International Journal of Gynecology and Obstetrics 130 (2015) E37–E41

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

SUPPLEMENT ARTICLE

"In rape cases we can use this pill": A multimethods assessment of emergency contraception knowledge, access, and needs on the Thailand—Burma border

Margaret Hobstetter [a,*], Cari Sietstra [b,c], Meredith Walsh [c], Jennifer Leigh [d], Angel M. Foster [b,c,e]

[a] Bixby Center for Population, Health and Sustainability, University of California Berkeley, Berkeley, USA
[b] Ibis Reproductive Health, Cambridge, USA
[c] Cambridge Reproductive Health Consultants, Cambridge, USA
[d] Independent Consultant, USA
[e] Faculty of Health Sciences, University of Ottawa, Ottawa, Canada

ARTICLE INFO

Keywords:
Burma
Emergency contraception
Emergency contraceptive pills
Refugees
Thailand

ABSTRACT

Objectives: To evaluate availability, service delivery, and barriers to access to emergency contraceptive pills (ECPs) along the Thailand–Burma border. *Methods:* From June 2010 to May 2011 we undertook a multimethods qualitative assessment among cross-border populations, migrants, and refugees. We conducted 46 key informant interviews with representatives from 25 organizations, 18 focus group discussions with migrant adults, migrant adolescents, and healthcare workers, and a service mapping exercise with 22 stakeholders. *Results:* We found low use of ECPs among the target populations. Structural barriers and lack of evidence-based reproductive health protocols, education, and information restrict access to the limited family planning resources available in this region. Misinformation about ECPs was widespread among health workers and organizational policies were often non-evidence based. *Conclusion:* Potential policy and program interventions to improve access to ECPs along the Thailand–Burma border include integrating evidence-based practices into community efforts, expanding training opportunities for health workers, and improving communication and coordination among organizations serving populations on both sides of the border.

1. Introduction

Although the Burmese military junta ceded power to a civilian government after the 2010 elections, human rights violations, including forced labor, extrajudicial killings, rape, forced displacement, imprisonment, and destruction of food supplies, have long shaped the region of eastern Burma. This poor human rights situation combined with an overall lack of economic development has resulted in the migration of millions of people throughout the region. The cross-border population of Eastern Burma includes both internally displaced persons and individuals in conflict-affected and rural areas who are not technically displaced [1]. In Thailand, the population originating from Burma includes approximately 140 000 refugees and asylum seekers who reside in camps along the border and a much larger number of undocumented migrants who do not have legal status [2,3].

Population dislocation, disruption of services, and shortage of trained health service personnel characterize the region and these factors have exerted a substantial impact on reproductive health outcomes. Although the reported maternal mortality ratio (MMR) for Burma as a whole is 320 deaths per 100 000 live births [4], the MMR within the conflict-affected region is approximately three times higher [5]. The contraceptive prevalence rate is estimated to be 37% in Burma as a whole [6] but substantially lower in Eastern Burma and among internally displaced person areas [7,8]. Indeed, nongovernmental organizations (NGOs), community-based organizations (CBOs), and researchers have estimated that 80% of women in Eastern Burma have never used contraception [5,9] and that the unmet need for contraception is approximately 60% [5,10]. One of the main markers of such unmet need is the prevalence of unsafe induced abortion practices, which are a leading cause of maternal death in the conflict-affected areas [11–13].

Both refugee and migrant populations face appreciable barriers to accessing reproductive health services (including family planning) in Thailand; they are also at increased risk of rape and sexual exploitation [12–15]. The MMR in Thailand is estimated at 26 per 100 000 live births [16]; however, structural and legal barriers often prevent Burmese women from accessing services and so the MMR is estimated to be higher among this population. Furthermore, although induced abortion is legal in Thailand for a broad array of circumstances, women from

* Corresponding author at: Bixby Center for Population, Health and Sustainability, University of California Berkeley, 17 University Hall, Berkeley, CA 94720, USA. Tel.: +1 202 210 8511.
E-mail address: mhobstetter@berkeley.edu (M. Hobstetter).

http://dx.doi.org/10.1016/j.ijgo.2015.05.008

Burma who are resident in Thailand are often unable to access safe induced abortion care, even for legal indications. Consequently, the rates of both unintended pregnancy and unsafe induced abortion are high [13,17].

Emergency contraception has the potential to make a substantial contribution to addressing unmet pregnancy prevention needs on both sides of the Thailand–Burma border. Dedicated progestin-only ECPs are available in Thailand without prescription but are less widely available in Eastern Burma [18]. However, the limited research conducted on emergency contraception along the Thailand–Burma border suggests low awareness and under-utilization of this drug [18].

We aimed to identify unmet reproductive health needs among populations living in the Thailand–Burma border region. We initiated our project in June 2010 and focused on unmet family planning needs, maternal mortality and morbidity, and unsafe induced abortion. In 2012, Ibis Reproductive health published a comprehensive report of the findings to facilitate the efforts and coordination activities of local stakeholders [19]. This article centers specifically on the findings related to emergency contraception, particularly the availability and service delivery of progestin-only ECPs.

2. Materials and methods

Between June 2010 and May 2011 a team of investigators from Ibis Reproductive Health, Cambridge, USA, and the Global Health Access Program, Mae Sot, Thailand conducted a multimethods reproductive health assessment to identify unmet needs of cross-border, refugee, and migrant populations along the Thailand–Burma border. Our assessment included: (1) a review of documents and institutional statistics related to reproductive health projects, services, and outcomes;

Table 1
Composition of the 18 focus group discussions held at three locations along the Thailand–Burma border, 2010–2011.

Location	Participants	Description
Prop Phra	Adolescents (n = 10)	Burman, Muslim, and Rakhine migrants Aged 13–19 y Unmarried
Mae Sot	Adolescents (n = 7)	Burman, Karen, and Rakhine migrants Aged 16–22 y Unmarried Living in Mae Sot
Mae Sot	Adolescents (n = 12)	Burman, Karen, and Rakhine, migrants Aged 13–22 y Unmarried Living in Mae Sot
Mae Sot	Adolescents (n = 10)	Burman migrants Under 25 y Unmarried and married Living in Mae Sot
Mae Sot	Adolescents (n = 10)	Burman migrants Aged 17–22 y Unmarried and married
Mae Sot	Adolescents (n = 8)	Burman, Karen, and Rakhine migrants Aged 18–29 y Unmarried and married
Mae Sot	Adolescents (n = 8)	Karen migrants Aged 15–19 y
Chiang Mai	Adolescents (n = 12)	Lahu migrants Aged 13–27 y Unmarried and married Living in Chiang Rai province
Chiang Mai	Adolescents (n = 10)	Lahu migrants Aged 14–21 y Unmarried and married Living in Chiang Rai province
Prop Phra	Adult women (n = 11)	Burman, Karen, and Muslim migrants Aged 17–47 y Married
Mae Sot	Adult women (n = 17)	Burman, Karen, Rakhine, and Shan migrants Under 49 y Living in Mae Sot
Mae Sot	Adult women (n = 7)	Burman and Karen migrants Aged 28–65 y Married
Mae Sot	Adult women (n = 8)	Burman and Karen migrants Aged 28–44 y Married
Chiang Mai	Adult women (n = 17)	Burman, Kachin, Lisu, and Shan migrants Aged 22–43 y Unmarried and married Living in Chiang Mai and the surrounding areas Note: discussion group was divided into two separate sections after initial introductions
Prop Phra	Health workers (n = 6)	CBO and NGO health workers serving in border areas
Mae Sot	Health workers (n = 12)	CBO health workers serving in conflict-affected areas in eastern Shan State, internal displaced person areas in Karen State, three refugee camps, and Mae Sot
Chiang Mai	Health workers (n = 12)	CBO and NGO health workers serving Kachin, Kayah, Lahu, Rakhine, and Shan communities in migrant areas of Chiang Mai, cross-border internal displaced person areas and rural areas, and border areas

Abbreviations: CBO, community based organization; NGO, non-governmental organization.

(2) key informant interviews with representatives from 25 organizations working in the region; (3) a service mapping exercise with a subset of stakeholders (n = 22) to determine the location, scope, and catchment of various points of service delivery in the region; and (4) 18 focus group discussions (FGDs) with migrant adults, migrant adolescents, and healthcare workers in northern Thailand. We collected all information in English, Burmese, Karen, and/or Thai and all participants provided oral consent before being interviewed or joining an FGD. We deemed oral consent more appropriate than written consent given the low literacy levels in the region and the varying legal status of migrants.

Our 46 key informants represented 22 NGOs and CBOs, including two Thai-based health clinics and one network of clinics in Eastern Burma; one Thai Government district hospital; and two coordinating CBO networks that operated along the border. Of these 25 organizations, 10 served cross-border populations, 14 served migrant populations, and four served seven of the nine refugee camps; four of these organizations served multiple populations. Key informants held a variety of positions within their respective organizations, including senior staff (n = 7), clinicians (n = 5), and program managers (n = 34). We conducted the FGDs in three locations in Thailand (Mae Sot, Chiang Mai, and Prop Phra) and summarize the composition of our FGDs in Table 1. In total, 60 migrant adults (six FGDs), 87 migrant adolescents (nine FGDs), and 30 healthcare workers (three FGDs) participated in our discussions.

Two members of the study team served as interviewers and FGD facilitators (M.H., M.W.). These investigators took detailed notes during data collection and summarized the encounter and recorded reflective remarks immediately afterward. Interpreters assisted these investigators, when needed. We later transcribed (and translated, if applicable) all audio-recorded interviews and FGDs. We analyzed interview and FGD data for content and themes using pre-determined categories and codes and inductive techniques to identify emergent concepts. Analysis was an iterative process that began during data collection and continued through formal coding and interpretation, a process guided by regular meetings between three of the study investigators (M.H., M.W., A.M.F.). We resolved disagreements through consensus. We initially analyzed each component separately; we then integrated results from all components to identify concordant and discordant findings. We conducted formal and informal follow-up interviews with a dozen key informants to resolve inconsistencies between the results of the service mapping exercise and the other components.

Although the reproductive health needs assessment was not originally conducted for research purposes, we subsequently received ethics approval from the Research Ethics Board at the University of the Ottawa, Canada for secondary use of these data. We have masked and/or redacted all personal identifying information from direct quotes.

3. Results

3.1. Availability of emergency contraceptive pills is limited and inconsistent

> *[Women] cannot get ECP at Mae Sot Hospital if the condom breaks or if they forget to take a pill. Only in the emergency case of rape.* (Key informant representing a government hospital in Mae Sot)

All three target populations lacked consistent access to high quality dedicated products. The service mapping exercise revealed that dedicated progestin-only ECPs were available through the 26 clinics in Eastern Burma that were supported by the Burma Medical Association. However, both interviewees and FGD participants consistently reported that ECPs were not available in retail pharmacies. Furthermore, organizations providing mobile health services reported that they did not carry ECPs; faced with space constraints and a perceived lack of demand, other medications and contraceptive methods were prioritized. One organization serving cross-border populations indicated that medical staff would carry ECPs if women identified them as a priority.

> *In terms of what we send out with the medics, most women won't feel comfortable asking medics. They don't feel comfortable saying, 'I just had unprotected sex'. Not to say that there's no place for it, but it involves education as to its purpose, timing, proper use – why you would need it?* (Key informant representing an NGO serving conflict-affected areas of Eastern Burma)

Dedicated progestin-only ECPs are more widely available in Thailand than in Burma, and can be obtained without a prescription in retail pharmacies. However, FGD participants were nearly unanimous in citing security and fear of arrest as the main obstacles to obtaining contraceptive services, including ECPs, in local Thai shops. Several organizations serving migrant populations, such as the Mae Tao Clinic, the Adolescent Reproductive Health Network's Youth Center, the Burmese Women's Union drop-in center, and the Migrant Assistance Program, offered progestin-only ECPs without cost. However, these organizations reported low demand. For example, the Mae Tao Clinic recounted that approximately five women requested ECPs each month. According to organizations working in refugee camps, the supply of dedicated ECPs had been inconsistent since the late 2000s, resulting in a lack of availability. As camp-based populations experience restricted mobility, obtaining ECPs from the Thai retail sector was especially challenging. Finally, Thai sub-district health centers did not provide ECPs within the public health system and key informants indicated that ECPs were only available at the local district hospital in cases of rape.

3.2. Misinformation and non-evidence based service delivery abound

> *In rape cases we can use this pill—only for an emergency—within 24 hours to prevent the pregnancy. (*Key informant representing a CBO serving conflict-affected areas in northern Shan State)

Key informant interviews and FGDs with healthcare workers revealed considerable misinformation about progestin-only ECPs among service providers. Participants who served all three populations consistently revealed a lack of evidence-based knowledge regarding eligibility requirements, time frame for use, safety, efficacy, adverse effects, and complications. For example, many participants believed that progestin-only ECPs were only effective in the 24 hours after unprotected sexual intercourse and repeatedly reported that they denied women's requests for ECPs beyond that time point. Several senior-level key informants representing cross-border organizations indicated that program managers, midwives, and healthcare workers are generally misinformed about the safety of ECPs and eligibility for use, which creates an appreciable barrier to access when this product was available. This lack of healthcare provider knowledge about ECPs was also recognized among organizations working in the refugee camps. Indeed, the Planned Parenthood Association of Thailand developed evidence-based emergency contraception training initiatives for both volunteers and staff serving in five refugee camps to address this gap.

The misinformation prevalent among individuals working in reproductive health seemed to have shaped the service delivery protocols of individual organizations working along the Thailand–Burma border. Among organizations that dispensed ECPs, there was widespread belief that these products should be used only in emergencies; however, their definition of emergency was variably interpreted at the institutional level. For a number of organizations, such variation had either limited the provision of ECPs to rape survivors or created scope for individual providers to exercise personal judgment as to what constitutes sufficient justification for use. For example, the Karen Women's Organization referred refugee women who had been raped to a clinic for ECPs but would not provide information about this method or referrals for emergency contraception to women who had forgotten to take their oral contraceptive pills.

3.3. Lack of community-level awareness of or support for ECPs

> *Midwives and health workers in the hospitals do not know about this [ECPs], and the community does not know about this, so this is not provided in the community.* (Key informant representing a CBO working in conflict-affected villages in eastern Shan State)

Key informants, especially those working for organizations that provided services to migrant and cross-border populations, repeatedly reported low levels of knowledge about ECPs within the community. Our FGDs with migrant adults and adolescents confirmed this finding, as few participants expressed familiarity with any type of emergency contraception. The fact that organizations providing ECPs also reported little use of (and limited demand for) post-coital contraception was consistent with a lack of knowledge at the community level.

Lack of information about reproductive health issues seemed especially pronounced among young people, as revealed in our FGDs with adolescents. This dynamic is likely compounded by the lack of information and services directed toward adolescents and unmarried populations. Although organizations specializing in adolescent reproductive health engaged in several outreach and educational activities, some non-adolescent focused organizations reported that they limited contraceptive information and services to married women, as a matter of policy.

However, among organizations dispensing ECPs, program managers also attributed low demand for ECPs to women being shy about admitting underprotected or unprotected sex. For example, although the Karen Department of Health and Welfare stocked ECPs and had undertaken programmatic efforts to counsel women about this method, program managers reported that women were reluctant to ask for emergency contraception because of the stigma associated with need. This dynamic of social stigma seemed to be especially prevalent among adolescents:

> *Adolescents can come to clinic, but the barrier is from the community. They are shy to come because the people will look down on them… For single males it's a little easier to access family planning because they have more rights than females.* (Key informant representing a CBO serving conflict-affected areas in Burma)

Other organizations serving migrant and cross-border populations attributed low demand to women's underestimation of pregnancy risk. In the experience of one mobile health organization, a woman would only visit a clinician if she perceived her health issue to be a "significant problem." The requirement for ECPs was not conceptualized as rising to this level.

Emergency contraception does not appear to be widely discussed or used in camp settings. The perception existed among organizations that camp culture did not embrace the use of ECPs. A representative from the Planned Parenthood Association of Thailand reported that ECPs are not generally promoted because of a concern that the medication would be perceived as in conflict with traditional community values. Organizations that operated in the camps expressed concern that efforts to incorporate ECPs into broader reproductive health or family planning programs could undermine their activities. In Mae La Camp, one organization reported a need for community workshops dedicated to emergency contraception but warned that introduction of ECPs without adequate community engagement would result in a loss of trust within the camp community, as village leaders would probably oppose efforts to expand access. An NGO clinic serving migrant populations echoed the role of trust when introducing ECPs into a community:

> *I introduced this idea in the community five to six years ago, I don't try anymore because the community does not accept it. I have to be careful to earn their respect as medical providers. Even if I support to use, the community must trust me.* (Key informant representing an NGO clinic serving migrants in Chiang Mai Province)

3.4. Concerns among healthcare providers regarding "misuse" and "abuse"

> *Sometimes our staff doesn't have enough knowledge either. Even for me, I'm not sure. Can we use ECP every time? How many times per month can we use ECP?…If the adolescent has sex with two different people in one month, can she use the ECP both times? I don't know the complications if someone takes this too many times.* (Key informant representing a CBO serving conflict-affected areas in Eastern Burma)

Key informants and healthcare workers raised concerns that adolescents would be especially predisposed to "misuse" or "abuse" of ECPs if the medication was widely available. Our participants perceived "misuse" as using the medication more than once in a cycle or year and "abuse" as using the medication "repeatedly" and/or as a substitute for other methods of contraception. Despite low availability and demand, the perception that women used ECPs "too often" exerted programmatic impacts: one organization serving migrant populations stopped offering ECPs altogether.

4. Discussion

Emergency contraception has long been considered a core component of reproductive health service delivery in conflict, crisis, refugee, and emergency settings. Nonetheless, in the present study, structural barriers and lack of evidence-based reproductive health protocols, education, and information restricted access to the limited family planning resources available along the Thailand–Burma border. Our study also identified a need – particularly in cross-border areas – to ensure an adequate and reliable supply of ECPs. Use of ECPs was low among all three populations in the region. Health workers, program managers, and community members—particularly those serving in cross-border and migrant settings—either lacked information or were misinformed about ECPs. These deficits affected both requests for the medication and its provision. Additional information and education about ECPs are clearly needed for both stakeholder organizations and the public.

Misinformation about ECPs among organizations working with all three target populations led to inconsistent and often non-evidence-based service delivery guidelines and protocols. Some organizations deemed both women who experience consensual sexual intercourse (underprotected or unprotected) and adolescents as ineligible for ECPs. Camp-based clinics in particular have developed policies that limit ECP access to survivors of sexual assault. Although meeting the needs of this population is important, provision of ECPs should not be limited to this subset of women. Considerable need still exists for a border-wide effort to develop consistent, medically accurate, and evidence-based provision guidelines. This endeavor should include offering ECPs to all women wanting to prevent pregnancy after unprotected or underprotected sexual intercourse within the previous 120 hours and ensuring that women are provided with ECPs as often as needed [20]. Creating opportunities for organizations to discuss and share their provision protocols could be the first step in establishing border-wide norms and service delivery guidelines.

Beyond the establishment of organizational protocols, additional healthcare provider training is needed to ensure that provision of ECPs is evidence-based. Training should include detailed discussions of evidence-based practices for offering ECPs and values clarification exercises to explore individual provider biases surrounding provision. In addition, training should provide information about the realities of women's use (and repeat use) of ECPs and dispel misinformation about the "misuse" or "abuse" of these drugs. However, efforts to improve ECP service delivery will likely be for naught if women lack awareness of the method or community leaders oppose its distribution.

Organizations working with all three communities should increase outreach and education campaigns to raise community awareness and demand for ECPs.

Finally, there is a need to establish additional avenues for communication and coordination among organizations working on both sides of the Thailand–Burma border. Sharing resources, imparting lessons, and creating opportunities to exchange information about best practices will help ensure that the region's overlapping groups of cross-border, migrant, and refugee populations receive high quality services.

Acknowledgments

Funding for the present study was provided by the Richard and Rhoda Goldman Fund, Fordham University School of Law, Therese Caouette, and an anonymous donor. The Endowed Chair in Women's Health Research at the University of Ottawa (A.M.F.) is supported by the Ontario Ministry of Health and Long-Term Care. The authors thank Norda Prisangdat for assistance with interpretation and translation.

Conflict of interest

The authors have no conflicts of interest.

References

[1] The Border Consortium. 2010 Program Report, July to December 2010. http://www.theborderconsortium.org/resources/key-resources/. Published 2011. Accessed May 19, 2015.
[2] United Nations High Commissioner for Refugees. 2015 UNHCR Country Operations Profile—Thailand. http://www.unhcr.org/pages/49e489646.html. Published 2015. Accessed May 5, 2015.
[3] Thailand Burma Border Consortium. Burmese Border Displaced Persons: June 2011. http://www.theborderconsortium.org/media/11790/2011-06-jun-map-tbbc-unhcr-1-.pdf. Published 2011. Accessed May 19, 2015.
[4] United Nations International Children's Emergency Fund. Republic of the Union of Myanmar Statistics. http://www.unicef.org/infobycountry/myanmar_statistics.html. Published 2013. Accessed May 5, 2015.
[5] Back Pack Health Worker Team. Chronic Emergency: Health and Human Rights in Eastern Burma. http://burmalibrary.org/docs3/ChronicEmergencyE-ocr.pdf. Published 2006. Accessed May 5, 2015.
[6] United Nations Population Fund. The State of the World's Midwifery 2011: Myanmar. http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Myanmar_SoWMy_Profile.pdf. Published 2011. Accessed May 19, 2015.
[7] United Nations Population Fund. Cross-border migration and reproductive health study. Yangon, Myanmar: Department of Population and UNFPA Myanmar; 2002.
[8] Taw N. Country report on 2007 fertility and reproductive health survey, Union of Myanmar. Yangon, Myanmar: UNFPA Myanmar; 2009.
[9] The Burma Medical Association, National Health and Education Committee, Back Pack Health Worker Team. Diagnosis: Critical. Health and Human Rights in Eastern Burma. http://backpackteam.org/wp-content/uploads/2014/07/Diagnosis-critical-Eng-website-version.pdf. Published 2010. Accessed May 5, 2015.
[10] Mullany LC, Lee CI, Yone L, Paw P, Oo EK, Maung C, et al. Access to essential maternal health interventions and human rights violations among displaced communities in eastern Burma. PLoS Med 2008;5(12):1689–98.
[11] Ba-Thike K. Abortion: A public health problem in Myanmar. Reprod Health Matters 1997;5(9):94–100.
[12] Belton S, Maung C. Fertility and abortion: Burmese women's health on the Thai-Burma border. Forced Migr Rev 2004;19:36–7.
[13] Maung C, Belton S. Working our way back home: Fertility and pregnancy loss on the Thai-Burma border. Mae Sot, Thailand: Mae Tao Clinic; 2005.
[14] Women's Commission for Refugee Women and Children. Thai-Burma Border Reproductive Health Assessment. New York, NY: Women's Commission for Refugee Women and Children; 2006.
[15] Beyre C. Shan women and girls and the sex industry in Southeast Asia; political causes and human rights implications. Soc Sci Med 2001;53(4):543–50.
[16] World Health Organization, WHO, UNICEF, UNFPA, The World Bank, United Nations Population Division Maternal Mortality Estimation Inter-Agency Group Thailand. Maternal Mortality 1990–2013. http://www.who.int/gho/maternal_health/countries/tha.pdf?ua=1. Published 2014. Accessed May 5, 2015.
[17] Belton S, Whittaker A. Kathy Pan, sticks and pummelling: techniques used to induce abortion by Burmese women on the Thai border. Soc Sci Med 2007;65(7):1512–23.
[18] Sietstra C. The Thailand-Burma Border: Addressing Needs in Long-Term Conflict Settings. In: Foster AM, Wynn LL, editors. Emergency Contraception: The story of a Global Reproductive Health Technology. New York: Palgrave MacMillan; 2012. p. 239–53.
[19] Hobstetter M, Walsh M, Leigh J, Lee CI, Sietstra C, Foster AM. Separated by Borders, United in Need: An Assessment of Reproductive Health on the Thailand-Burma Border. http://www.ibisreproductivehealth.org/work/other/thaiburmaborder.cfm. Published 2012. Accessed May 5, 2015.
[20] International Consortium for Emergency Contraception, International Federation of Gynecology and Obstetrics. Emergency Contraceptive Pills: Medical and Service Delivery GuidelinesThird Edition. ; 2012. http://www.cecinfo.org/custom-content/uploads/2014/01/ICEC_Medical-and-Service-Delivery-Guildelines-English_June-2013.pdf. Published 2012. Accessed May 5, 2015.