Kathy Pan, sticks and pummelling: Techniques used to induce abortion by Burmese women on the Thai border

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Abstract

Forced migrants face particular reproductive health problems. Migrant Burmese women in Thailand often need to work to support themselves and their families, and mistimed and unwanted pregnancies are a common problem. They have limited access to culturally appropriate reproductive health services and no access to safe elective abortion. They are at risk of deportation or at least harassment by Thai authorities if they travel. They use traditional methods such as herbal medicines, and employ lay midwives to provide pummelling and stick abortions to end their pregnancies. This ethnographic study used various methods to collect data over 10 months in Tak Province, Thailand. The authors describe the women’s motives and means of ending their pregnancies and some of the difficulties in obtaining reliable modern methods of contraception. This study highlights the need for reproductive health care for displaced populations.

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Introduction

The International Conference in Population and Development (ICPD) Programme of Action officially recognised the particular problems of ‘migrants and displaced persons who in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights’ (United Nations, 1995, Chapter 7, point 7.11). There is now increased awareness of the need for provision of reproductive services to displaced populations but there remain impediments to effective implementation (Marsh, Purdin, & Navani, 2006; Palmer, Lush, & Zwi, 1999). This is especially the case among populations who fall into ambiguous categories, are driven out of their country due to ongoing conflict and economic collapse, and yet are neither technically recognised as refugees nor accorded full legal status in the receiving country. In this paper we examine the needs of one such group, Burmese migrant workers along the border with Thailand.

Here, we use the name Burma rather than the Union of Myanmar as this follows the convention preferred by our informants. The term ‘Burmans’ is used to refer to the ethnic majority group and ‘Burmese’ to designate all those who live within Burma.

There is an estimated one million migrant workers in Thailand, the vast majority originally from...
Burma, the majority of whom are undocumented (Asian Migrant Centre & Migrant Forum in Asia, 2003; World Health Organization, 2004). Diverse categories are used to describe the Burmese people who live in Thailand; for example, those who seek protection in United Nations High Commission for Refugees (UNHCR) camps, resettlement sites or holding centres along the Thai Burmese border are referred to as ‘temporarily displaced persons’ rather than refugees. This is in spite of their length of stay in the camps, as Thailand is not a signatory to the Refugee Convention (1951) or the 1967 Protocol (Caouette, Archanvanitkul, & Pyne, 2000; Lang, 2002). UNHCR has assisted in a process of consolidating the number of camps, and in 2003 there were 10 camps holding 145,316 people (Committee for Coordination of Services to Displaced Persons in Thailand, 2003). Burmese found outside of such camps have ambiguous legal status; they are called ‘migrant workers’ but would be better classified as forced migrants, and it is this group that our study concentrates upon. Those without immigration papers are described by Thai authorities as ‘irregular’, ‘undocumented’, ‘unregistered’, or ‘illegal’ migrants and face legal sanctions and deportation from Thailand.

Access to abortion

This paper documents the methods used to induce abortions among Burmese migrant women living in the border province Tak in Thailand. The majority of the women in this study are forced migrants, working in Thailand for a variety of reasons, including poverty, lack of life opportunities, political insecurity and to escape human rights abuses. This paper forms part of a broader study undertaken on reproductive health and the problem of fertility management and induced abortion for these women (Belton, 2005). Abortion law in Burma is restrictive, only allowing a legal abortion if the woman’s life is in danger (Ba-Thike, 1997; UNFPA & Ministry of Immigration and Population Union of Myanmar, 1999). Similarly, abortion is restricted in Thailand, although these restrictions have recently been modified (Whittaker, 2004). Although the majority are technically illegal, abortions by medical staff in private clinics are available in Thailand, but Burmese women are unlikely to use the Thai system due to a lack of knowledge, prohibitive cost and inability to travel. As this study shows, despite these illegalities, induced abortion using a variety of unsafe techniques remains an important means of fertility management among vulnerable Burmese women migrants. Violence, poverty, an unmet need for reproductive health services, and low-quality information contribute to the high rates of unwanted pregnancy and unsafe abortion.

Literature review

Few studies have examined abortion or reproductive health issues for migrant workers in Thailand. However, the Royal Thai Government recorded a rate of abortion 2.4 times higher in the Burmese population than that of the local Thai population in a study conducted in three provinces (Royal Thai Government, 2001). It is clear that unwanted pregnancies and the lack of access to contraception is a major public health issue in Burma (United Nations Population Fund & Ministry of Immigration and Population Union of Myanmar, 1999). The Myanmar Department of Health ranks abortion in their top 10 health problems for the country based on hospital morbidity and mortality and the third main cause of hospital morbidity (Ba-Thike, 1997; Chandler, 1998, Chapter 14). Maternal mortality is poorly recorded and may be 360/100,000 live births (Population Reference Bureau (Access date 14 February 2007); at least half of the deaths of women due to pregnancy-related reasons are believed to be linked with abortion (Ba-Thike, 1997). For displaced Burmese women or those who live in remote areas, the estimated maternal mortality increases to 580/100,000 per live births (Lanjouw, 2001), which reflects in part their lack of access to health services and their marginality in relation to the state. Modern methods of contraception are not widely used in Burma. Only 32% of fertile-age women in Burma use a modern method

1Recently the Thai government regulations concerning abortion have been modified so that abortions can now be performed in the following situations: 1. The pregnancy causes harm to a woman’s physical or mental health. 2. The pregnancy is a result of rape. 3. The fetus is diagnosed with an anomaly or hereditary disease and the woman does not want to continue her pregnancy.

(footnote continued)

In these circumstances abortions can now be performed without gestational limits at public hospitals, or at private clinics up to 12 weeks gestation. (Royal Thai Government Gazette, 15 December 2005, 7 Book 22, Section 118g).
Reproductive health in the camps

There are relatively few studies that examine reproductive health for Burmese women inside the camp system. In a camp-based survey of 500 men and women, Wassana Im-Em, Suksinchai, Sartsara, and Thorsuwan (2000) found that the majority of people living in these camps were Karen following by Karen and Shan. Most respondents were married with two children, although half reported wanting four children. Between 8% and 29% of fertile age women were current users of a family planning method (Guest, Archanvanitkul, & Suksinchai, 2000; Wassana Im-Em, et al., 2000).

In a survey of 900 married Karen women in Tak Province, Thailand half of the women had never attended school, half were Christian, 233 reported working outside the camp—although this is not allowed—and 40% of women had given birth to four or more children (Suksinchai, 1999). This study reported 74 miscarriages per 1000 pregnancies. This was attributed to the combination of smoking habits (over one half of women smoked tobacco) with poverty, prolonged under-nourishment, poor sanitation and inadequate health care. It is unclear how many of the miscarriages reported in the study were induced. Higher levels of ‘miscarriage’ in women who were working outside camp settings were also found, but the author did not consider the connection between a woman’s need to find paid work and the disruption to income-earning potential a pregnancy and birth can bring.

Reproductive health outside the camps

Research on migrant women’s reproductive health outside the camps is even more limited partly due to the difficulties in accessing this population. The most comprehensive research on reproductive health issues, and specifically abortion in migrant workers, has been conducted by Caouette et al. (2000). Using questionnaires, focus groups and observations, they recorded the responses of 428 women and 399 men who lived in Chiangmai and Ranong on topics such as migration routes, work conditions, violence, sexual health and mobility. They questioned Burmese who were Shan, Mon and Tavoyan. The general picture is of a mixed flow of migrants, who live and work in extremely difficult circumstances with very limited access to health care in Thailand. Migrant workers are described as multi-ethnic, between 15 to 50 years of age, Buddhist (97%), generally poorly educated, often living with a partner, with about half having living children. The lack of access to health care and education for displaced Burmese in either Burma or Thailand leads to ‘high-maternal mortality and morbidity rates, unwanted pregnancies, unsafe abortions and sexually transmitted diseases (including HIV/AIDS)’ (Caouette et al., 2000,p.28). The authors found that 17% of the people they interviewed (99 out 587 respondents) attempted to obtain an abortion and 45% succeeded in ending the pregnancy. Just over half of the abortions were performed in Burma and the rest were performed in Thailand or in the border areas. Untrained people performed most induced abortions. Lay midwives were the main suppliers of this service (44%), followed by other health personnel (18%); 38% of respondents stated that they acted alone or with the help of friends or husbands. The migrant workers reported using herbal medicines, injections, massages and the insertion of objects into the genitals to induce an abortion. They also reported serious complications that were expensive to treat. The reasons given for the abortions were: being unmarried; too many children; not living in secure conditions; and a lack of access to reliable contraception. The study did not indicate if there was any difference between the group that did not disclose an unplanned pregnancy/abortion and the group that did (Caouette et al., 2000). Additionally, the authors determined that access to sexual health information or contraception is uncommon in Burma. Many respondents reported their knowledge increased after they entered Thailand. Violence, both at the level of the local community and inflicted by state actors, is common, yet despite their onerous living conditions, the Burmese planned to remain and work in Thailand. Health knowledge and information was very low and the type of health care chosen by pregnant women migrants was influenced by their degree of access to services in the formal health care system, ability to travel, ability to speak Thai, cost, and their dependence on their employer (Caouette et al., 2000).
Methods

This ethnographic study used a variety of methods to collect data over 10 months of fieldwork in 2001 and 2002 in Tak Province, Thailand. Ethics approval for this study was granted from the University of Melbourne and the two health facilities involved. Verbal informed consent was gained from all participants. No real names of patients were recorded and hence all names of patients and staff used in this paper are pseudonyms.

The study site was Mae Sot town at the border of Thailand and Burma. Each year large numbers of women with post-abortion complications from spontaneous or induced abortion present at the local Thai public hospital and the Mae Tao clinic with pain, excessive bleeding, infection, and occasionally perforation of internal organs. The most complicated cases are usually referred to the Thai public hospital. The Mae Tao Clinic is unusual in that it is led by Burmese dissidents in exile and serves the local Burmese refugee and migrant worker populations. In 2002, this informal Clinic treated 45,000 cases of illness in its inpatient department (IPD) and outpatient departments (OPD), provided delivery care for 783 women, admitted 193 women with post-abortion complications and recorded 3,965 visits about family planning (Maung, 2003).

Retrospective medical record review

The methods used in this study included a retrospective review of the medical records of all women with any type of early pregnancy loss who attended the OPD of the Mae Tao clinic in 2001. This produced 196 records from Mae Tao. In addition, the records of 36 Burmese women referred to the Thai public hospital were also reviewed. The first author, who has clinical training as a midwife, recalled the medical records of women with any type of abortion diagnosis such as vaginal/uterine bleeding, suspected induced abortion, spontaneous abortion, threatened, incomplete, missed, or septic abortion, perforated uterus or other abdominal or pelvic injury. This provided data on the number of abortion complications seen at these clinics and provided an estimate of the number of complications due to induced abortions in one year.

Discussions and interviews

In addition to the record review, Burmese women who attended the Mae Tao clinic OPD and 50 traditional midwife trainers from Karen State in Burma who participated in a skills workshop were invited to free-list and sort terms associated with fertility control. Burmese lay midwives (lē the—Burmese) from urban and rural areas in Thailand also generated free-lists. Snowball recruiting was used to bring 15 lay midwives together for directed group discussions on topics of their local knowledge, midwifery craft, modern and traditional fertility management and abortion. The focus groups were also useful in identifying particular midwives who were knowledgeable on certain subjects and willing to speak for further individual interviews. Finally, women inpatients with post-abortion complications (43), their male partners’ (10), health workers (20), and community members were interviewed either by semi-structured interviews or informal conversations about abortion, contraception and fertility management. Women inpatients were prospectively identified by the Burmese and Thai nursing staff over a period of five months who invited them to talk with the researchers. Only five women declined. Women were interviewed in a private room by a female research assistant after verbal consent was collected. Data was collected in English, Thai, Burmese, and two Karen dialects with the skills of a male and a female research assistant.

Limitations

The major limitation of this study is that most of the women and men who contributed to knowledge about pregnancy loss and induced abortion were recruited in a hospital setting. Many women in this area manage their miscarriage/induced abortion at home or do not experience severe blood loss, infection or pain at levels that warrant a visit to a health worker. Hospital cases only represent those who come to hospital not those who may have stayed at home or visited alternative health services. Despite this limitation, the study does provide detailed understandings of the circumstances, techniques used and motivations for induced abortions by these women.

Findings

The combined inpatient and outpatient departments at the Mae Tao clinic alone treated 467 women for post-abortion complications. The medical records of women with post-abortion complications...
show at least a quarter were self-induced. As there is no definitive test to differentiate between a spontaneous abortion and induced abortion, we relied on a combination of medical signs and symptoms, the women’s disclosure and the health workers’ diagnosis. Septic abortions are indicative of unsafe abortion but not always, some women’s notes had genital trauma or foreign objects recorded, and in some cases the health worker recorded the woman visiting an abortionist or taking abortifacients.

The vast majority of women were married, a third of the women experiencing an abortion had no children, while 12% had four or more children. A third of the women had five or more pregnancies. Thirty-one Burmese women with complications were referred from the Mae Tao clinic to the Thai public hospital for post-abortion care during 2001. The cost of 116 days of post-abortion care in the hospital for these 31 women was 71,432 Baht (US 1748). This meant that women had to pay 2300 Baht (US 56) on average for their hospital bill. As the majority of Burmese women in Thailand earn less than 3000 Baht (US 73) a month it gives an indication of the financial burden on women and their families. Mae Tao clinic paid the costs of cases they referred from the Mae Tao clinic to the Thai public hospital, most of which were for Burmese women. Three-quarters of the women stayed three days or less for post-abortion treatment and some women required life-saving treatment such as blood transfusions, antibiotics and surgery.

Not all women survived. The medical case-notes held at the Thai public hospital recorded 14 maternal deaths during a two-year period. The senior obstetrician found that three women died due to induced abortion complications related to infection. Of the 14 dead women, two were Hmong (Hilltribe) and 12 were Burmese nationals. No Thai woman died during the two-year period in this hospital. Most of the women died within 24 h of admission to hospital. Such maternal deaths are not recorded in Thai Ministry of Health statistics, which only record Thai citizens. Hence Thai statistics for the same two-year period in Tak province indicate incorrectly that maternal mortality is low. They record 2 maternal deaths in 2001, 1 death in 2000, and no maternal deaths in 1999 (Ministry of Public Health, 2003).

Of the 43 women who agreed to be interviewed as they recovered from their pregnancy loss in both health facilities, the youngest was 18 and the oldest 41 years. The average age at marriage was 21 years and nearly all women were in a married or long-term relationship. More than a third of the women disclosed inducing their abortion on their own or with the help of an abortionist. The majority of women already had children and only eight had no living children. The women had lived in Thailand for an average of three years, and 35 were in paid employment working in a range of poorly paid jobs, in factories (12) and as farm labourers (9). They spoke of the poor economic conditions in Burma, the military regime’s burdensome taxation and forced labour that prompted their move to Thailand. Some respondents disclosed their persecution due to political or religious reasons. The majority of the women were Karen (15) and Burman (14), and 36 followed Buddhism. Most had only minimal education of up to four years and spoke little Thai. Only nine of the women in paid employment had valid work permits. Workers without work permits can be arrested and deported by Thai police, so women were reluctant to travel to any type of health service and often waited until they were very unwell before doing so. However, having a work permit was also a motivation to end pregnancies as there is scrutiny to ensure women are not pregnant at the time of a permit’s issue, and once employed there is pressure from employers to remain non-pregnant or face unemployment and deportation (Suksanan, 2002).

Jumping shrimps—ethnophysiology

In order to understand the techniques used to end pregnancies, it is important to understand local understandings of pregnancy. Regular menstruation is an important indicator of health for Burmese women. The absence of regular periods does not always indicate a pregnancy is but associated with weakness (a: ne—Burmese) and is a potential sign of more serious ill health. As studies with women living in conditions of poverty confirm, malnutrition, poor
development, anaemia, and chronic infections can thwart fertility and interfere with menstrual cycles (Sobo, 1996). For Burmese women, a cessation of menstruation can be interpreted as the blood congealing inside the body which may rise to the head and cause serious illness and mental disturbance (Skidmore, 2002). Similar beliefs occur in Thailand and in Cambodia in the post-partum period (White, 2002; Whittaker, 2004). As a consequence, along with dietary measures, there is a widespread use of emmenagogues and blood purifiers in Burma, ‘to see the blood’ (Population Council & Department of Health Union of Myanmar, 2001; Skidmore, 2002, also Whittaker, 2004, in Thailand). The ambiguity surrounding early pregnancy and menstrual regulation allows multiple interpretations of the meanings of missed menstruation and actions to restore it (Sobo, 1996). Use of such measures can be viewed as a sensible prophylactic measure and not necessarily associated with the stigma of abortion. Amenorrhea explained as blocked menses is reported widely, from Polynesia, Mexico, Malaysia, Afghanistan (Nichter & Nichter, 1998), Indonesia (Hull & Hull, 2001), and Jamaica (Sobo, 1996).

Lay midwives describe foetal development as ‘only a blood clot’ for the first few months which later, in the third or fourth month becomes human-like when it moves and looks like a ‘jumping shrimp’. A Karen Christian abortionist was clear about when she felt she could offer a massage abortion: ‘I don’t do it if they are human, only if they are blood’. The five Islamic women interviewed also subscribed to a similar view of foetal development. Movement is a key concept for the definition of human life. Around four months gestation when foetal movements can be felt, a pregnancy is confirmed as ‘human’, containing a ‘life-force’, and actions taken to induce abortions after this point are greatly stigmatised. Some foetuses however, are attributed with autonomy and may choose ‘not to stay’. In this region where there are high rates of spontaneous abortion, pregnancies are experienced as tenuous, and it is a socially understood idiom that provides another ambiguous explanation for pregnancy losses, both spontaneous and induced.

Techniques: ‘Hot medicines’

The women interviewed used many methods to end their pregnancies. Attempts to induce an abortion usually begin with self-medications and methods controlled by the woman. If ineffective, women would then resort to more invasive and dangerous methods. Often there was a combination of methods used. Initial actions ‘to see the blood’ include the consumption of humorally ‘hot’ foods and substances such as alcohol, dog meat, ginger, sugarcane, pepper and hot water. In addition, women’s medical records note histories of accidental falling, tripping and slipping. Carrying heavy loads and working hard are also attributed to early pregnancy loss and, incidentally, are also considered ‘heating’ activities which may cause abortion. In addition, ‘hot’ medicines or thwei: zei (Burmese) are most commonly tried. Several brands of thwei: zei are marketed in the region and similar medicines are reported in Thailand (Whittaker, 2000; Yoddumnern, 1985), Indonesia (Hull & Hull, 2001), and across the region (Van Esterik, 1988).

The most common brand of thwei: zei is the Burmese emmenagogue Kathy Pan. It is affordable at 15 Baht per sachet and readily available in local shops and the market place. A 35-year-old Burman woman with an induced abortion described her use:

I didn’t take Kathy Pan before the bleeding. I took it after the bleeding started. It is for bad blood, it helps to clean out the blood. I am scared because some people told me that Kathy Pan is for abortions. I thought the baby didn’t want to stay with me and I had bad blood. Most women from Burma take it during their periods to clean the blood. You can see it on TV—there is a famous actress talking about it. Kathy Pan makes you more beautiful. Two packets of Kathy Pan costs just 5 Baht. I don’t know how much a big box costs. I never took it before. I never had pain like this before. There are 5 pills per sachet, you mix it with water and it smells quite bad.

Kathy Pan is a common Burmese medicine for ‘menstrual ailments’ produced by a Burmese business in San Chuang Township in Rangoon (Myat Chan-Tha Medical Hall, 2003). It is widely available in pharmacies, herbal shops and local markets in both Burma and Thailand. The packet informs the purchaser that Kathy Pan is made of ‘rare, costly herbs’ although there is little secret about the ingredients: Indian redwood tree, black pepper, nutmeg, cloves, sandalwood, camphor, and in smaller quantities, rosy leadwort, red sanders, white sandalwood, fennel, garden cress, and dill. The very specific instructions for women that are included in
packets of Kathy Pan or Ne kwet zei (another ‘hot’ medicine) relate directly to humoral health, to the balance of hot and cold in the body, and to restore and promote the flow of blood.

Kathy Pan packages contain a leaflet inside about how to take it in several languages: Burmese, Thai, Chinese, Hindi and English. This is an export product. The directions on how to take Kathy Pan are specific, but it is difficult to tell whether it is a contraceptive, emmenagogue, hormone replacement or menstrual analgesic-antispasmodic medicine. The dosages increase according to the amenorrhea. Prescribing alcohol potentiates the heat of Kathy Pan as it too is humorally ‘hot’. The instructions in multiple languages are explicit (Table 1).

The Burmese health workers at the Mae Tao clinic are aware of Kathy Pan and other ‘hot’ methods used to induce abortions. The out-patient medical record review includes 20 cases of women ingesting either Kathy Pan or other thwei: zei and 31 cases where the woman disclosed visiting the lê the (total number of induced abortions = 50). However, not all cases of induced abortion recorded the method used, and many women cited multiple methods so these figures are likely to be an underestimate. During interviews with women who had attempted to end their pregnancy, 7 out of 17 disclosed taking ‘hot’ medicines before their admission to hospital.

From the interviews, it is clear that not only are such thwei: zei used sporadically to induce abortions but that some women use them regularly as prophylactic contraceptives. A 29-year-old married Burman woman who had three pregnancies and two children described her preference for Kathy Pan:

My husband told me to stop taking them [oral pills and injectable contraceptives] but I continued. Then he blamed me when I complained of pains. The only thing I can take regularly with no problems is Kathy Pan. I take one sachet every ten days.

For this woman there are no discernable side-effects from Kathy Pan, although some health workers report that it causes perspiration and red eyes. Other women who took large quantities over short periods of time said they felt ‘dizzy’. The quantities of Kathy Pan consumed can be substantial. One woman said she took 30 Kathy Pan tablets but they did not end her pregnancy as she had hoped. The ambiguity of the use of this medicine is evident in this woman’s description of her use. She has always had regular menstruation. She took Kathy Pan when her period was 10 days late after she married:

This is my first pregnancy. I wasn’t sure if I was pregnant or not—I only knew that my period was ten days late. I took Kathy Pan, 10 tablets per day for two days. I took four packets or 20 tablets in total. The next day I bled a little. There was no pain. I never used it when I was single. My periods are normally regular. They always come at the same time of the month.

This is not contraception but menstrual regulation or an early abortion. Kathy Pan is linked with the idea of abortion both for women and in the wider community. The same woman went on to say:

I won’t use Kathy Pan again. I won’t need it. I didn’t realise what was happening and now that I know that I can get pregnant I will use htow: zei (injectable contraceptive). I feel ashamed of myself because now everyone thinks I aborted my baby. I think there are better things to do than take Kathy Pan.

Pummelling abortions

Apart from the use of ‘hot’ medicines to regulate menstruation, women described seeking assistance from lê the (lay midwives) to conduct ‘massage’ or ‘stick’ abortions. Another external technique...
described by Karen le the is to ‘melt’ the foetus, whereby a hot stone is placed on the abdomen. Often methods are combined. The traditional methods of fertility management used by abortionists in Tak province are rudimentary and cause harm, but they are also effective in ending unwanted pregnancies. They are in demand by women who wish to limit their families, space their babies or defer motherhood to a later point in time.

In the case-note review, there were 31 records of women who visited the le the for either massage or stick abortions. Women, health workers and le the gave accounts of vigorous physical actions glossed as massage abortions. An experienced community health-worker described this type of abortion in more detail:

I have a friend in Burma who is a TBA [traditional birth attendant] who does massages, deliveries and abortions. She is very skilled. She uses a special root to poison the baby. She can do very strong massage with her foot into the woman’s perineum and pelvic area which produces an abortion. I heard a story once about a female massage abortionist who had such strong hands she could break the baby’s neck through the wall of the womb. They say you could hear it snap!

These types of physical manipulations are more than deep pressure massage as described by Whittaker (2004) in Northeast Thailand—this is pummelling, vigorous enough to displace well-developed foetuses and shear off placentae, causing haemorrhage or uterine rupture. They are painful and physically traumatic. Here a 19-year-old Karen house-maid, who earns 1000 Baht per month, describes her massage-stick abortion:

I went to see the old woman (ahpwa: gji—Burmese). She is about 50 years old. She felt my stomach, she said, ‘You are pregnant but only two months.’ She put the stem of a flower inside me. Ahpwa: gji said if there was any pain to call her and she would come. I paid her 900 Baht because she told me she would fix it. When she did the massage it hurt and ached a lot.

Two days later she returned to ahpwa: gji who tried to pull the foetus out with her hands. At this point the young women, in extreme pain, returned to her Thai employer who took her to the local hospital where she was admitted for three days, had a D&C and borrowed 1400 Baht from her employer to pay her hospital bill.

Stick abortions

The insertion of sticks is an effective and dangerous method of abortion and the cause of the most serious complications seen in this study. O Htoo Kler, a senior health worker in the reproductive health department at the Mae Tao clinic, has a collection of abortion sticks. It is a motley collection of old sticks, cotton buds and pieces of leaf matter. The two hsei: jou (medicine stick—Burmese) measured 8 and 9.75 cm long, have been bent into a V shape by the abortionist. These sticks were from the kapok tree but other women suggest that hsei: jou originate from the tobacco leaf. They are round wooden sticks and would probably absorb moisture like osmotic dilators and also irritate the cervix. They cause cramping, fresh blood loss and eventually infection, with fever and malodorous vaginal discharge. The risk of perforation of the uterus, bladder or bowel is high. Apart from herbal matter, other objects are sometimes used. O Htoo Kler described one case that shocked her:

One woman had been to the le the that put a chicken quill inside her. This did not work the first time so she returned twice more. She only bled a little afterwards. The le the did not tell her what she was doing so this woman did not understand that the le the was putting a chicken feather in her. Then the woman came to me and I examined her. She had a high fever and she was two months pregnant. I was shocked when I saw it. ‘I said do you know what is inside you?’ The woman said no. I showed her the feather. I was scared to think what would have happened to her if her womb had been perforated. I felt very sorry for this woman that she did not understand what had happened. This woman was very poor and could not afford to care for a baby. This woman told me that this was the method that this le the did to everyone. I felt so worried for these women.

The following case of Ma Nwe Ni shows the determination and desperation involved in a stick abortion. She experienced high fever and extreme pelvic pain and was referred to the Thai public hospital. She was interviewed on her seventh day in the hospital. Her chart showed that she was taking ampicillin, metronidazole and gentamycin.
The ultrasound showed a foreign body in her uterus and marked inflammation in her fallopian tubes with bilateral 10 and 15 cm abscesses. She was 26 years old, married and worked in a factory for 85 Baht per day. She speaks about her abortion:

I crossed over the river and went to the Burmese side with my friends. I went to the abortionist (kjei: za: lè the—mecenary midwife-Burmese). She doesn’t do deliveries—if you give her money she will do an abortion. She is 30 years old and she seems a very nice woman. I asked her how much should I pay? It was 5000 Kyats (350 Baht). I was only one month and 10 days pregnant. She put her fingers inside my vagina. She didn’t wear gloves but she did wash her hands. She put hsei: jou (stick) 6 cm into me. It seemed like she was a clean woman. This is what she did. She put the stick in with one hand and pushed my womb down with the other hand to meet it. I heard something inside pop, but it did not hurt. Some blood did come out. When she took her fingers out there was some blood on them. I started to bleed but in a stop–start way. I stayed in her house for four days and each day she would change the sticks. Some days she would put two sticks inside me in one day. When I started to bleed she massaged me on the right side. She kept her fingers on the outside of my pelvic area and she pushed and pushed. She massaged my back too. It really hurt then. After four days I came back to Thailand to get my salary and see my husband. During the night the pain was very bad and I couldn’t stand it so my husband took me to Mae Tao clinic.

Ma Nwe Ni spent two weeks hospitalised in Thailand due to a foreign object in her uterus, two tubal-ovarian abscesses and a blood infection. Her fertility is most probably compromised irreversibly. Her account is remarkable in that she travelled to Burma and back into Thailand while the border was closed. Most women found their lè the in the town or close to where they lived in Thailand. The pain associated with the process of the stick abortion extended over four days, the process also involved several insertions and repeated pummelling and illustrates Ma Nwe Ni’s determination to end the pregnancy.

Apart from these techniques, injections of ‘Menstogen’ and oxytocic drugs such as ergot and syntocinon are purchased in the market place and administered by lè the to induce abortions. Although misoprostol was reportedly used in the past, it no longer appeared to be available in Mae Sot. Induced abortions conducted by trained Thai medical staff can also be obtained at private clinics in regional towns. Fees charged range between 3000 and 7500 Baht (US$70-$174) depending on the service and gestation of the pregnancy. However, their illegality forces the prices up and there is little follow-up care. Undocumented workers are unable to travel to such clinics, and the need to show documentation and the prohibitive cost mean women rarely access these services.

Motivations to end pregnancies

Women give multiple and overlapping reasons for terminating their pregnancies. They reported poverty, relationship problems and abuse, and lack of knowledge of contraception as major contributing factors in their decisions (Belton, 2005). As noted earlier, many women are in Thailand to earn money because of the poor economic situation in Burma. Hence, concerns about earning capacity, debts, the need to send remittances, the costs of raising a child and threats of sacking and deportation by bosses if pregnant were common reasons given by women. Some women spoke of the pressure they received from their families to abort because of their economic situation. Women’s right to work for equal pay, right to work during a pregnancy or any notions of maternity leave is non-existent for Burmese workers in Thailand. As most women interviewed did not have a work permit, they were a particularly vulnerable population.

Domestic violence was another major reason given in several Burmese women’s accounts of their motivation to end the pregnancy. De Bruyn (2003) calls for further attention and research to be paid to the links between violence and abortion. There is little research on the violence women experience when they are pregnant (Hunt & Martin, 2001) and even less on women who have miscarried or intentionally aborted (de Bruyn, 2003). Domestic violence is not recorded in the medical casenotes, but some women were willing to talk about their relationships in their interviews. Five women out of 18 women who induced their abortion reported surviving various forms of domestic violence ranging from emotional abuse to violent beatings. Three out of 10 men disclosed controlling, threatening and beating their wives to the male research assistant. Violence may directly cause some
abortion among women and may make other women feel that they do not want to form a family and rely on violent men (see Belton, In Press). The domestic violence women experience occurs within the broader context of political violence many experienced in Burma and structural violence of their uncertain status within Thailand that leaves them vulnerable to arrest and deportation and with poor access to health care.

Another major issue that emerged from interviews was poor contraceptive knowledge. Many women interviewed had minimal knowledge of the concept of family planning, and what they did know, they tended to learn from friends and through trial and error. Men interviewed were similarly ignorant about contraceptives. Those who had lived in Thailand for a number of years were generally more knowledgeable. The many pharmacies and market vendors in Mae Sot offer a range of condoms, oral contraceptives, and injectable hormones (albeit sometimes past their expiry date), as do the Mae Tao clinic and the Thai public hospital, but knowledge of appropriate use and cost remains a barrier. Continuity of supplies is also an issue, especially for those who travel regularly to Burma where supplies are limited and expensive and for undocumented workers who find it difficult to travel to the clinics for supplies due to their fears of being arrested by police at the numerous checkpoints on Tak’s roads.

Conclusions

The refugee—migrant workers from Burma described in this paper are among the most marginalized people in Thailand. The maternal deaths of Burmese migrant women are underreported and the rate of induced abortion is under-estimated. Burmese migrant women face particular problems concerning unwanted pregnancies and often attempt to terminate their pregnancy. The methods used to terminate their pregnancies are crude and unsafe and place them at risk of serious complications and death. When post-abortion complications arise, treatment in hospital can be expensive and leave a woman with considerable debts.

This study highlights the need for reproductive health care for displaced populations. Firstly, there is a clear unmet need for information, reliable affordable supplies and appropriate counselling on modern contraceptives including emergency contraception for this population. The general insecurity of the area and restrictions on travel exacerbate the problem. Furthermore, the difference in languages and culture erect barriers to understanding and trust between Thai public health workers and the Burmese. Women resort to their own traditional or local knowledge that is not always effective and sometimes very dangerous. Experience at Mae Tao clinic suggests that modern methods of family planning are acceptable if offered at the time of need and in culturally appropriate ways. Further mobile outreach services are needed to reach the fluid populations of migrant workers on the border. Bi-cultural workers in Thai public health services to assist Thai staff to communicate with their patients and to provide information and contraceptive supplies for women while they are still inpatients would also assist in targeting a high-risk population.

In addition, there is a clear need for innovative means to deliver better post-abortion care for this population. Recent literature reports a model to improve post-abortion care in Burma that includes formally trained midwives and le the in post-abortion care provision (Thein Thein Htay, Sauvar-in, & Khan, 2003). They suggest that lay midwives can act as community educators and health promoters to inform women how to avoid unsafe abortion by other means of fertility management, and how to detect the signs and symptoms of abortion complications and refer women on to other practitioners. The Mae Tao clinic in Tak province is a unique model of refugee-led primary health care that provides quality post-abortion care and family planning services to refugee-migrant workers. However, abortion and post-abortion care are not yet included in the current traditional birth attendant training curricula taught by Mae Tao clinic. A module on abortion and post-abortion care needs to be developed so that TBAs recognize the danger signs of post-abortion complications like pain, haemorrhage and fever and refer women for formal medical treatment early. While the demand for induced abortions and the illegality of abortion remains, it is unlikely that the abortion practices of some le the will cease, but education of le the and women about the potential complications and the need to seek treatment following an abortion may avert some of the consequences of the crude techniques used.

Finally, the uncertain and ambiguous legal status of Burmese workers in Thailand, restrictions placed on pregnancy among migrant workers, the constant fear of deportation and their poor economic
conditions contribute to a context in which abortion becomes a necessity for many women finding themselves with an unwanted pregnancy. The legal restrictions on abortion in both Burma and Thailand make safe abortions expensive and inaccessible to these marginalised women. In the absence of other options, women seek out dangerous methods and unqualified abortionists. The challenge remains to create conditions in which vulnerable groups of women such as these have ready access to legal, clean and skilled abortion.

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