school. The authors report that the Burmese government's excessive spending on the military to control ethnic insurgency groups has resulted in a lack of funding for health infrastructure and services. In addition, the authors explain, the lack of ethnic minorities' access to health care disproportionately affects women who lack access to care during pregnancy and childbirth and children's access to care. Their situation is accentuated by the lack of women's rights within families, with no choice over birth spacing and subsequent unwanted pregnancies due to dire economic hardship, unsafe abortions and women's deaths. The report notes UNFPA's estimate that 750,000 abortions occur annually, or approximately 2,000 per day. Pregnant women are also required to endure dangerous risks with their pregnancies, such as forced labor, poor nutrition and health care. The authors report that rape with impunity is used as a weapon of war in Burma by the State Peace and Development Council (SDPC) and survivors are fearful of retaliation for attempted legal recourse. In addition, the authors report that while rape in Thailand is more opportunistic than systematic, in border countries Burmese women are raped by authorities, employers and others exploiting their vulnerable situations, including their illegal status, while perpetrators are protected by "deeply entrenched systems of patronage in the government, police and army in Thailand." The authors report that other forms of gender-based violence, such as trafficking and forced prostitution, are serious problems in the context of the breakdown of Burmese women's social and cultural supports and their naïve circumstances in unfamiliar countries outside of Burma. The authors further explain that while some women make the difficult choice of sex work, in other situations women are coerced into sex work and find themselves sex slaves of debt bondage without any family or community supports to avail themselves of.

Included in this paper are descriptions of how local women have organized, including the development of some 25 local women's organizations from Burma, and activities they have carried out in order to survive and work towards gender equality in working for political and social change.

Thailand Reports

Ministry of Public Health - Thailand, *Basic Health Population and Reproductive Health Information*, 2002.

This small brochure outlines basic information about the Thai health care system, including the 9th National Health Development Plan (2002-2006) and the Reproductive Health Policy: "All Thais, both men and women, will enjoy a good and more equitable reproductive life." Also provides MCH data from 2001. Statistics are noted to vary among various sources.

Ministry of Public Health - Thailand, *Thailand National Family Planning Program*, 1999.

This folder provides a series of brochures developed to offer an overview of the Thailand National Family Planning Program and "is intended for visitors." The series includes: How Thailand Achieved its Initial Goals in Family Planning (which notes that the rural population has not yet benefited equally from the economic development of the country; HIV/AIDS is also addressed); Family Planning Service Delivery System; Research and Evaluation; Administration System; Communication and Information Support; Human Resource Development.

Ministry of Public Health - Thailand, Reproductive Health Services Division, Department of Health, *Reproductive Health: Thailand's Experiences*, June 2002.

This booklet is akin to an annual report on RH, describing recent activities and data about the 10 RH components: family planning; MCH; HIV/AIDS; reproductive tract infections; malignancy of reproductive tract; sex education; abortion (goal is to reduce the incidence and its related complications); adolescent RH; infertility; and post-reproductive age and old age care. Two new areas of RH focus are violence against women and children and environmental impact on RH. Also adolescent health and sex education are noted as components that could help to solve other RH problems.

Office of the Economic and Social Development Board and United Nations Country Team in Thailand, *Thailand Millennium Development Goals Report*, 2004.

The United Nations Millennium Development Goals (MDGs) are international objectives established by the United Nations (UN) in 2000 at the Millennium Summit to advance the quality of life and health of world populations. The resultant Millennium Declaration outlined the following eight goals to be met by the

year 2015: 1) eradicate extreme poverty and hunger; 2) achieve universal primary education; 3) promote gender equality and empower women; 4) reduce mortality among children under five by two-thirds; 5) improve maternal health; 6) halt and begin to reverse the spread of HIV/AIDS as well as other major diseases such as malaria and tuberculosis; 7) foster environmental sustainability; and 8) develop a global partnership for development. Each goal has corresponding targets and indicators to measure progress toward achieving the overall goals. Thailand has achieved its targets regarding poverty, hunger, gender, HIV/AIDS and malaria; the education goal is on track to be achieved soon; and progress is being made in reaching child and maternal health targets and environmental sustainability. Due to its early achievements in some areas, Thailand has developed "MDG Plus," which sets more ambitious targets for achievement of goals such as poverty reduction, education, health, gender equality and the environment. However, Thailand's challenges lie in the disparities that persist among regions and groups within the country, particularly in the Northeast, the highlands of the North and the three predominantly Muslim areas in the south. Ethnic minorities living in northern Thailand represent one of the poorest groups in the country. The report also notes the need to pay specific attention to marginalized and vulnerable groups, including migrants; however, people living in refugee-like circumstances are not mentioned. Thailand must also look toward improving the quality of education and health care as well as strengthening the capacity of the local government to support the country's decentralization efforts. In particular, HIV is described as "spreading unchecked" among some groups such as informal commercial sex workers and injecting drug users (IDUs) and is recognized as a risk in industrial hubs and border areas as well as among youth and mobile populations, including migrants. However, the measurement of HIV prevalence is only being undertaken among IDUs. Protecting women from sexual violence, the sex trade, trafficking and domestic violence is highlighted as a challenge that could be addressed by establishing a national network of centers to support women who have experienced human rights violations. Finally, Thailand states that it is willing to share technical expertise and experience to support other countries in reaching their development goals.

UNAIDS, *Epidemiological Fact Sheets Thailand; 2002 Update*. Accessed May 2003 at www.unaids.org

The UNAIDS website updates epidemiological information about HIV/AIDS by country each year. Where data is available (e.g., via sentinel surveillance, etc.), it is incorporated into the fact sheets, and where it is not available estimates about the local epidemic are made. A country-specific historical perspective is also included. This 2002 update notes that HIV infection is highest among injecting drug users (IDUs) from 40 to 51 percent and female sex workers (FSWs) from 6.7 to 10.5 percent. Education efforts reduced the number of men visiting FSWs and made condom use the norm; however, limited success has been had in reducing risk behavior among IDUs. UNAIDS estimates that until the end of 2006, 50,000 people will die from AIDS-related causes annually and 90 percent of the deaths will occur in people aged 20-44 years of age. Approximately 670,000 people are currently living with HIV, almost 30,000 new infections occur each year. Unfortunately, the MOH budget to address HIV has decreased since the economic downturn of 1997 and many international donors are no longer contributing to the country.

UNAIDS, *Country Profile: Thailand*, December 2003.

Accessed January 9, 2004 at http://www.unaids.org/nationalresponse/print_html.asp

Thailand is often referred to for its success in employing strong political commitment and a multi-sectoral approach to prevent the spread of HIV/AIDS in the country. However, with 1 in 60 people out of the 62 million population infected and AIDS now being the leading cause of death, it is faced with serious socioeconomic and epidemiological consequences. The country is challenged to rejuvenate HIV prevention efforts, provide care and support to people living with HIV/AIDS and maintain political commitment to address HIV effectively. Prevalence rate among 15-49 year-olds is 1.8% (2001).

UNFPA, *Thailand Report, 2001. United Nations Population Fund Proposed Projects and Programs*.

UNFPA program proposal for assistance in RH to Thailand for years 2002-2006, stating a goal "to contribute to an improved quality of life through better reproductive health and a balance between population dynamics and economic development." Despite success in the areas of general health and family planning, a considerable unmet need for family planning and other RH services remains among women, men and adolescents. Current contraception usage is: pills (23 percent), female sterilization (22 percent) and injections (17 percent) and indicates condoms and vasectomies are under-utilized. In

addition, the reduction in the Thai government's budget for contraception due to the recent economic crisis has resulted in a lack of integration of RH services and insufficient attention to under-served groups. In addition, Thailand lacks a comprehensive data base to collect RH statistics including data on international migration and cross-border transmission of HIV. Finally, a gender gap persists despite Thailand being a signatory to CEDAW and the high literacy rate among Thai women. UNFPA places an emphasis on youth-centered strategies and also notes that the program would encompass migrant and minority ethnic groups.

UNHCR, *Country Operations Plan, Thailand, 2004*. Accessed January 9, 2004 at <http://www.unhcr.ch/cgi-bin/texis/vtx/home/openssl.pdf>.

Current relations between Thailand and Myanmar are positive and expected to continue to improve in 2004. The Thai government is predicted to pursue repatriation of refugees to Myanmar to so-called "safe areas," not places of origin. UNHCR noted that repatriation would be contingent upon conditions being suitable to a safe and dignified return, including an improved political situation in Myanmar, amnesty for refugees and UNHCR's access to monitor repatriation and return on both sides of the border. In addition, UNHCR continues to pursue a permanent presence in the refugee camps. UNHCR reports that there are approximately 2 to 3 million illegal migrants in Thailand, mostly from Myanmar, and admits that it is likely that there are refugees among this population. However, because the Thai government has made the process of seeking refugee status so difficult, most people choose to remain illegal and unregistered given the alternative of arrest, detention and deportation if their asylum claim fails. Movement of refugees continued to be severely restricted with refugees found outside of the camps risking arrest and deportation, a strategy meant to persuade refugees to consider repatriation. Refugees continue to be known as "displaced persons" and camps are called "temporary shelters." Provincial Admission Boards have become inactive in the past two years, a government policy that discourages further camp registration. UNHCR continues to advocate for camps located close to the border to be moved to safer locations; no cross-border attacks have been reported recently but past attacks highlight this serious protection issue. The Thai government's "war on drugs" has resulted in a reported 1,500 extra-judicial killings and consequently has also increased the risk of arrest and deportation of Burmese political dissidents hiding along the border. UNHCR plans to focus activities on ensuring *non-refoulement* and physical protection, addressing GBV issues, administering justice in the camps, ensuring the right of movement, registering and issuing identification documents, relocating camps away from the border and dialoging with refugees to find durable solutions. UNHCR notes the importance of providing psychosocial support and mental health services to GBV survivors and also encourages the Thai authorities to prosecute perpetrators. UNHCR estimates that there are 300,000 ethnic Shan living along the border; UNHCR does not have access to them and they are not allowed into the camps, which are mostly occupied by Karen and Karenni ethnic minorities. The Thai government states that admission to the country is only for those "fleeing fighting" whereas UNHCR advocates for a broader definition that includes persons "fleeing the consequences of fighting," such as forced labor, forced relocation, excessive taxation, physical abuse and other human rights abuses. Finally, UNHCR observes that the number of refugees applying for asylum has steadily increased in the past two years a consequence the Thai authorities making large scale arrests of political dissidents from Myanmar.

U.S. Committee for Refugees, *World Refugee Survey*. 2003.

The Thailand section of this global survey includes a description of the Burmese refugee situation, including updates on the lack of action in 2002 to review applications for asylum, the forced return of Mon and Karen refugees who fled fighting inside Burma, and the Shan, whom Thailand considers illegal immigrants and prohibits from residing in camps. USCR reports that Thailand hosted 336,000 refugees and asylum seekers at the end of 2002, almost all from Burma, including 133,000 Karen and Karenni living in camps, 50,000, mostly Karen, living outside camps, 150,000 Shan dispersed among the local population, and approximately 1,400 Burmese UNHCR-recognized refugees. Some 2,000 to 3,000 Burmese continued to cross the border into Thailand each month in 2002. USCR notes up to 2 million other Burmese live in "refugee-like" circumstances throughout Thailand, at least a quarter of a million of whom are suspected to have fled human rights violations. In addition, the Burmese Refugee Committee estimates 300,000 Shan fleeing forced relocation in Shan state live in Thailand and cannot be accessed by UNHCR which most likely would consider them *prima facie* refugees.

Whittaker, Andrea, *Intimate Knowledge: Women and Their Health in North-East Thailand*, Allen and Unwin, 2000. This book provides a vivid and original study of what it means to be a woman in a village in rural Thailand. As a study on health this book concentrates upon the intimacies of women's bodies while simultaneously exploring how experiences of health and illness are shaped by the wider context of the developing Thai state. The book addresses the broad forces impacting on women's health, discussing gender relations in Thai society, migration and work, the effects of poverty and uneven development. This work also makes accessible some complex theoretical issues using rich ethnographic detail to discuss approaches to the body and embodiment, agency and resistance, the effects of development and modernity. It illustrates the tensions between what is seen as "traditional" and "modern" knowledge and practices and the ways in which these are understood to align poverty and underdevelopment with ethnic and cultural difference. All of these issues are illustrated through chapters covering a wide range of women's health experiences, gynecological problems, STDs/HIV, family planning and maternity, and the controversy of abortion within a Buddhist nation. Women's voices feature throughout the book, telling of the intimacies of their lives and bringing to life the ramifications of broader social forces and policies in Thai society. (This entry has not been reviewed by report authors but is listed as a resource; description provided by publisher.)

World Bank Group, *Health and Nutrition in Thailand*, Social Policy and Governance in East Asia and the Pacific Region. No date. Accessed May 2003 at <http://www.worldbank.org/eapsocial/countries/thai/health1.htm>

This is the website of a special regional project supported by the Asia-Europe Meeting (ASEM) Trust Fund and coordinated by the World Bank, which was launched in 1996 and addresses relevant issues in Thailand, Indonesia, Korea, the Philippines and Malaysia, including health and the economy. The report points out key progress points in Thailand's health status as well as highlighting the disparities in health indicators between rural and urban populations (infant mortality rate was double in areas outside of Bangkok as compared to rates in the city). The site also notes the inefficiency of the health care financing system which provides duplicate coverage for some citizens while leaving more than a third of Thais without any coverage. Finally, this information highlights the challenges resulting from the Asian economic crisis which will inevitably impact the health of the poor and more vulnerable groups the most.

Other Information Sources

Aide Medicale Internationale, *Health Messenger, Special Issue: Reproductive Health*, Issue 19, March 2003. Published in Burmese and English, this issue of *Health Messenger* expands from its usual concentration on purely medical topics to encompass health-related social problems. This issue focuses on RH and provides substantive information on GBV, including social, cultural and medical guidance, including case studies, frequently asked questions and counseling tips. Other articles present guidelines for prevention, assessment and treatment of unsafe abortion; explanations of how to limit mother to child transmission of HIV/AIDS (MTCT); information on nutrition for pregnant women; and parenting tips. (Email publisher at: hmess@loxinfo.co.th)

Aung Su Shin, *Burmese Migrants and their Employers Warned*, *The Irrawaddy*, Vol.11, No. 3, May 29, 2003. Accessed at www.irrawaddy.org

This article, in *The Irrawaddy*, an online and print version newspaper published by Burmese in exile since 1992, seeks to promote press freedom and access to unbiased information. This article warns of the Thai government's crackdown on illegal Burmese migrant workers. The chief of Thailand's immigration police warned Thais not to house and employ illegal migrant workers from Burma and told more than 500 detained Burmese in Mae Sot that they should find a job in their own country and not return to Thailand, where they will face harsh penalties if arrested.

BBC World Service, *Talking Point: Aung San Suu Kyi*, www.bbcworldservice.com, December 15, 2002.

Interview and responses to telephone and email questions with Aung San Suu Kyi, including current insights into education, the pace and necessity of political change, democracy and ethnic diversity in Burma.

Burmese Border Consortium, *Relief Program Report for the period July to December 2002*.

This annual report and funding appeal provides an historical overview as well as an update about the circumstances of the Burmese refugees in Thailand and the IDPs in Burma. The document provides population-based statistical updates, an organizational diagram of the structure of relief assistance, excellent maps and information about specific camps, in addition to the annual BBC program and organizational report. The BBC notes that its staff and expenditures have grown dramatically in recent years in order to comply with new international standards relating to food aid and humanitarian practices in addition to the increasing number of refugees and higher food prices. The BBC's funding target for 2003 is 768 million baht (approximately \$18.2 million USD) and its caseload of refugees at the end of 2002 was 144,358. A decrease in the number of refugees expected in the latter half of 2002 could be partly due to the Thai government policy to not accept any new arrivals which results in many refugees hiding uncounted in camps or disappearing into other parts of the country. The BBC registers its concern about the admissions procedures managed by the Provincial Admissions Boards (PABs) which have rejected almost all new arrivals on the basis that they were not "fleeing from fighting" and have not met on a regular basis. Of the 33,427 persons who sought admission to Thailand since May 1999 (43 months=777 per month), only 35 percent (11,731) were accepted, resulting in a growing unregistered camp population that does not have access to daily survival needs. The BBC suggests that the relationship between the Thai government and the SPDC improved during this reporting period with the Thai-Burma border re-opening after a closure by the Burmese government in May 2002 in response to alleged Thai support for Shan resistance forces. Despite attempts by the Thai government to register migrant workers since October 2001 and hopes for a comprehensive policy to address the situation of migrant workers, harassment and arrests of migrant workers continue with the potential danger of many being sent back to Burma where they face persecution by the Burmese military. The official Thai policy states that any unregistered persons will be arrested and deported. Initially, despite the high fees and security concerns, the registration process attracted some 568,249 workers, the majority of whom were Burmese, but continued registration appeals were closed to new workers and the numbers of workers re-registering with health checks dropped to approximately 300,000 one year later.

The BBC provides detailed information on the situation of IDPs in Burma: an estimated 2,500 villages have been destroyed, relocated or abandoned since 1996, resulting in the displacement of approximately 1 million people; over 200,000 have fled to Thailand, some 365,000 people are living in 176 relocation sites, while another 270,000 live in temporary shelters or are in hiding. Appendix A describes the evolution of BCC from 1984 (called the Consortium of Christian Agencies at that time) to present day, the relationship with the Ministry of the Interior and Royal Thai Government, and how the Committee for the Coordination of Services to Displaced Persons in Thailand (CCSDPT) was established to coordinate relief efforts among the various NGOs working on the border. The report also notes that UNHCR established a presence on the border in late 1998 and opened offices in Mae Hong Son, Mae Sot and Kanchanaburi in 1999 focusing on monitoring and protection of refugees. Appendix C illustrates the steady advance of the Burmese army from 1984 to 1997 into border territory previously held by ethnic insurgent groups, leading to forced village relocation starting in 1996, and resulting in an increased number of refugees crossing into and staying in Thailand (144,000 refugees were counted in border camps in 2002). Appendix D describes the relief program and includes the BBC's gender policy which promotes equal representation, participation, opportunities and access to resources for refugee men and women. The BBC notes that 6 percent of households are headed by single females, women are typically the ones to collect BBC rations and that awareness is increasing among the population about the importance of women's rights. The report states that since 1998 due to Thailand's economic crisis and a series of security incidents involving armed Burmese actors tolerance for refugees by the Thais has decreased and has resulted in accusations against the refugees of perpetrating environmental damage, bringing diseases into the country, taking Thai jobs and being involved in drugs, prostitution and trafficking.

Centers for Disease Control and Prevention News Updates, *Burma's Leaders Slowly Moving to Combat HIV*, San Francisco Chronicle, R. Frankel, April 8, 2003.

This article highlighted by the CDC News Updates provides estimates of HIV prevalence in Burma by various organizations which are necessary because the Burmese government tightly controls all information resulting in a lack of accurate HIV/AIDS information. UNAIDS estimates an under 1 percent prevalence among the 15-49 year age range for 2001 while a WHO/Johns Hopkins researcher estimates the prevalence to be much higher at 3.5 percent for 1999.

Committee for the Coordination of Displaced Persons in Thailand (CCSDPT) and UNHCR, Unpublished Report, *Protection is a Shared Responsibility*, 2002.

This document provides a summary of nine meetings and workshops attended by representatives of more than 40 organizations on protection issues across sectors, such as education, food, water, sanitation, health and gender-based violence hosted by the CCSDPT/UNHCR Protection Working Group from August 2000 through February 2002. Recognizing that protection is about “enabling refugees and displaced people to enjoy their human rights,” the principal theme of the protection working group is that protection is a shared responsibility. The meetings and workshops in this report bring a wide range of actors together to: raise awareness about the protection of refugees and displaced persons from Burma; encourage commitment among UNHCR, NGOs and refugee committees for the shared responsibility of protection; facilitate coordination on protection issues; promote information sharing and advocacy about protection issues; make recommendations to improve protection; and take concrete steps to address protection problems.

Human Rights Watch, *Unwanted and Unprotected: Burmese Refugees in Thailand*, September 1998.

This report reviews the lack of protections afforded to Burmese refugees in Thailand under the Thai government due to the government's unwillingness to sign the 1951 Refugee Convention and 1967 Protocol. However, Thailand is subject to other international human rights conventions it has signed, including the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of Discrimination Against Women (CEDAW). In addition, it must also respect customary international law and as a member of UNHCR ExCom must abide by the principle of *non-refoulement*. There is no regional refugee instrument in Asia (as exists in Africa and Latin America) and Thailand's only domestic legislation states that undocumented asylum-seekers are “illegal migrants” and thus may be deported. Thailand's history of recognizing refugees from Laos, Vietnam and Cambodians has soured its stance on providing protection to Burmese refugees because the government saw its policies as attracting refugees who otherwise might not apply for asylum if its policies were more restrictive. By not internationalizing the refugee issue, the Thai government can more easily escape responsibility for the Burmese refugees in its country. Although the Thai government has provided temporary protection to over 100,000 refugees in camps along the Burma border since 1984, it also has violated refugee standards by forcing large numbers of refugees back over the border, rejecting new arrivals and deporting individuals who have a valid fear of persecution upon their return to Burma.

The report also describes UNHCR's history in Thailand beginning in 1977 with a regional representative in Bangkok, followed by a downgrading of the office in 1983 to a branch office, and finally its current status since 1997, again as a regional office. In 1998, under a new Thai administration, UNHCR was permitted to have an official role and greater presence in Thailand to assist Burmese refugees but a role circumscribed by the Thai government's restrictions. UNHCR does manage a restricted determination process, but due to the Thai government's position it uses the term “person of concern” rather than “refugee.” Refugees must also come to Bangkok to apply to UNHCR, which puts them at risk of deportation if found outside their camp. Previously, refugees living in camps along the border were known in Thai terminology as “temporarily displaced” people; the camps were not called “refugee camps” and camp residents were not recognized as *prima facie* refugees until 1993. UNHCR's limited role in assisting Burmese refugees has generally acceded to the Thai government's categorization of two Burmese groups: students who fled the 1988 uprising and whose claims of political persecution were accepted, and ethnic minorities who were deemed to be only “temporarily displaced.” Ethnic minorities, particularly the Shan, are treated with more suspicion than the student group due to extensive drug trafficking in the Shan state and are typically labeled as economic migrants. UNHCR is not capable of providing sufficient protection to Burmese refugees due to four reasons: 1) UNHCR's limited definition of a refugee; 2) an inadequate system of documentation; 3) UNHCR's inability to prevent deportations; and 4) the Thai government's interference in UNHCR procedures. HRW also cites examples of UNHCR not complying with its own procedures for determining refugee status, for instance, not stating in rejection letters the reason for rejection and making an appeal difficult. In addition, UNHCR policies in Thailand did not

comply with basic international protection principles that guarantee refugees freedom of movement but rather aimed to keep refugees in border camps and out of urban areas.

In addition, the report describes the complicated relationship between Thailand and Burma which has been driven by Thailand's desire for lucrative investments and good trading status with Burma and Burma's pressure on Thailand to not harbor ethnic rebel groups opposed to the Burmese regime. The report also profiles each of the refugee groups: students and ethnic minorities, including the Karen, Mon, Karenni and Shan, and offers a regional analysis on Thai policy toward the ethnic minorities that highlights the lack of protection afforded refugees from cross-boarder attacks, forced repatriation and inadequate access to humanitarian assistance. HRW concludes that "protection for Burmese refugees in Thailand over the past 14 years has been inconsistent and all too often non-existent, due largely to the policies of the Thai government and UNHCR." Factors causing this lack of protection on the part of the Thai government are strategic and economic interests, experience from the Indochinese refugees and the lack of a legal framework. UNHCR's role has been curtailed by its need to maintain relations with the Thai government, a discriminatory system of refugee status determination, and a narrow definition of "refugee."

Karen Women's Organization, *Empowerment, Equality, Freedom*, Annual Report, 2001.

This annual report describes the recent activities of the Karen Women's Organization which works to empower and support Karen refugee and IDP women and is a member of the Women's League of Burma. KWO central office is based in Mae Sariang. Projects include a literacy program initiated in four camps, the establishment of the Karen Young Women's Leadership School, income generation activities, a community care giving program, which includes supporting safe houses where women who have suffered GBV, trafficking and other abuses can seek shelter and other assistance, and capacity development and empowerment activities which feature a various skill building trainings and education.

Manderson, L. and L. R. Bennett, Eds. *Violence Against Women in Asian Societies*, London and New York, Routledge Curzon, 2003.

Related to the 2000 Melbourne consultation of the Global Forum for Health Research, the publication of these ten specialist papers makes available much until now largely unknown information about sexual, domestic and structural violence against women in Asia. The papers cite research and case material dealing with Muranao Muslim women in Mindanao, Bugis people in Sulawesi, acid attacks in Bangladesh and elsewhere in South Asia, gender differentials in violence in Myanmar, rape in Cambodia, sexual coercion amongst adolescents in a urban slum near Delhi, and challenges faced by Malaysian women and women's organizations. The closing paper contributes to both gender-based violence and positive remedial action. The chapter by Monique Skidmore is particularly relevant to the Thai-Burma context. (This entry has not been reviewed by report authors but is listed as a resource; description provided by publisher.)

Refugees International and Open Society Institute, *Pushing Past the Definitions: Migration from Burma to Thailand*, December 2002.

This report provides background since the 1990s on migration from Burma into Thailand resulting in the estimated 2 million Burmese people who reside in Thailand today. Report authors discuss the categorization of the population into three groups: temporarily displaced; students and political dissidents; and migrants. These classifications are often misleading, as they do not accurately describe people's reasons for fleeing Burma (e.g., forced relocation, human rights abuses, political oppression, etc.) and also determine a person's legal status and their eligibility for protection and support. The Thai government's position is based on the assumption that most Burmese cross into Thailand solely seeking employment, ignoring these underlying causes of flight. The report also examines how the Thai government's registration policies for migrant workers has led to arrests and deportations of numerous Burmese creating an environment in which many live in fear of deportation back to dangerous situations in their country. Some of those arrested have been detained at reception centers on the Burma side of the border where mandatory testing for HIV, malaria, tuberculosis and sexually transmitted infections have been carried out in blatant disregard of human rights. The report concludes with recommendations to the governments of Burma and Thailand and the international community for improving the current situation.

Reproductive Health for Refugees Consortium,¹ *Reproductive Health Among Burmese Refugees in Thailand*, December 1997.

A component of *The Next Step* progress report (following entry in this bibliography), this report describes the RHRC October 1997 assessment visit to Thailand. The RHRC notes that the health status of the refugees in Thailand is better than that of the displaced in Burma and refugees and migrants living outside of camps in Thailand. The RHRC points out that reproductive health has significantly improved in camps on the Thai-Burmese border since 1994 when services were nearly nonexistent. As the major health provider to 70-80 percent of the refugees, it was of concern that MSF did not offer comprehensive RH services like other NGO health providers. Family planning, safe motherhood and STI/HIV prevention and education are provided; however, GBV, although known as a problem, is not discussed openly, thus hindering efforts to address it. Although abortion is illegal in Thailand, referrals for complications from abortions were being made by NGOs, indicating that unsafe abortion practices are a problem. Malaria during pregnancy was noted as a serious problem due to the severe consequences during pregnancy and was being addressed by the Shoklo Malaria Research Unit, which had expanded beyond malaria prevention and control efforts to establish comprehensive RH services in the camps in which it was working.

Most of the RH programs are collecting good quality data, but evidence is lacking that the information collected is used for program management and development. For the Burmese migrants/refugees who are living and working illegally in Thailand, general and reproductive health care are seriously lacking. Major recommendations include: ensuring that data collection is used for effective program management; more widely advertising STI counseling services and affording a private space for counseling to take place; increasing availability of condoms; targeting men more strongly on health education activities; and placing an increased focus on post-partum and family planning to balance the usual emphasis on prenatal care.

Reproductive Health for Refugees Consortium, *Refugees and Reproductive Health Care: The Next Step*, 1997. The RHRC reports on the progress made in addressing reproductive health for refugees since the 1994 Women's Commission for Refugee Women and Children's report, *Refugee Women and Reproductive Health Care: Reassessing Priorities* (listed later in this bibliography), documented the lack of reproductive health services in conflict settings. This 1997 report on the state of reproductive health, which notes that progress has clearly been made although a great deal more remains to be done, was based on desk research and visits to refugee settings in twelve countries. Eight key observations and recommendations are made that serve as a programmatic guide to "next steps." See previous entry, *Reproductive Health Among Burmese Refugees in Thailand*, which provides the basis for the chapter on Thailand in this report.

Reproductive Health for Refugees Consortium, *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings, Country profiles Burma/Thailand*, Ward, J., April 2002. The overall objective of this report is to provide an account of the major issues, programming efforts and gaps related to the prevention of, and response to, GBV among conflict-affected populations around the world. The report profiles twelve countries, including Burma, providing a history of GBV in Burma and a description of the types of GBV perpetrated against Burmese refugee women in Thailand, and a summary of GBV programming available on the Thai-Burma border. The author highlights the lack of GBV programming available to Burmese refugees despite the fact that the population has been in a stable setting for some 15 years and numerous reports have documented the sexual abuse by the Burmese military against the refugee population. Limited efforts have been undertaken by a few international NGOs linking with local women's groups and UNHCR to protect the GBV survivor. Of note is that UNHCR's efforts to pursue GBV cases are hindered by the lack of protection for refugees under Thai law. In Nu Po camp, the women's group responds to five or six reports of domestic violence per month, providing couples counseling or, in more extreme cases of abuse, referring the case to the Burmese camp council which may restrict the husband's access. In Umpiem Mai camps, rape survivors who have come forth have not been provided with follow-up medical care. There is no protocol for identifying and supporting

¹ The RHRC recently changed its name to the Reproductive Health Response in Conflict (RHRC) Consortium to acknowledge its concern for all conflict-affected populations and not limiting its activities to refugee settings.

GBV survivors upon arrival into either camp. UNHCR's presence in the camps has served to identify vulnerable women and thus prevent possible violence and exploitation; however, UNHCR's ability to ensure protection in verified cases of violence is unclear. The Karenni National Women's Organization (KNWO) estimates that 60 percent of Karenni women in the camps in the Mae Hon Son area are exposed to GBV, with domestic violence the most common form of violence followed by abuse by the Burmese military and Thai civilians. Although this number may be high, it underscores the perceived pervasiveness of the GBV problem and the range of violence – from reports of domestic abuse and rape by the Burmese military, Thai civilians and Karenni men inside the camps to forced marriage by the Thai military and sexual abuse by Thai police. Comments by camp leaders reflect a denial of the problem and a lack of reporting to medical and camp authorities confirms that women do not feel there is an outlet for their concerns.

Mae Sot has an estimated 16 brothels and a strong textile industry thus creating a large population of refugees and migrants who are without protection. Mae Tao Clinic in Mae Sot has attempted to facilitate awareness raising and trainings for its health staff on GBV but no systems are in place to address the medical and psychosocial needs of survivors of violence or to document cases. The clinic also sees a high caseload of unsafe abortion cases. A safe house in Mae Sot provides assistance and shelter for exploited sex workers but it does not have interventions to address the effects of violence. Some training efforts have been undertaken in all areas visited but efforts are on an ad hoc, uncoordinated basis. The lack of comfort in discussing the issue on the part of survivors as well as service providers and the lack of legal rights of the displaced populations contributes to the gap in programming to address the GBV issue. The author offers a number of recommendations that call upon UNHCR, the Thai government and local and international NGOs to develop a comprehensive system of identifying and reporting incidents, implement a code of conduct for all Thai military and security personnel, train service providers on essential medical and psychosocial protocols for treatment of GBV survivors and involve the local women's groups and communities to address the problem of GBV through education, awareness raising and skills training.

Reproductive Health for Refugees Consortium, *Gender-based violence: Emerging Issues In Programs Serving Displaced Populations*, Vann, B., September 2002.

This report provides an overview of GBV programming and issues around the world based on site visits by the RHRC GBV technical advisor (TA). In the Thailand section of the report, the author notes that the lack of documentation of GBV incidents makes it impossible to verify the extent or severity of the problem. Anecdotal information includes: women reporting rape by combatants in Burma prior to flight; increase in reports of domestic violence; one case of child sexual abuse where the father/perpetrator was sentenced to 5 months in the camp "jail"; young women and adolescent girls as the primary target of sexual exploitation and abuse sometimes resulting in woman being forcibly married to the perpetrator. GBV programming for prevention and response is nonexistent. Many Burmese women's organizations assist survivors but reporting mechanisms are informal, health care is not usually sought and legal justice is deferred to the camp committee, often resulting in the retraumatization of the survivor as human rights are not respected. In Nu Po and Umpiem Mai camps the GBV TA reviewed and made recommendations on ARC's GBV protocol, provided and reviewed key resources, conducted trainings with health and community services staff and the KWO in Nu Po camp and met with NGOs in Umpiem Mai to introduce GBV concepts. The GBV TA conducted an awareness raising and problem-solving meeting with community organizations and MHD's RH staff and provided a training to teachers in Mae Kong Kha camp. In Mae Hong Son, technical assistance was provided to IRC's RH manager on key resource materials, coordination of prevention and response activities was discussed with the Karenni Health Department and a meeting was held with women's organizations to encourage their leadership on GBV issues. Two main recommendations from the report are to: 1) establish a multi-sectoral system for coordinating action and strategy planning for GBV prevention and response in refugee communities in Thailand; and 2) increase knowledge and awareness among humanitarian actors to influence change in refugee communities and among any actors or staff that have contact with refugees.

Shoklo Malaria Research Unit, *Publications on Malaria in Pregnancy*, Volume I, 1990-2002.

The Shoklo Malaria Research Unit (SMRU) was established in 1986 in Mae Sot as a field station to Mahidol University's Faculty of Tropical Medicine. SMRU conducts extensive research on malaria, with a

particular project focus on malaria in pregnancy and infancy, leading to the agency's providing MCH services along the Thai-Burmese border. This volume is a collection of 24 publications of SMRU's scientific research on various aspects of malaria and pregnancy, including one research letter on how smoking of cheroots by pregnant women reduces the birth weight of their babies. More information on the SMRU can be found at www.shoklo-unit.com

Whittaker, A., *Women's Health in Mainland South East Asia*, 2002..

This book shows how war, military regimes, industrialization, urbanization and social upheaval have all affected the choices Southeast Asian women make about their health and health care. First-person accounts from Thailand, Cambodia, Vietnam and Burma provide insight into the lives of women dealing with drastic changes in their societies. Case studies examine how social, cultural and economic forces contribute to the way women make personal health care decisions. Topics addressed in the book include: a proposed new approach to women's health, where treatment is determined by society, culture and gender rather than by biology alone; the relationship between menstruation and other aspects of life for Burmese women: the politics of abortion in Thailand; the difficulties of seeking care for reproductive tract infections in Vietnam; the influence of local culture on the treatment of reproductive health problems in northeast Thailand; occupational health hazards faced by women working in the electronics industry in northern Thailand; and the links between migration, sex work and HIV/AIDS among female garment factory workers in Cambodia. (This entry has not been reviewed by report authors but is listed as a resource; description provided by publisher.)

Women's Commission for Refugee Women and Children, *Fear and Hope: Displaced Burmese Women in Burma and Thailand*, March 2000.

This report describes findings of a Women's Commission delegation trip to investigate the causes of displacement, with special attention to factors affecting women and children – and particularly RH and education – within Burma and from Burma into Thailand. The report includes case studies on Burmese women who have fled to Thailand for different reasons and the dire circumstances they have faced. In addition, a description of the work of the Mae Tao Clinic in Mae Sot is provided. The AIDS epidemic is highlighted as a major issue of concern for Burma, particularly given the lack of response by the Burmese government. The delegation heard that although 50 million condoms are needed each year, perhaps only a tenth of this amount are available. Family planning is discouraged and abortion is illegal in Burma as part of the government's pro-natalist policy. The economic crisis in Burma is also described as having driven women and girls into the commercial sex industry; it is estimated that 80 percent of commercial sex workers in Thailand are Burmese.

Having visited both Burma and Thailand, including a meeting with Aung San Suu Kyi in which the National League for Democracy leader expressed her cautious support for direct, transparent assistance in combination with consistent international condemnation of the Burmese military regime, the delegation concluded that it would be possible to provide carefully designed humanitarian assistance in Burma without strengthening the military government. The team also viewed HIV/AIDS as a possible entry point for humanitarian organizations to implement a multi-sector approach in Burma to address the far-reaching impact on the population – particularly women and girls - as the military government is beginning to recognize the severity of the situation. Until conditions improve sufficiently for return to Burma, refugees in Thailand require protection against forced repatriation and opportunities for skills development and education. Humanitarian assistance must be extended to undocumented migrants living in refugee-like circumstances with a particular focus on health and reproductive health. Finally, the delegation recommended supporting women's groups on both sides of the border which are a critical resource in addressing the gaps in education, reproductive health and income generation.

Recommendations also include supporting the provision of medical and other humanitarian assistance, including reproductive health care for non-registered people in Thailand living in refugee-like circumstances; promoting income generation projects and training with a special emphasis on women and adolescents; supporting education beyond the primary level; and supporting refugee women's groups and local nongovernmental organizations with funding, capacity building, including building networks with the international community.

Women's Commission for Refugee Women and Children, *Refugee Women and Reproductive Health Care: Reassessing Priorities*, June 1994.

The Women's Commission's groundbreaking report documents the lack of reproductive health information and services available to refugee and displaced women and laid the groundwork for the subsequent efforts that have since begun to address these gaps. The study was conducted in eight countries – six refugee and two IDP settings. Major findings reveal that women in refugee settings were having a high number of children for a variety of reasons; the focus on maternal and child health (MCH) services in these settings excluded a broad population, leaving single, teenage, childless and infertile women without health services; and comprehensive reproductive health services that address STIs, HIV/AIDS prevention and education, abortion, rape and other issues were not offered. In addition, the important link between mother and child survival demanded that activities should be undertaken to improve the reproductive health status of refugee women through policy-level discussions, establishment of guidelines and demonstration projects and improved evaluation of MCH programs.

The field visit to the Thai-Burma border describes the general and reproductive health conditions for refugees living in and outside of camps. Major health problems in the camps included malaria, parasites, upper respiratory infections, other infectious diseases and poor nutritional standards. Children had not been vaccinated against measles and pregnant women had not received tetanus infection immunizations. Researchers found high birth rates, low standards of maternal health and that family planning was unknown and unpracticed. Generally, conditions were only slightly better than inside Burma. A Burmese doctor working in the Karenni camps near Mae Hong Son was appalled by the standards of maternal and child health and was proposing an effort to address these gaps. No family planning was available and immunizations, except measles, were not done due to a lack of cold chain facilities. In the Mae Sot area, the following statistics were provided: 90 percent of Karen women become pregnant under the age of 18; 90 percent of women who reach the age of 30 have had 10 pregnancies and most women have an average of 15 pregnancies by the end of their childbearing years; 80 percent of women deliver with untrained birth attendants; 10 percent of all infants die during delivery or before their first birthday; and 50 percent of children die before their fifth birthday.

Women's Commission for Refugee Women and Children, *Trafficking in Women and Children, With a Focus on the Thai-Burma Border*, 2003.

This paper examines the links between armed conflict and the illegal movement of humans in order to sell them or exploit their labor, and the specific vulnerabilities faced especially by refugee and migrant women and children. The paper notes that in 1995 the total revenue from prostitution in Thailand equaled nearly 60 percent of the Thai government's budget for that year. An inherent problem in halting the sex trafficking problem is that aside from those who profit from it, many rural families depend on the income that women send back from their work in urban centers; in fact, it is estimated in 1998 that some US\$30 million was transferred by women working in the sex sector to their families. Also alarming, it is estimated that 80 percent of the commercial sex worker population in northern Thailand is Burmese, with 40,000 Burmese girls and women forced into Thailand's sex industry each year and of the children trafficked in between the Thai, Burmese and Chinese borders, 70 to 80 percent are girls. The commercial sexual exploitation of children in Thailand is associated with poverty, lack of education and poor social conditions – forcing many adolescents without any education, skills or other alternatives into the industry to help earn money for their families. In one town in Thailand along the Burma border, seven of every ten families have sold at least one daughter into prostitution; young girls command a premium price because it is assumed that they are less likely to be HIV infected. In Burma, HIV infection rates among sex workers was reached forty percent among some populations in 2001; on the border, the HIV/AIDS rate among local sex workers is approximately 24 percent. This extensively referenced paper also includes descriptions of responses by the Burmese, Thai and U.S. governments to the situation and an annotated bibliography of organizations working on the trafficking issue. .

Women's Commission for Refugee Women and Children, *Untapped Potential: Adolescents Affected by Armed Conflict; A Review of Programs and Policies*. 2000.

This study documents the needs of adolescents affected by armed conflict. It relates the experiences of adolescents in war and persecution and stresses that these crisis-affected youth are in great need of attention and support by the international community. The study highlights some risks faced particularly

by adolescents girls who may be more likely than younger girls to be sexually abused or abducted and held as sexual slaves, may be targeted for sexual abuse because perpetrators consider them to be less of a risk for contracting STIs/HIV, and may also be forced into prostitution to meet their daily survival needs. In general, adolescents have less access to information about reproductive and other health care than adults and are the least likely of all groups to access health services. The health sector is the most developed and coordinated response by the international community to adolescents affected by armed conflict with efforts to address their reproductive health needs such as preventing the transmission of STIs/HIV. However, few operational health programs target adolescents specifically – an indicator of the challenges ahead in addressing the needs of children affected by armed conflict in a comprehensive manner. The report concludes that with amazing capacity, adolescents rise to the occasion to confront the obstacles they face; however, they require support and capacity building efforts to fulfill their potential. The report articulates six basic elements to be addressed in “A Call to Action” and provides numerous examples of the struggles of conflict-affected youth as well as strategies for addressing their issues.

Reference and Resource Materials

The Committee for the Coordination of Services to Displaced Peoples in Thailand, *Health Statistics Monthly Report Form*, April 2003.

Aide Medicale International, *Burmese Border Guidelines*, 2003

These are clinical guidelines for care developed for local medics and medical providers working on the Thai-Burma border based on medical literature and World Health Organization guidelines and reflecting the specific medical pathologies and limitations of the Burmese border context. The guidelines were developed with funding from USAID through the International Rescue Committee (IRC) and with input from agencies including Aide Medicale Internationale (AMI), American Refugee Committee (ARC), Burmese Border Consortium, International Rescue Committee (IRC), Malteser Germany (MHD), Médecins Sans Frontières (MSF), Mae Tao Clinic (MTC) and the Shoklo Malaria Research Unit.

The 2003 edition includes new sections primarily based on requests of medics, including shock, hemolytic anemia, rapid diagnostic tests for malaria, sinusitis, rheumatic fever, epilepsy, diabetes, leprosy, joint disorders, cellulites, herpes simplex and zoster, scrub typhus, dengue, leptospirosis, drug and alcohol intoxication, common psychiatric disorders and gender violence. Technical areas of reproductive health covered in the guidelines include family planning, gender violence, sexually transmitted infections, HIV/AIDS and common obstetric problems.

International Rescue Committee. *Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations*, Kumarian Press, 2003. intranet.theirc.org/docs/Protecting_the_future.pdf

The IRC's *Protecting the Future* is the first publication that has been designed specifically for health workers who are developing comprehensive programs for HIV among displaced and war-affected populations. It is the first publication designed specifically for health workers developing programs for HIV-infected and at-risk populations and outlines a practical, step-by-step process to implement these programs. Based on IRC's work, this book shows how relief agencies can work with refugees and local people to minimize further spread of HIV and provide care and support to those affected. The manual is complete with training exercises, activities for engaging the refugee population in HIV prevention work and references for HIV resources. *Protecting the Future* is useful not only for humanitarian workers, but for any health professional establishing HIV programs in resource-poor settings.

International Rescue Committee, *Obstetrics, Gynecology and Pediatrics Manual, Upgrade Training for Medics and RCH Workers*, November 2002.

This manual was developed by IRC staff in Mae Hong Son to provide a user-friendly guide for medics and RCH workers. Part one focuses on obstetrics and gynecology, including female anatomy and physiology, sexually transmitted infections, family planning, antenatal care, obstetric emergencies, breastfeeding and other topics. Part two is dedicated to pediatrics covering patient history-taking, physical examination, nutrition and malnutrition, vitamin deficiencies, a range of diseases, immunization and other useful subjects.

Mae Tao Clinic, *Reproductive Health Program Guidelines*, April 2002.

The guidelines contain a preliminary set of protocols to guide the Mae Tao Clinic's reproductive health program staff. The guidelines are designed to be used as tools to assure quality of care. Examples of topics include quality primary health care services, quality assurance, universal precautions, responding to sexual violence, prenatal care, normal labor and delivery, essential newborn care, postnatal care, sexually transmitted infections and surveillance.

Nang Lao Liang Won, *Guidelines on Strategies & Responses to the Needs of Burmese Migrant Women in Thailand*, Asia Pacific Forum on Women, Law and Development, 1999.

This book serves as a guideline for organizations that work on program and policy issues for the protection of Burmese migrant women. This rich guide describes the context and problems encountered by migrant women and suggests strategies and responses for dealing with the complex circumstances the women face.

The Population Council, Policy Brief on Reproductive Rights: Unplanned Pregnancy, Burmese and English.

The Population Council, Policy Brief on Reproductive Rights: Conclusion from the Meeting on Indicators of Reproductive Health, Burmese and English.

The Population Council, Policy Brief on Reproductive Rights: Violence Against Women, Burmese and English.

Reproductive Health Response in Conflict Consortium, *Gender-based Violence Tools Manual for Assessment & Program Design, Monitoring & Evaluation in Conflict-Affected Settings*, 2004.

Informed by a working group comprised of representatives from the RHRC Consortium, UNHCR, WHO and others, the GBV Tools Manual provides the first compendium of tools specifically designed and field-tested to facilitate GBV data collection as well as programming. The manual includes assessment tools such as guidelines for conducting a situation analysis, program design tools like the causal pathway framework and program monitoring and evaluation tools including monthly statistical report forms. Each section of the manual has an introduction that explains its contents, which can be used as a guide to information-sharing about the manual. The manual also can be used to create opportunities for information-sharing with community members interested or engaged in GBV-related work. The tools manual is one of several outcomes of a four-year global Gender-based Violence Initiative spearheaded by the RHRC Consortium and funded by the U.S. State Department that is aimed at strengthening international and local capacity to address GBV in refugee, internally displaced, and post-conflict settings.

Reproductive Health Response in Conflict Consortium, *Guidelines for the Care of Sexually Transmitted Infections in Conflict-Affected Settings*, Women's Commission for Refugee Women and Children, 2004.

The STI guidelines are aimed at individuals and organizations concerned with improving the quality of care of STIs in conflict-affected settings. The document primarily targets workers involved in resource allocation, programmatic decision-making and management. The guidelines should be useful to health coordinators, program managers and technical advisors, both in government and non-governmental organizations (NGOs). While technical components relevant to clinical health workers are included, the guidelines will also provide non-clinical staff with insights into the scope and complexity of an important public health issue. In addition, the guidelines provide a framework for clinic-based care of STIs and aim to show that STIs are an important public health problem in conflict-affected settings; conflict-affected settings pose challenges but also present opportunities for STI control; effective STI care requires investment in technical capacity to design and implement appropriate, technically sound programs; effective service delivery is based upon reliable data, drug management, training and supervision, as well as effective clinical care; and advocacy is needed to ensure that STI control receives the necessary attention in conflict-affected settings. Finally, this document aims to raise awareness of the complexities of STI care and to highlight areas where improvements may be possible. Sections 2 and 3 describe STIs and provide a broad overview of the STI problem. Section 4 highlights the implications of STIs in conflict-affected settings. Section 5 provides a contextual framework for STI programs and reviews the debate around syndromic management. Section 6 introduces an approach to clinic-based STI care in conflict-affected settings. Sections 7, 8 and 9 describe components of clinic-based care including data collection, service delivery and utilization. Recommendations for both minimum and comprehensive responses are presented, acknowledging the need to adjust responses to the phase of the emergency. Section 10

presents an overview of key points and a summary of recommendations. Section 11 includes supplementary documents and suggestions for further reading.

Reproductive Health Response in Conflict Consortium, *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers*, Women's Commission for Refugee Women and Children, 2004.

This 5-day course on HIV/AIDS prevention and control aims to assist humanitarian workers to deepen their individual understanding of the complexities of HIV/AIDS and to equip participants with the knowledge and skills needed to improve HIV/AIDS program design and implementation in their communities. HIV/AIDS programs which should provide prevention, treatment and care services for refugees and internally displaced persons are often weak and limited. We encourage your organization to use the facilitator's manual as a resource within your institutions and communities to improve the prevention and control of HIV/AIDS in conflict-affected settings. The activities in this manual, which have been field tested in Sierra Leone, Kenya, Thailand and Pakistan, are designed to encourage participants working in conflict settings to apply the information in this course to their own contexts and to share examples from their own experiences. The course is also flexible in that general awareness raising, on issues like stigma, and technical topics, such as voluntary counseling and testing, can be pulled out as separate shorter trainings depending on the needs of your staff. Two CD-Roms accompany the facilitator's manual, containing PowerPoint presentations, posters, handouts and additional resources for use both during the course and for supplemental research. Also included are audio interviews with a group of HIV-positive students from South Africa who share their stories, allowing course participants to personalize the HIV/AIDS issue.

Shoklo Malaria Research Unit, *Obstetric Emergencies: A Guide for Health Workers on the Thai-Burmese Border*, 1999.

This manual provides guidance on universal precautions, early and late pregnancy, labor, post-partum, newborn and general obstetric information. Appendices include a partograph and STI guidelines. This dual language guide is published in English and Burmese.

UNHCR, *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*, 1999.

In 1995, UNHCR, UNFPA, WHO and more than 50 United Nations, governmental and nongovernmental organizations (NGOs) met at a symposium, following which 30 of the groups formed the Inter-Agency Working Group (IAWG) on Reproductive Health in Refugee Situations. The IAWG developed the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* for people assisting refugees and distributed it around the world for field-testing resulting in the production of this 1999 revised version. Field managers of health services in refugee situations are the primary audience for the Field Manual. Community-services officers, protection officers and others working to meet the needs of refugee women, young people and men should also benefit from the guidance offered in the Field Manual. The purposes of the Field Manual are to: serve as a tool to facilitate discussion and decision-making in planning, implementing, monitoring and evaluating RH interventions; guide field staff in introducing and/or strengthening RH interventions; and advocate for a multi-sectoral approach to meeting the RH needs of refugees and foster coordination among partners. Chapter One lays the foundation for the subsequent technical chapters on reproductive health and provides guiding principles for undertaking all RH care. The components of the Field Manual are: Minimum Initial Service Package; safe motherhood; sexual violence; sexually transmitted infections, including HIV/AIDS; family planning; other RH concerns; and RH of young people.

UNICEF and Education Minister of Myanmar, *Teachers Guide for a Healthy Lifestyle and HIV Prevention for Primary School Children*, May 1998. (Burmese language).

Teachers guide for teaching primary school children ages 5-12 years. Topics include hygiene, diarrhea prevention, communication skills, smoking prevention, decision making, HIV prevention, body changes, nutrition, dengue, drug prevention, dialogue, emotion counseling.

UNICEF and Education Minister of Myanmar, *Teachers Guide for a Healthy Lifestyle and HIV Prevention for Youth*, September 2001. (Burmese language).

Teachers guide for teaching youth ages 13-24 years. Topics include reproductive health, family planning, STI, HIV Counseling, decision making, TB, care for HIV/AIDS prevention.

UNICEF, *Facts for Life*, October 2000.

Resource for leaders, teachers, education department, media, religious leaders, youth organizations. Topics include: child spacing, safe motherhood, reproductive health, maternal nutrition, breast feeding, child growth and development, ARI, malaria, HIV/AIDS, hepatitis B, dengue, TB, vitamin deficiency, water/sanitation, child development and psychology.

Working Group for Health Information System (HIS) in Border Areas, *Data Collection and Health Information Training*, December 20, 2002 to January 14, 2003.

This is the outline of a training that took place to improve the quality of data collection and health information systems in the Thai-Burma border areas. The training focused specifically on the collection of data rather than on the use of data for program management.

I:\REPRO\Assessments\Thailand\report drafts\bibliography.nov04.doc