

Chapter Two

THAILAND

Why Are the Refugees There?

Myanmar, formerly known as Burma, has been torn apart by civil war for more than 40 years. Ethnic minorities, including the Karen, Karenni, and Mon, have clashed violently with the Myanmar government in their efforts to win independence. Over the years, tens of thousands of people have fled Myanmar to escape grinding poverty and harassment by the military regime known as the SLORC (State Law and Order Restoration Council).¹

After the SLORC seized power in 1988, reports of its rampant human rights violations began to surface in the international community. Reported violations include targeting women for rape (according to Amnesty International, girls as young as seven have been raped; and at least one girl is known to have died as the result of such an attack); and using women and children as human shields during the fighting. In a bid to quell mounting criticisms and demonstrate a willingness to reform, the SLORC established an open-market economy in Myanmar. But the political system remained firmly closed. Although the National League for Democracy (NLD),

led by Aung San Suu Kyi, overwhelmingly won the 1990 election, the SLORC has, to date, refused to relinquish power. Many NLD leaders and members face detention and/or arrest.

More than two million people now live as refugees from Myanmar. About half of them work illegally² in Thailand with little or no access to health care, education or basic necessities. Approximately 117,000 ethnic minority refugees live in camps along the Thai-Myanmar border. Many others have been excluded from camps because they are from a different ethnic group than the camp's majority population. The Thai government does not officially recognize the people who fled Myanmar as "refugees." Rather, they are considered to be illegal or undocumented immigrants.

Which Relief Agencies are Assisting the Refugees?

There are many NGOs working within the refugee camps as well as those working with economic migrants in cities and towns. They include: the American Refugee Committee (ARC), Burma Border Con-

¹ The SLORC recently announced that it will be changing its name officially to the State Peace and Development Council. See "Burmese Laureate Reserves Judgment on Changes," *New York Times*, November 25, 1997, section A.

² Most of these people have fled Myanmar/Burma for economic reasons. Others, primarily women, were sold into servitude with or without their families' knowledge. These migrants do not reside in the camps and so will be referred to in this report as "economic migrants".

sortium (BBC), Mae Tao Clinic (commonly known as Dr. Cynthia's Clinic), Empower, the International Rescue Committee (IRC), Médecins Sans Frontières (MSF), the Migrant Assistance Program (MAP NET), the Shoklo Malaria Research Unit (SMRU), and Women's Education for Advancement and Empowerment (WEAVE).

General Camp Conditions

Most of the refugee camps along the Thai-Myanmar border have been in existence since 1984. The great majority of the initial inhabitants of the camps used to be women and children. Men stayed behind in Myanmar to fight the SLORC. But as the SLORC began to overpower ethnic minority resistance, increasing numbers of men fled to join their families. Now there are almost equal numbers of men and women in the camps in Thailand.

Recent visits to Camps 2 and 3 near Mae Hong Son, and Maela and Wangka camps near Mae Sot found that the camps are well organized. The cross-border governing organizations, such as the Karenni and Karen leadership committees, control and participate in every aspect of camp life, including health services. The local governments-in-exile run schools, organize development activities and police the camps. Food distribution (by the BBC) is regular and adequate, despite rapid changes in camp populations. Water and sanitation is excellent.

A common complaint among camp residents is the lack of work. Aside from daily household chores, there is very little to occupy people's time. Residents



Rachel Jones

Karenni refugee woman holds her young child.

complain of monotony, malaise and feelings of uselessness. A few people have managed to obtain small plots of land on which they grow fruit or vegetables and raise a few animals, but available land is scarce in the crowded camps. WEAVE has established income-generating projects for women in some camps, and participants in the projects clearly enjoy a greater sense of self-worth and self-esteem. Literacy projects for men and women could also bolster self-sufficiency and self-esteem.

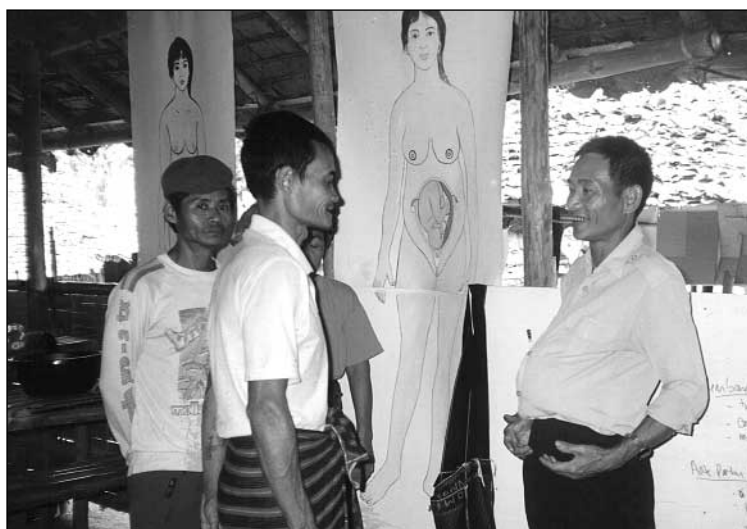
General Health and Reproductive Health Conditions

The health status of people in Myanmar is probably worse than that of the refugees living in Thailand.³ New arrivals in the camps have rarely been immunized, carry heavy disease burdens (such as acute respiratory infection, malaria, tuberculosis, cholera, measles), and suffer from a high average number of closely-spaced births. Their health appears to improve rapidly once they are stabilized in camps and partake of services provided by local governing committees and NGOs. Infectious diseases and malnutrition, however, persist. Evidence suggests that infection with HIV/AIDS is becoming a problem, although data is sketchy.

The RH services for refugees in the Thai-Myanmar border camps have vastly improved since 1994 when they were virtually nonexistent. Clinics within the camps provide family planning, safe motherhood, and STD/HIV prevention and education. Emergency obstetric care is obtained via referrals to Thai hospitals which are equipped to treat all obstetric emergencies. NGOs meet the cost of emergency obstetric care for those refugees residing in the camps under their care. The NGOs usually provide transportation as well. Radio contact is maintained between refugee clinics, staffed by health personnel from Myanmar living in the camps, and NGO headquarters in towns. Although Médecins sans Frontières (MSF) is the largest health NGO on the Thai-Burma border (it serves nearly 80 percent of the refugee population), the agency has not taken a leadership role in offering RHR.

³ *Asia Week*, September 19, 1997.

Refugee programs on the Thai-Myanmar border make an enormous effort to recruit and employ refugee health personnel. In fact, there is a huge demand for health-care training among the refugees; and many refugees are trained in Dr. Cynthia's Clinic. The trained refugees then have a useful skill to bring back with them when they return home. While all workers must be literate to be trained, there is a great variety of ages and levels of training. MCH workers in the camps generally aspire to be trained as full-



Male TBAs at WEAVE training in Thailand.

Courtesy of WEAVE/Kim Green

fledged “medics” which, they believe, will help them get work later on. Younger, unmarried health workers report they feel at a disadvantage when approaching older female patients.

NGOs working along the border meet regularly to discuss their work. Collaborations in malaria protocols and blindness prevention have proved very effective. IRC employs a highly-skilled specialist who works with NGOs encouraging collaborative efforts. Over the last two years, NGOs in the area have begun

working together to prepare and distribute health education and HIV/AIDS materials. Local staff from Myanmar are attending these meetings and becoming actively involved in the campaigns.

Family Planning and MCH

The concept of child spacing and family planning is gaining wide acceptance among both young and older women. With greater availability of contraceptives, use is increasing, particularly in camps with well-organized programs and effective education and counselling. Thailand has an excellent national family planning program and high levels of contraceptive use. There is some anecdotal evidence that information passes to the refugees, especially to those who have contact with the broader Thai community or who live in villages outside the camps. The BBC estimates the average refugee family is composed of two adults and four children.

Contraceptive supplies were sufficient in the camps visited; but ordering procedures, delivery logistics and storage were less than optimal in many camps. Every camp clinic visited offered at least two kinds of pills, Depo Provera and condoms. In some places, condoms were freely distributed outside of the MCH clinic (though the clinic attracts primarily women and children). But more often than not, condoms were distributed hesitantly. The quality of counseling and client follow-up varied widely among the camps visited. A few camp clinics gave users an unbalanced view of contraindications without presenting advantages and placed other kinds of medical barriers in the way of potential users. The SRMU had effective counseling services, close client follow-up and, not surprisingly, the high-

est use rate. Most MCH workers had a good general knowledge of family planning methods; some were highly dynamic and enthusiastic. We also learned that some refugee women seek services, including a limited number of tubal ligations, at Thai Government clinics and hospitals or with private practitioners in town. This practice does not appear to be widespread.

The Maela Camp run by SMRU was the only camp offering Norplant as a contraceptive option. Norplant is popular among the women in the camp because



Rachel Jones

Shoklo Malaria Research Unit Clinic. Few refugee programs offer Norplant, but under the right conditions—and if there is demand for services—all methods can be offered.

strong counseling, well-trained personnel, and adequate facilities exist. Because the method requires guidance and must be inserted and removed by trained professionals, refugee camps give careful consideration before offering this method, especially to women who may return home to situations where follow-up could be difficult. At the Maela Clinic, women appear to be making sound choices based on good information and thorough counseling.

NGOs make hospital referrals for complicated pregnancies and women requesting tubal ligations. The hospitals are nearly an hour's drive from the camps in

Mae Hong Son or Mae Sot. Complicated surgeries and critical cases are referred to Chiang Mai which has an intensive care unit. Surgical procedures such as tubal ligations and vasectomies can be handled in Mae Hong Son Hospital. The hospital can also test for HIV,

but is not equipped to offer any form of treatment or counseling.

Transportation to hospitals is usually provided by the NGO making the referral. The NGO is then also responsible for paying the patient's bill. In emergen-

DEPLOYING THE MINIMUM INITIAL SERVICE PACKAGE

From the end of September to mid-November 1997, a steady stream of Cambodian refugees poured across the border into Thailand. The American Refugee Committee (ARC) was the only NGO on the scene to offer emergency relief and primary health care, including RH services, to some 40,000 refugees who had arrived at the remote Khao Plu and Mamuang camps in Trat Province. It was one of the few occasions since the RHR Consortium began its work that the Minimum Initial Service Package (MISP) was deployed at the height of a refugee influx.

Sterile medical supplies were readily available, both from ARC's own stocks and from the refugee community itself. ARC supplied gloves, obtained condoms in Trat town, and held training sessions on Universal Precautions for HIV/AIDS prevention for health workers in both camps. Refugee women with emergency obstetric complications benefitted from an established camp referral system that provided transportation to the Trat provincial hospital, where a full range of obstetric services was available to the refugees. Though camp midwives denied knowledge of any incidents of sexual and gender-based violence in flight or in the camps, ARC offered the midwives training sessions on emergency post-coital contraceptives and on identifying and treating women who are victims of sexual violence.

"In the first days, the refugees went through a shock phase. Their priorities were shelter, food and water," says Sandra Krause, International Health Advisor at ARC who coordinated the MISP along the Thai-Cambodian border. "But day by day, more health workers came forward to work in the community and in the clinics. They were motivated and eager to learn." Rapid responses in similar crisis situations would be more assured if field offices of international agencies, such as UNICEF, UNHCR and/or UNFPA stocked MISP supplies/kits or knew how to obtain them quickly. "We were fortunate in Thailand," says Krause, "because you can buy medical supplies in most large towns and assemble essential materials and basic kits; and that's what we did. But UN organizations should stock emergency supplies regionally. You need them on the first day." Essential to the success of MISP is the presence of a focal person, experienced in emergency settings, to oversee the program. "You need someone who can set up the MISP in the environment of a potential cholera or measles epidemic," says Krause, "Someone who can see how the MISP fits into the situation, but doesn't compromise the response to other emergency needs; who sees what can be done, and does it."

cies, and when an NGO representative and vehicle are not available, camp residents' vehicles are used to transport the patient. If no vehicle is available, the patient may have to be carried—sometimes for hours—to the nearest village to find transportation. Recent visitors to the camp were unable to assess how efficiently the decision-making and referral processes are working, especially at night and for obstetric emergencies.

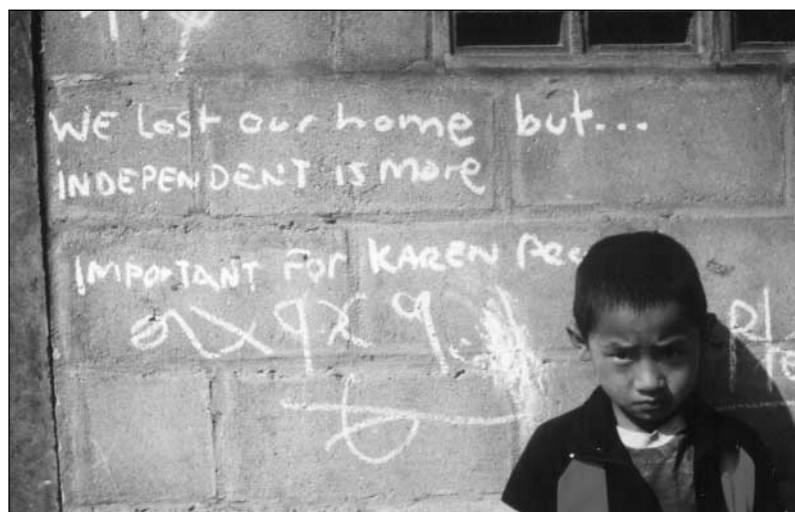
Attendance for prenatal care in the camps is very high, possibly because food supplements are given routinely to pregnant women and at-risk children under five. In most camps, women also receive home visits after they deliver, but fewer women come for postnatal care or family planning. Immunization rates, on the other hand, are high. Malaria during pregnancy is not common, but can be very serious. SMRU is conducting an extensive research project to determine the prevalence of malaria in the refugee population, particularly among pregnant women and children.

Most labors and deliveries take place at home, but women seem to know about risk factors and referral sites when complications arise. Women in this community traditionally walk around during labor and squat while giving birth. Most deliveries are conducted by TBAs, though sometimes MCH workers are also in attendance. WEAVE responded to women's preference for home births by training TBAs in camps along the border and producing educational materials for an illiterate population. TBAs were trained to recognize complications and refer clients for treatment, and to promote

public health measures such as hand washing, family planning and HIV/AIDS prevention.

Abortion

Abortion is illegal in Thailand, and statistics on spontaneous or induced abortion are not available. None of the NGOs provide abortions on request, but they do refer women to hospitals for incomplete abortions or complications. Women reportedly use herbs and massage to induce abortion, but the extent of the practice and its impact on maternal health is not known.



Courtesy of WEAVE

STDs including HIV/AIDS

The incidence of STDs in rural refugee camps is reportedly low, but there is no way of verifying that information. Low rates of STDs may be a result of the community's cultural mores: monogamy is highly valued and adultery used to be punishable by death. But under-reporting, which would indicate a lack of trust in the services and/or confidentiality at the clinics, could also be a factor. Condoms are available, but they are not always displayed. Only in Wangka

camp, where STD rates are high due to its proximity to the city of Mae Sot, are condoms displayed in the clinics overseen by MSF so that anyone may come and take some. In other camps, condoms must be requested, without confidentiality, and are sometimes

available only to women, who may not know how to use them.

Although actual numbers of AIDS cases are now very low, there is a general consensus among health professionals in the region that the numbers are rising,

FALLEN THROUGH THE CRACKS— MIGRANT WORKERS IN THAILAND

Approximately one million people left Myanmar to find work in Thailand. Since the Thai Government considers them illegal migrants, they have no access to health care, education or basic necessities and often will not pursue such services for fear of deportation should their illegal status be discovered. Many are exploited in the sex trade or as low-paid (and sometimes *unpaid*) construction workers. Their needs are the same as those of refugees (as defined by the UN Convention); yet because they do not fall under the mandate of UNHCR, they do not benefit from international protection and their basic needs often go unmet.

Sex workers, most of whom are illiterate, have extremely limited access to RH care, though such services are particularly vital to their health. Sex workers are subject to miserable working conditions because their illegal status leaves them little or no recourse. They are often not allowed to refuse customers and cannot insist on the use of condoms. According to Empower staff members, brothel owners will often force injections of the contraceptive Depo-Provera upon their workers to ensure their continued productivity. Brothel owners decide whether their workers may be tested for HIV; then they may or may not reveal the results. A sex worker in the late stages of AIDS is usually forced to leave the brothel and is left without care until she dies. The organization Empower offers condoms to sex workers but does not pressure women to use them. Because the risk of HIV infection is so high, many of these women see no point in even trying to prevent HIV or STD transmission by using condoms.

Empower has established a drop-in center that offers Thai language classes, health counseling, social work/low level therapy, legal counseling and human rights training to sex workers. The center also has a small emergency room that can accommodate some medical care refused by Thai health clinics or hospitals. Empower is trying to set up some of these services within brothels for sex workers who cannot leave the premises. The plight of illegal immigrants poignantly illustrates the limitations of current refugee laws and agreements.

“The least the Thai government can do is to provide proper refugee camps for these people so that they won’t be forced in to exploitative work situations.”

Udom Opakam, MAP NET

and an epidemic is not far off. According to a 1996 KAP survey conducted by IRC among Karenni refugees in Thailand, 66 percent of all 344 Burmese Karenni refugees surveyed had never heard of HIV or AIDS. Of the 34 percent who had, only 9 percent had entirely correct information. Sixty-one percent of those surveyed had never heard of STDs before.⁴

Health-related NGOs along the border have formed an "HIV/AIDS Coalition" to encourage cross-organization cooperation. Individually, NGOs are devising creative ways to get the message across. IRC recently organized activities in the three main Karenni camps in observance of World AIDS Day. Through such activities as traditional dancing, art contests, speeches by community leaders, HIV-related role playing involving community members, and the distribution of Burmese-language HIV/AIDS pamphlets, community health educators focused on causes and prevention of HIV infection. SMRU recently produced an educational video on HIV/AIDS to be shown as a movie preview and distributed to other NGOs for presentation.

Information-Gathering/Foresight

Most programs include precise and accurate data collection; yet there is little on-the-ground evidence that the information collected is used for program management, especially at the camp clinic level. To

provide for sustainability and lessen reliance on NGOs, refugees are taught clinical and management skills in nearly every program. Dr. Cynthia, for example, provides medical and RH training to refugees who work on both sides of the border.

The Next Step

Though most of the many NGOs working in the area have successfully integrated RH services within their programs, greater collaboration is needed between and among them to improve services and create common formats for data collection. This would help avoid the pitfall of collecting too much useless information and would make it easier to compare programs and clinics. While NGO RH activities have made it much easier for refugee women to obtain RH services, planning should now focus on who is *not* being served as well as who is.

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⁴ Knowledge of HIV/AIDS among Karenni Refugees in Thailand: Results of the 1996 Knowledge, Attitude and Practice Survey, Burma Border Program, International Rescue Committee, Thailand, February 1997.