CHAPTER 2

Essay: Recognizing the Impact of Migration on Reproductive Health in Myanmar

2.1. Introduction

Migration has been recognized by the United Nations Commission on Population and Development as one of the four sensitive issues urgently requiring the attention of the international community in the coming years (United Nations, 1996). As noted in Population Reports (1996):

> *Migrants, refugees, and internally displaced persons are among the world's most vulnerable people. Clustered on the margins of cities or culturally isolated within them, housed in camps meant to be temporary or without homes at all, they often have urgent health needs, including reproductive health.*

In countries where large migrant populations[1] exist, their reproductive health[2] needs must be addressed in research, policies and programs.

Myanmar[3] has been selected as a case study due to their large migrant, refugee and internally displaced populations within the country, in neighboring countries and throughout the country leaving migrants particularly vulnerable. In addition, Myanmar faces serious reproductive health morbidity and mortality with extremely limited health services (World Health Organization, 1997). However, there is little effort made to include the issues and needs of migrant populations in reproductive health policies, research or programs in Myanmar. The Government of Myanmar (GOM) enforces strict censorship laws placing serious constraints on health providers and researchers that have been researched by various international non-governmental organizations (Smith, 1996). Therefore, international organizations have a critical role to play in calling attention to migrant populations and including their realities in their reproductive health policies, interventions and research, particularly within the context of Myanmar.

Estimates of five million people have migrated within Myanmar and into its neighboring countries. This is over ten percent of the population given the estimated

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[1] Migrants in this essay will refer to all people who have moved from their homes for any number of reasons either internally within Myanmar or into neighboring countries. People from Myanmar who have migrated beyond neighboring countries will not be covered in this paper.

[2] This essay will use the definition agreed upon at the 1994 International Conference on Population and Development. The definition claims "reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."

[3] Burma was officially renamed Myanmar on June 18, 1990.

Population of 44 million.[4] The estimate of five million migrants is comprised from data collected by a wide range of non-governmental sources as governmental data is either unavailable or extremely limited. By 1990, 1.5 million people in Myanmar had been affected by the GOM's "resettlement programs." Since then, estimates of between 1 and 1.5 million more people have been relocated (Venkatesvaran, 1996; Smith, 1996). Estimates of internally displaced minorities within Myanmar are over one million (Smith, 1996). In Thailand over 100,000 refugees from Myanmar are residing in camps (Human Rights Watch, 1997a) and another 800,000 are working as illegal migrants (Archavanitkul & Koetsawang, 1997). By 1992, 250,000 people from Arakan State in Myanmar crossed into Bangladesh (Human Rights Watch, 1997b) and although nearly 190,000 have been repatriated, many were not allowed to return to their original homes. Approximately 140,000 refugees and displaced persons are living along or across the China border (Smith, 1996) and reports of massive relocations along the India border with over 40,000 living in camps across the Indian border (Images Asia, 1998). Myanmar has also experienced mass migration to border areas for trading, gem mining and other jobs which have become available in recent years. This is in addition, to the ongoing rural to urban migration that has been taken place throughout Asia.

Myanmar has some of the highest rates of maternal morbidity and mortality in the world. The World Health Organization and UNICEF estimate the maternal mortality rate (MMR) in Myanmar to be as high as 500 per 100,000 live births (World Health Organization, 1997). The GOM estimates MMR in the country at 140 per 100,000 live births, but even this figure makes Myanmar the third highest MMR in the

[4] This estimate was based on data from the last census in 1983 and published by the Department of Immigration and Manpower in 1995.

East Asia and Pacific Region (Smith, 1996). With abortion illegal in the country and contraceptives illegal until 1991, over fifty percent of all maternal deaths have been estimated to result directly from illicit abortions (Smith, 1996). For example, UNICEF estimated in 1992 that 58 women were dying every week from illegal abortions (UNICEF, 1992). These realities are directly related to the limited availability of reproductive health services and information, problems of access to what services do exist, discrimination in policies and practices, and absence of means for protection and monitoring (Freedman, 1994).

Mobile populations have been documented to be particularly vulnerable to five critical reproductive health issues (Population Reports):

- Contraceptive access and use
- Risks of HIV/AIDS and other sexually transmitted diseases (STDs)
- Safe motherhood
- Unsafe abortions
- Violence against women

Data available on HIV/AIDS and violence against women highlights the increased reproductive health risks of migrants within and from Myanmar. However, there is little known about the vulnerabilities of abortion and safe motherhood among this population. More research is needed to identify migrant populations within and from Myanmar in neighboring countries and their reproductive health needs in the broader context of their lives.

Due to the strict censorship laws and constraints on basic freedoms within Myanmar, international and non-governmental organizations have a critical role to play in raising the issues surrounding migration and reproductive health. Research and documentation can begin to identify migrant populations and describe their reproductive health situation, concerns and needs in the broader context of their lives. International organizations are in the best position to gather and disseminate the information as well as use it in their own program planning. Finally, the international organizations can strategically begin to raise some of the key issues with the GOM and governments in neighboring countries with sound evidence and suggestions for intervention on behalf of migrant's reproductive health needs.

2.2. Impact of Migration on Reproductive Health

Four critical aspects of the migratory process outlined by Population Reports (1996) will provide the framework for analyzing the laws and policies, vulnerabilities and recommended strategies for intervention. These are selection, disruption, differences and adaptation. *Selection* refers to the fact that not all people migrate and emphasizes the importance of looking at the characteristics of those migrating. *Disruption* refers to the changes that occur when migration takes place. *Differences* refer to the distinguishing characteristics of a migrant from others in their new places of residence. *Adaptation* refers to the process and affects of assimilation on migrants to their new surroundings.

2.2.1. Selection

Selection explores the political, economical, environmental and human rights factors that influence an individual, family or community's decision to move. Selection moves beyond asking who is going where to determine the wide range of laws, policies and social dynamics influencing the migration. In addition, defining characteristics such as age, gender and family and community roles provides insight into who migrates and their relationship to other family and community-members back home and in the new environment. Therefore, selection of migrants moves beyond asking who is going where to explore a wide range of issues reflecting social dynamics as well as individual characteristics.

2.2.2. Disruption

Migration results in *disruption* for any migrant but is even greater for those who relocate with little or no planning and those who arrive in unknown environments (Smith, 1996). Many migrants in Asia move into crowded, substandard and often unsafe environments. Illegal migrants typically live and work in conditions of poverty, pollution and violence. In addition, families and communities are scattered to varying degrees in the migratory process. Disruption strips migrants of their familiar environments and social networks, often leaving them with little or no support or services to address their reproductive health concerns and needs. The migrant therefore, is left without the resources to deal with both common and emerging reproductive health issues.

2.2.3. Differences

The extent to which *differences* between migrants and those in their new surroundings greatly influences their ability to seek reproductive health information and services. Not only is understanding language and culture a critical determinant, but also the ways in which the migrant is distinguishable from and discriminated by the larger society affects such behavior. Often migrants are unable to understand neither the language of products, service providers nor the western concepts of reproductive health and care. In addition, many migrants are marginalized by the mainstream society and not encouraged or supported to seek reproductive health care services. If migrants do seek out health services, often little or no care is taken to translate, explain or obtain informed consent for the interventions they receive. These differences are exacerbated when the migrant is illegal and the society they reside in resents their presence or makes them scapegoats for social problems.

2.2.4. Adaptation

The *adaptation* process is often directly related to the extent of differences between the migrant and their new environment as well as the support and acceptance they receive in their adjustment. The more fluent the migrant becomes with their new environment the sooner they are able to access reproductive health resources and services, although not necessarily ensuring the effectiveness of these interventions. For example, the wide availability of birth control products and drugs in some Asian countries may result in greater access, but not their correct usage. Another example

may be increased use of milk formula without knowledge and sanitary conditions to ensure proper practice. Migrants are often isolated or undocumented and likely to attempt self-treatment and misuse contraceptives and drugs resulting in higher rates of mortality and morbidity.

2.2.5. Framework for Analysis

As noted earlier, these four aspects (selection, disruption, differences and adaptation) will define the framework for discussing laws and policies, vulnerabilities and recommended strategies for interventions that impact migrant populations on their reproductive health. The aspects of selection will be addressed in the next two sections (2.3. and 2.4.) of this essay which outline the GOM's laws and policies impacting migration and reproductive health. Understanding the laws and policies that determines who is and isn't migrating and receiving reproductive health information, will allow for insight into the vulnerabilities of migrants and potential interventions and limitations. The impact of disruption and differences faced by migrants will be used in fifth section (2.5.) of this report to identify the vulnerabilities of migrants within and from Myanmar. Finally, adaptation leading to support and acceptance of migrants will be the goal of the potential interventions discussed in the last two sections (2.6. and 2.7.) of this essay.

2.3. GOM policies impacting internal and cross-border migration

The GOM's policies has either forced or left its citizens with few or no other options but to migrate. An overview of these policies will be presented in this section to highlight the critical role the GOM has in determining the "selection" of migrant populations. However, to clarify the migrant populations and terms used, a profile will be given first in order to facilitate the following discussion.

2.3.1. A Profile of Migrants within and from Myanmar

The general description of migrant populations, moving within and beyond the borders of Myanmar, aims to facilitate the analysis of their situation and its impact on their reproductive health. Population Reports (1996) refers to three different migrant populations; internally displaced, refugees, and migrant workers and traders. These categories offer a background profile to consider when assessing the impact of the migratory process. However these categories should not be use to focus on distinctions between the different groups. This is a crucial point as migrant populations within and from Myanmar are dynamic and individuals may often come under several different categories over time (Portor, 1994). The broad profiles presented here have been summarized from a wide range of references (noted in this essay) as well as from the author's own experiences over time in working with these various populations from Myanmar.

* *Internally displaced persons* in Myanmar are typically made up of entire families or even communities who have fled fighting, forced relocations, human rights abuses and/or fear of persecution moving to other areas within their country. The majority of those displaced have been from minority populations in contested areas or low-income families in urban areas. In many instances, the GOM has designated specific areas in which these populations are to be moved though many have avoided these places (for a variety of reasons) and sought other places to relocate.

* *Refugees* from Myanmar have largely been from minority populations and have moved as family units or with several family members to neighboring countries due to fighting or political repression. There have also been over ten thousand students and intellectuals who fled their country following the uprisings in Myanmar in 1972 and 1988 made up largely of males who are alone, though several hundred single female have also been among them. Refugees from Myanmar have fled to all of the countries bordering Myanmar (Thailand, China, Bangladesh and India) except Laos. The vast majority of refugees have lived in camps just over the border from their homeland.

* *Migrant workers and traders* have moved largely to the border areas where the demands for labor and business opportunities have expanded with the opening of border crossings. Large migrant populations from Myanmar have been documented on its borders with Thailand, China and India. They are largely young people who live on either side of the border. In Thailand, many migrants from Myanmar have sought work throughout the country while in neighboring countries they are predominantly located along the border areas. The young migrant workers and traders are typically alone or

with only one or two members of their families and are largely from ethnic minority populations. They have a wide range of reasons for migrating and largely seek to earn money to send back to other families deeper inside of Myanmar. The types of jobs available to migrants are largely based on gender. Female migrants typically obtain jobs in the service sectors often as domestic or sex workers while males are employed in fishing and constructed related industries.

2.3.2. GOM policies which have directly impacted migration flows

The GOM's policies addressing the country's political, economic, environment and human rights situation has largely determined who is migrating within and from the country. Although there are also pull factors attracting migrants to move, the majority of the relocation in Myanmar is the direct result of policies implemented by the GOM.

POLITICAL

Myanmar has had a one-party political system for over thirty years, which has repressed any opposition and resulted in large-scale migration. Many of those who have challenged the one-party system have been killed, arrested, hidden underground, forcibly relocated, joined opposition groups at the border areas or gone further abroad. The ethnic minority populations in Myanmar have been greatly affected by this political system which has not been open to cultural diversity, but has sought to impose a national language, culture and religion. During the past thirty years, wars have been fought with ethnic opposition groups seeking autonomy from the system they find

culturally oppressive. These wars have been fought throughout the country particularly in the border areas. In addition, many intellectuals, students, monks, health professionals and others throughout the country have also been forced to migrate due to the fear of political persecution. Refugees and displaced persons are found in all countries neighboring Myanmar as a result (Lintner, 1994; Smith, 1991a).

The GOM has implemented "resettlement programs" since the 1950s with there having been an escalation of these initiatives since 1988. These resettlement programs have been imposed by the GOM either for 'urban development' and 'counter-insurgency' operations. In some areas, with large minority populations, up to twenty percent of the population has been forced to move (Venkateswaran, 1996). For example, in one resettlement scheme alone 250,000 people were relocated from Yangon[5] to two new satellite towns outside the city. This resettlement scheme, like others, gave people between seven to tens days notice with little or no compensation for their homes or land. The new locations received a massive influx of people with extremely limited infrastructure and social services (such as health care and education) available.

Forced labor has been a national policy of the GOM since the one-party system began and has been largely imposed on those in the rural areas. Forced labor has been used on a variety of government projects such as: construction of roads, airfields, railways, hydroelectric plants and army barracks. Apart from being imposed, the labor is not paid and those conscripted suffer severe work conditions, especially in minority

[5] Yangon, the capital of Myanmar, was previously named Rangoon and was changed along with the name of the country in 1990.

areas. These policies have been extended to include forced conscription of porters for military troops, often encountering severe injuries and even death (United Nations Special Rapporteur on Myanmar, 1993).

Finally, it is critical to point out that the GOM has strict citizenship laws that make it extremely difficult for many of the people in Myanmar to qualify. The Citizenship Law in Myanmar defines three classes of citizens, which discriminates particularly against racial and ethnic minorities. It requires that a person produce evidence that his or her ancestors were settled in some part of the national territory prior to 1824, when the British colonized Burma (Venkateswaran, 1996).

Economic

Myanmar was designated by the United Nations as a Least Developed Country in 1987. The GOM's policy of the *Burmese Way to Socialism* promoted isolation that sealed the country off from the outside world for nearly thirty years. The economic impact of this policy can be seen in rice exports (a critical product for the predominantly agrarian society): In 1962, as this current regime came to power, rice exports were up to two million tons per year. In 1988, despite a doubling in production, the exports were virtually none (Smith, 1991a). While during the same period opium production and exports increased 8,000 percent to approximately 2,575 tons of raw opium in the 1992-1993 harvest season (Lintner, 1994). Another example of the government's isolation is its control of the country's exchange rate of 6.7 kyats to one US dollar while the black market value is over 200 kyats to one US dollar. Finally, corruption in Myanmar is a chronic problem throughout the country.

The GOM introduced an *Open Door Trade* policy in 1988 to move from a "socialist centrally-planned" towards a "free market" economy. This policy included an opening of border crossings particularly into Thailand and China and encouraged foreign investment in the country. This further encouraged migration as economies flourished at the border areas. In addition, the trade with foreign investors largely revolved around the purchase of natural resources with limited opportunities for economic investments that would provide for a higher standard of living among the people of Myanmar (Lintner, 1994).

Environmental

With the new *Open Door Trade* policy the GOM has sold concessions for timber, rubies, oil and fishing. All these concessions have resulted in mass migration and relocation to either work for the new businesses or to make room for them. For example, estimates of as many of one million Burmese have gone to the northern ruby mines for jobs. While others, such as local fishermen, have been forced to migrate as a result of the concessions sold to over 280 modern trawlers from eight Thai companies which were allowed to renew in 1993 depriving the Burmese of their livelihood (Smith, 1994). There are numerous examples of the new concessions for Myanmar's natural resources forcing local residents to migrate.

The GOM's gas and hydroelectric projects have begun and will continue to displace hundreds of thousands if not millions in their development. In addition, such projects are known to damage to fish, wildlife and the ecosystem. This will lead to the increased vulnerability of many others and their likelihood to also migrate.

Finally, logging in Myanmar has resulted in a deforestation rate of 800,000 to one million hectares each year, one of the fifth highest in the world (Rainforest Action Network, 1993). This is the result of the GOM concessions as well as those sold by the minority opposition groups along the border areas. As a result, many families have been forced to move as the logging ventures directly destroy their homes and/or livelihoods.

Human Rights

The GOM has countless laws and policies severely restricting basic human rights such as freedom of movement, information and association (Venkateswaran, 1996). These basic freedoms are upheld in the Universal Declaration of Human Rights proclaimed by the United Nations General Assembly in 1948 (Center for the Study of Human Rights, 1994):

Article 13:

1. *Everyone has the right to freedom of movement and residence within the borders of each State.*
2. *Everyone has the right to leave any country, including his won, and to return to his country.*

Article 19:

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20:

1. *Everyone has the right to freedom of peaceful assembly and association.*
2. *No one may be compelled to belong to an association.*

The denial of these basic freedoms has led to the movement of people within the country, cross-borders and further abroad and their increased vulnerability.

Even with newly opened border crossings, the GOM has restrictive laws on movement which are often enforced at the discretion of officials. These orders together with the Immigration Law of Myanmar Burma Immigration Act 1947 (section 4.2. and 13.1.) state:

> *No citizen of the Union of Myanmar shall enter the Union of Myanmar without a valid Union of Myanmar Passport or a certificate of the Union of Myanmar.... Shall be punished with six months to five years imprisonment or with a fine of a minimum of Ks 1500 or with both.*

This law leaves the traders and migrants increasingly vulnerable due to their lack of documentation. Another Immigration policy issued in 1996 (Government of Myanmar [GOM], 1997):

> *Prohibits young women between the ages of 16-25 years old from crossing the border unless accompanied by a legal guardian*

Though this law was issued to protect women, it has had limited effectiveness given Myanmar's extensive borders and ultimately places the criminality on the young migrant verses the traffickers. This seems to have no affect on limiting migration, but rather has increased the vulnerability of young female migrants to arrest and violence as they seek often covert routes to cross borders. Finally as these policies and laws increase the vulnerability of migrants and often leads to subsequent migration and those moving temporarily to be caught in a longer-term relocation.

However, the overriding social factor is the GOM broad and comprehensive censorship laws, which severely restrict freedom of movement, information, and association. On June 7, 1996 the GOM made it an offence to instigate, protest, say, write or circulate information on anything which could:

> *Disrupt and deteriorate the stability of the state, communal peace and tranquillity, and the prevalence of law and order... affect or destroy the national consolidation... affect, destroy and belittle the tasks being implemented*

at the National Convention... and cause misunderstanding among the people (Venkateswaran, 1996).

This law and other similar martial decrees have been used to arrest and imprison numerous health professionals (Smith, 1996; Chelala, 1998). Dr. Khin Zaw Win is one example of a qualified dentist and former employee of UNICEF who went abroad to study attending conferences and continuing his contacts with international health officials and was arrested upon his return to Myanmar. He was sentenced to 15 years in prison for "spreading false news" and other offenses (Chelala, 1998).

The GOM has banned political parties and other non-government organizations and imprisoned thousands of people in a direct denial of the freedom of association. This not only impacted individuals, but communities and institutions throughout the country. For example, this ban, together with the other censorship laws and martial decrees, have been used to justify the closing all Universities and control of all forms of media throughout the country (Venkateswaran, 1996; Smith, 1996; Lintner, 1994). These realities have led to deep dissatisfaction and a desire to migrate to places where basic human rights are upheld and opportunities for information and education are available.

2.4. GOM Reproductive Health Laws and Policies

Selection will also be emphasized here to discuss the factors which determine who does and does not receive reproductive health services in Myanmar. This will

provide a means for exploring the particular reproductive health vulnerabilities of migrants. The vulnerability of migrants will be discussed in the following section after an analysis here of the GOM's laws and policies impacting on the reproductive health of the people of Myanmar.

Freedman's writings (1994, 1995) identify several critical areas to be included in analyzing reproductive health laws and policies. Freedman has focused particularly on laws and policies that have impacted on women's right to control their fertility claiming that:

> *Contraceptives help women to control the consequences of sexual encounters, including direct biological consequences such as STDs and the morbidity and mortality associated with pregnancy, as well as a whole host of psychological, social and economic factors linked to childbearing and sexuality.* (Freedman, 1995).

In realizing the pivotal role controlling one's fertility has in determining many other aspects of reproductive health, this essay will focus on contraceptive laws and policies in Myanmar. At the same time, the laws and policies affecting contraceptive knowledge and use in Myanmar will also highlight critical factors to be considered when analyzing other reproductive health issues in the country.

Freedman (1994, 1995) raises a number of factors to be considered in analyzing the impact of contraceptive laws and policies. In this essay, these factors will be summarized in the following three components:

- provision of and access to contraceptive commodities and services
- discrimination in the delivery of contraception
- right to information

These three areas will be used below to analyze the contraceptive laws and policies in Myanmar and how they determine who does and doesn't receive reproductive health care and information.

2.4.1. Provision and Access to Contraceptive Commodities and Services

Up until 1991, the GOM had promoted a pro-natalist policy since its independence from England in 1948 (Ministry of Home Affairs National Population Committee, 1994). However, in a study done in 1983 in the capital city, found approximately 20 percent of married couples were using or had used some form of birth spacing method (Kyaw Tint, 1983). In another study carried out in 1989 (Hla Pe, et al., 1992) in two rural populations, nearly 35 percent of the couples interviewed had practiced birth spacing at least once in their married life. What was more disturbing about the findings of the latter report was that the occurrence of abortions was higher among couples who practiced birth spacing (36.63 percent) than those who did not practice (20.42 percent). Thus the report concluded a statistical association between birth spacing practices and abortions showing a high rate of

contraceptive failure (Hla Pe, et al., 1992) also confirmed by Ba Thike (1997). Such data, together with the high MMR due to unsafe abortions[6] stresses the critical unmet need for contraceptives documented by the World Health Organization (1997).

The GOM recognized in 1991, that making contraceptives available was an important way to prevent unwanted pregnancies and reduce the high rates of abortion and maternal and infant mortality rates. The GOM refers to its contraceptive programs as "birth spacing" which upholds their pro-natalist position. In addition, the GOM only legalized the sale and use of condoms in 1993, which has not only had an impact on contraceptive choices, but also on the protection against sexually transmitted diseases (STDs), especially HIV/AIDS (Beyrer, 1998).

The limited availability of general reproductive health commodities, services and information is the result of GOM laws and policies as well as their implementation. As a result, just over half of the country receives general reproductive health services and an estimated 70 percent of the people in Myanmar are unable to obtain safe and effective contraceptives. This is not entirely the result of lack of resources to provide contraceptives, but also reflects the GOM's laws and policies that limit their availability and access. For example, international organizations have had to withdraw or place a hold on their assistance to the GOM due to the "inappropriate health practices and distribution problems" (Smith, 1996). The International Committee for the Red Cross raised their concerns with GOM's health and humanitarian practices and ultimately withdrew from Myanmar in 1995 due to a lack of response. In addition, UNDP put a hold on their aid to

[6] Induced abortions are illegal in Myanmar.

Myanmar in 1992 in order to review that the aid was actually reaching the people it was intended for (Smith, 1996).

The GOM estimated in 1995 that 65 percent of the population in Myanmar had access to primary health services (Central Statistical Organization, 1995) while other sources claim less than half (Smith, 1996). In addition, 80 percent of births take place at the home with limited or no health care services. The GOM has developed a multi-layer health care system with Township Health Stations, Rural Health Centers and Sub-centers. Though the system in theory provides access for people at the village level, there are many obstacles that interfere with the provision of care. These include "chronic shortages of drugs, insufficient equipment and inadequate numbers of staff in many areas" (World Health Organization, 1997).

The first government supported birth spacing project was introduced in Zigone Township in Bago Division in 1991. It was funded by the Family Planning International Assistance (FPIA). By 1994, the FPIA project had expanded to four sites including Mandalay and Magwe Divisions. By 1992, the United Nations Population Fund (UNFPA) also expanded the model project of MOH and FPIA to twenty additional townships. In 1994, United Nation Develop Program (UNDP) funded birth spacing programs in six other townships (Thein Thein Htay, 1996). Thus, by 1994, thirty townships were receiving birth spacing services with plans announced to expand birth spacing services to 79 of the 324 townships[7] following the agreement between the Government of Myanmar and UNFPA to a three-year birth spacing project of US$3.5 million (Government of Myanmar [GOM] & United Nations Population Fund [UNFPA], 1994). In addition, UNHCR and

MMCWA have funded birth spacing[8] on emergency basis to those repatriated from Bangladesh (Smith, 1996).

In addition, due to the limited services, drugs, equipment and staff mentioned earlier, clients are faced with health service providers who are inadequately trained. For example, one assessment found that between 400-500 intra-uterine devices (IUDs) were received by each township with birth-spacing programs however, only 38 percent of the government health centers reported having instruments for insertion. In another study among the Lady Health Visitors and Midwives, it was found that 78 percent were trained to insert IUDs, but most did not insert IUDs because they lacked the necessary instruments (McConville, 1995).

As a result, most people in Myanmar have sought to obtain contraceptives from the private sector. Several studies from central Myanmar where birth spacing programs have been established report up to sixty percent of the couples using contraceptives purchased them from the market place, street vendors, friends or relatives (McConville, 1995; Hla Pe, et al., 1992; Than Than Tin, San Shwe, & Thein Thein Htay, 1994). This is true not only for contraceptives, but drugs and goods for a variety of health care needs. The private health sector provided have also played an increasingly role in meeting the broad range of health care needs in Myanmar (Smith, 1996).

However, there remains a critical unmet need for safe and effective contraceptives to be provided by trained service providers in Myanmar (World Health Organization,

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[7] This would provide coverage of about 22 percent of the country.
[8] Under the technical assistance of Mynamar's Department of Health.

However, there remains a critical unmet need for safe and effective contraceptives to be provided by trained service providers in Myanmar (World Health Organization, 1997). In a study conducted by the Myanmar Ministry of Home Affairs (1992) found 46.4 percent of the women did not want any more children and 24 percent wanted more later. If all these women had become contraceptive users, the prevalence rate would have increased from 16.8 percent to over 70 percent (UNFPA, 1996). These realities are most dramatically seen in the high maternal mortality rates in Myanmar, which range from 100-500 per 100,000 live births. Two studies found abortions to be the leading cause of maternal death (Krasu, 1992: and UNICEF, 1991).

This is in addition to the fact that the townships that are not covered by the GOM health care system are all from ethnic minority areas. Considering that only 79 townships out of 326[9] have been targeted for birth spacing programs, it will be a long time until such services reach the predominantly ethnic minority areas.

As noted earlier, most of the townships do not receive government birth spacing services and therefore, most people rely on the private sector for contraceptives. Many of the contraceptive products available in the markets and private sector are not monitored for their quality, safety or efficacy. In fact some contraceptives drugs did not source the expiration date, country of origin or instructions for use. In addition, many of the private sector providers of contraceptives are not health care providers, but retailers who are not qualified and cannot advise on the suitability or safety of the product. Many traders purchase drugs and contraception from neighboring countries and return

[9] Two more townships have been added since 1994.

to sell them in the markets throughout Myanmar. These traders or retailers have little or no knowledge of how to use the product or of the side effects or treatment of them upon use. Even IUDs are typically bought in the market and taken to a GP for insertion (McConville, 1995). However, even including private sector contraceptives Ba Thike (1997) claims contraceptive prevalence in Myanmar is only 34 percent in urban areas and ten percent in rural areas with high mortality from clandestine abortions as a result of both lack of availability and high contraceptive failure rates.

The GOM's birth spacing policy has begun to address the high demand for contraceptives throughout the country and ongoing expansion will be necessary. However, as the program expands it is critical that aspects of the current GOM birth spacing programs that determine who can and cannot receive contraceptives be identified and addressed.

2.4.2. Discrimination in the delivery of Contraceptives

It is critical to look beyond individual characteristics by acknowledging that factors determining one's health, especially reproductive health, are also socially produced and socially ameliorated (Freedman, 1994). Therefore, understanding how reproductive health issues are framed and identifying factors that interfere with an equal and non-discriminatory approach to them is crucial. The following provides an analysis of how the current birth spacing programs in Myanmar identifies and discriminates against potential users and explores some of the social factors which influence current policies.

Gender

Contraceptives in Myanmar have primarily focused on women. Condoms remained illegal until 1993 and still carry a great deal of stigma throughout the country (Smith, 1996). In addition, male sterilization (vasectomies) remains illegal in Myanmar and therefore not offered through government health services (World Health Organization, 1997). However, vasectomies are unofficially provided through private clinics and are reportedly `popular' (McConville, 1995; Hla Pe, et al., 1992). There has been no active campaign in Myanmar to promote condom use nor has an explanation been given for why vasectomies remain illegal. The lack of access to contraceptive methods for men limits their options as well as places additional responsibility and often burden on women as a result.

Women in Myanmar have limited opportunities to raise their concerns and provide input into policy decisions. Although women make up forty percent of the labor force and attend university in larger numbers than men, few women have ever been allowed to rise to top government positions. In addition, there is no official agency or ministry in Myanmar to advance or protect the status of women (Smith, 1996).

In addition, violence against women is well documented in Myanmar and has a direct impact on their health and in their ability to seek intervention and care. Particularly disturbing is the numerous accounts of rape well documented throughout the country (Asia Watch, 1992; ALTSEAN, 1997, Amnesty International, 1998; Earthrights International, 1998). In addition, conservative estimates of 10,000 girls and women from Myanmar each year having been trafficked into the sex industry into neighboring

countries, particularly Thailand and China (Asia Watch, 1993). These issues and others surrounding violence against women have not been actively addressed by the GOM and remain ongoing realities that go largely unnoticed within Myanmar.

Marital Status

Given the pro-natalist stance of the GOM and the fact that contraceptives have only been legalized since in 1991 under the guise of "birth spacing" maintains the government's position that all couples should have children. In addition, birth spacing programs are provided for "married women of reproductive age" (MWRA). This assumes that all couples are married and will have children and is framed in a way that could discriminate against couples who are not married or do not want children immediately or at all.

The findings from the following two studies provide some insight into the demand and potential discrimination associated with the focus on birth spacing for women already with children. In one study of two rural populations in 1989 (Hla Pe, et al., 1992) women who married as teen-agers (less than 20 years old) used birth spacing practices the most (36.4 percent) followed by women who married between the ages of 20-24 years of age (31.3 percent). In addition, 24.4 percent of the couples interviewed with no children practiced birth spacing. Similar findings were also noted in the Thanatpin Study (Bo Kywe, Maung Maung & Saw Sein, n.d.) where 44 percent of MWRA without children were currently using contraceptives compared to 14 percent who had more than five children. However, contrary to these studies, birth spacing programs in Myanmar focus on

providing contraceptives to women already with children and assumes that contraceptives use is a concern for older women and couples who already have several children.

Birth spacing policies, programs and research in Myanmar have focused exclusively on Married Women of Reproductive Age (MWRA). There has been little effort to address the contraceptive needs or provide related services for unmarried women or adolescents although the need has been documented. The few studies that have focused on the pregnancies and deliveries among adolescents in Yangon show an increased health risk to both the young mother and their newborns (Ba Thike, Khin Thet Wai, Nan Oo, & Khin Htar Yi, 1993; Aye Aye Thein, Ba Thike, & Myint Maung Maung, 1995). Even more concerning is the increasing numbers of unsafe (illegal) abortions among adolescents (Ba Thike, et al., 1992; Ba Thike, et al., 1993). Ba Thike and others have pointed out that:

because of social unacceptability, unmarried pregnant women may be more at risk of serous abortion complications, both because of delays in finding someone to do the [illegal] abortion and also in seeking treatment for complications.

In addition, the World Health Organization (1997) also noted the insufficient data on the reproductive health of adolescents in general though noting indications that youth may suffer from a high incidence of STDs.

Ethnicity

The ethnic minorities constitute an estimated one third of the population of Myanmar and include over twenty different groups. The minority populations have been at war with the current government and its policy of promoting a Burman society with one culture, religion and language. Their lack of autonomy has resulted in minority opposition groups taking up arms against the military regime for over thirty years (Smith, 1991a; Lintner, 1994). Consequently, the pre-dominantly minority areas have been largely cut off from not only the central government, but also to outside observers and international aid. Although fragile cease-fire agreements have been made with many of the minority opposition groups there has been little change in the situation which has continued to include exchange of artillery, displacement and human rights abuses.

As a result, the ethnic minority areas of Myanmar have had limited public health care services, if any at all. There is a serious lack of doctors willing to work in these areas and those who are forced to do so rarely turn up for work or simply apply for a transfer immediately upon arrival. For example, in 1995, the GOM reported that 500 government health posts were vacant and in some minority areas more than a third of the positions for doctors remain unfilled (Smith, 1996). This is addition to the fact that the 79 townships targeted for birth spacing programs are in predominantly in central Myanmar and no concrete plans have yet been made to provide such services to the predominantly ethnic minority areas.

Inability to Pay

The health services in Myanmar, both public and private are provided according to client's ability to pay and unless the client can pay, there are no or extremely limited services available (Smith, 1996). Payments are not only necessary for basic drugs and services, but also for many smaller items such as needles, dressings and even a bed or sheets in the hospital. In addition, drugs and supplies are often unavailable and patients must purchase them from the markets. This is largely due to chronic under-funding, underpaid staff and large-scale corruption. Ba Thike (1997) also notes that the cost of contraceptives and reproductive health services, although low, remains a critical barrier for poor women. As a result, women often rely on cheaper contraceptives available in the markets that are of questionable quality and safety.

Arbitrary Discrimination

Finally, the military in Myanmar plays a strong role in the political and the public services system, which often results in discrimination among citizens not connected to or in support of their position. The GOM frequently imposes laws and policies without clear guidelines and local military officers make decisions (Smith, 1991b). Consequently, many of the laws and policies are arbitrarily implemented at the local level without any means for recourse to confront discrimination or challenge the decisions or actions.

An example of how this directly impacts contraception is seen in the GOM policies for sterilization. In order for a woman to receive a tubal ligation at a public

hospital, she and her partner must apply to the government for permission. This requires the couple to complete an application form for submission to the `Sterilization Board' at the district (or State) level requesting the procedure for health reasons. However:

> *The term 'health' is considered in a broad sense and each individual case is evaluated on its own grounds. There are no specific set of requirements that applicants have to fulfil regarding age and parity but most Obstetricians have arbitrarily set the minimum age as 30 years and already at least three children.* (Ba Thike, et al., 1993).

In other areas no explanation has been given to those not approved. For example in 1990, out of 6,694 applications to the Yangon Sterilization Board, 5,889 were approved. This process can take several months and those rejected were not informed of the reasons why (Ba Thike, et al., 1993). Finally those accepted must be able to pay between 1,500 and 10,000 kyats for the public service, which is out of reach for most poor people (World Health Organization, 1997).

Other examples of health care providers deciding contraceptive methods for the patient have been documented. In one study on *Knowledge and Practice of Service Providers in Relation to Birth Spacing* (Thein Thein Htay, et al., 1996) among 140 health care providers and 27 drug store owners in four townships in Central Myanmar. This study found that 44.3 percent of the providers claimed they decided on the choice of contraceptive compared to only 52.1 percent who stated that the client chose the method.[1] In another study in Taikkyi Township, ten percent of the health providers "do not consider

consumer's choice because of their ignorance of appropriate methods" (Myint Myint Soe, et al., 1995). Even where government birth spacing programs are available target contraceptive goals have been established (Government of Myanmar [GOM] & United Nations Population Fund [UNFPA], 1994) which could arbitrarily decide on behalf of a client the contraceptive method they will use. This is another means of discrimination that can deny a woman their right to make informed choice in the contraceptive method they prefer.

2.4.3. Right to Information

The right to access and publish a wide range of information directly impacts on contraceptive policies, services and choices (Freedman, 1995). The strict censorship laws in Myanmar (noted above in section 2.3.2.) have placed serious constraints on the freedom of information and expression among policy makers, health providers and potential and actual contraceptive users. The limited opportunities to receive or provide information directly impacts contraceptive decisions with serious consequences for women's overall reproductive health as does the denial of other basic human rights.

The need to develop and implement a more effective information, education and communication (IEC) campaign was recognized by Dr. Thein Thein Htay (1996) as critical to the success of the birth spacing program. With access to information, education and communication on a wide range of contraceptive methods, concerns and discussions, government officials, health providers, private sector contraceptive suppliers and the people of Myanmar would be able to make better decisions and responses to their

reproductive health needs. The recent announcement of the GOM development of a manual on reproductive health will not adequately offer health policy makers, providers nor the clients a broad perspective and discourse on contraceptives and broader reproductive health issues. Such a manual by its nature focuses on the GOM objectives and language providing only one point of view on a divers field of knowledge and perspectives.

Training materials on contraception, and IEC (information, education and communication) for providers and clients locations and are heavily censored or not available at all (Smith, 1996). The censorship laws in Myanmar seriously limit the opportunities to obtain information, conduct research, publish findings and undertake training and dissemination of education materials. Although there is a growing awareness of reproductive ill health, these barriers seriously restrict public discussion and information dissemination. As a result, the understanding of reproductive health concepts and implication for health services have yet to be developed (UNFPA, 1996) and are restricted in their ability to meet the demands for contraceptives.

Given the limited availability of information, research, training and education materials, health care providers and women are making choices based largely on word of mouth, availability and cost (Thein Thein Htay, 1996). This raises concerns about informed consent of the clients in choosing their contraceptive methods, dealing with side effects, requesting termination or changes.

In addition to censorship are the problem of literacy and an imposed national language that is not used by the many ethnic minority populations. The illiteracy rate among ethnic minority women has been reported as high as 86 percent in some areas (Portor, 1995). The illiteracy rate in Myanmar is uniformly higher among women and particularly high for both male and female in the minority areas (Smith, 1996). This is both the result of the few educational opportunities and GOM policies that public programs for education, health care and other services and information be implemented in Burmese language (Smith, 1991a). It is rare therefore, to find educational opportunities and information in ethnic languages further limiting access to information and education of large ethnic populations who don't speak and/or write Burmese. This has had a direct impact on the GOM birth spacing services. For example, in Arakan State[10] Depo-Progestrone injections[11] were introduced. When Depo-Progestrone was made available in Arakan State rumors of forced sterilization were spread and strong protests against the contraceptive were made. This was largely due to the lack of any information about this type of contraceptive as well as procedures and monitoring to ensure informed consent among the receivers of this method. This gap in information and distrust particularly among minority populations of the GOM requires access to health information, public explanation and debate (Smith, 1996) in a language and media that is understood and accessible by all its citizens.

In conclusion, it is also important to note that the GOM lacks laws to ensure informed consent to birth spacing services and the monitoring of contraceptive products

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[10] Arakan State is the one ethnic minority area where birth spacing services were provided in collaboration with international organizations to refugees returning from Bangladesh (see section 2.1. of this essay)

[11] Depo-Progestrone is a contraceptive injection given every three months.

and their safety. These both requires providing the citizens of Myanmar with a wide range of information (in languages and medium that are understood and accessible), clear channels for exchange from the providers and potential and actual users of the contraceptives available in the country.

2.5. The Reproductive Health Vulnerabilities of Migrants within and from Myanmar in Neighboring Countries

Migrants are less likely to be able to receive reproductive health commodities, services or information given the "disruption" and "differences" they experience (Population Reports, 1996). Having explored the GOM policies and laws to determine the "selection" of who is migrating and receiving contraceptives (as an indicator of reproductive health more generally) it is possible now to explore the reproductive health vulnerabilities of migrants within and from Myanmar.

As noted earlier (in section 2.1) there are five critical reproductive health issues that have been identified as vulnerabilities among migrants. These are contraceptive access and use, HIV/AIDS and other STDs, safe motherhood, unsafe abortion and violence against women (Population Reports, 1996). As contraceptive access and use has been covered in the previous section below will review the current situation in Myanmar of the remaining four reproductive health issues. This will be followed by a review of the reproductive health risks currently known among migrants within and

from Myanmar. Finally, this section will present reproductive health concerns among migrants within and from Myanmar that has emerged from the analysis of this essay.

2.5.1. HIV/AIDS and other STDs

According to UNICEF (1993), STD and maternal child health (MCH) services are under utilized to avoid stigmatization and due to the poorly equipped facilities.

> It is estimated the 70 percent of STD cases are being treated either by the private sector or by self -treatment.... The majority of women and the youth, particularly those with little income, revert to ineffective self-treatment, relying on drugs from the limited open market and traditional medicine (UNICEF, 1993).

Due to the fact that most people prefer to treat STDs themselves or through private health providers where no records are kept, the nature and extent of STDs in Myanmar cannot be accurately determined. The data that is emerging is that surrounds the HIV/AIDS epidemic, which also reflects the likely presence of other STDs.

By the end of 1994, WHO estimated that the number of HIV-positive persons in Myanmar ranged from 400,000 to 500,000. In addition, WHO pointed out that those infected were no longer confined to individuals engaged in high-risk behavior and that the disease is now affecting the general population, including women and children (UNICEF, 1995). Given the estimated HIV infections in Myanmar as of March 1996,

46.7 percent of those infected were among women attending pre-natal care (MCH) clinics. This estimate equates to 214,420 HIV positive pregnant women in Myanmar (Department of Health, 1996). This large estimate which surpasses every other high-risk category is probably the most reliable in understanding the HIV/AIDS epidemic in Myanmar. First because it is easier to predict the number of pregnant women than those in other at risk groups and their routine testing provides a more valid sampling. Thus, it has been concluded that if these rates of infection among pregnant women are accurate, the other figures are much too low as "it is unlikely that so many `low risk' women could be infected without very large number of married men" (Southeast Asia Information Network, 1995).

2.5.2. Safe Motherhood

Given the high rates of maternal mortality in Myanmar, safe motherhood is a critical issue throughout the country. It is estimated that eighty percent of the births are delivered at home and over sixty percent of the pregnant women in Myanmar suffer from anemia (UNICEF, 1995). Basic health services are provided to 209 of 329 townships in central Myanmar where 70 percent of the population lives. However, basic health services only reach about 48 percent of the population in the 209 townships according to the GOM and UNFPA (1994). For those populations not receiving basic health services (predominantly the outlying ethnic minority areas) infant mortality rates are nearly four times higher (UNICEF, 1995).

2.5.3. Unsafe Abortion

In various studies throughout Myanmar, abortions accounted for at least one third of all maternal deaths (Ba Thike, 1997; UNICEF, 1991; Khin Than Tin & Khin Saw Hla, 1990) and women with no formal education and low income were found to be more likely to seek unsafe abortions (Ba Thike, 1997). All of these studies acknowledge underreporting of induced abortions given that it is illegal in Myanmar. One study which attempted to document under-reporting found that only 30 percent of women known to have had induced abortions would admit to it upon follow-up visits (Figa-Talamanca, 1986). Finally, this data is based on studies and government statistics in townships predominantly in seven divisions of central Myanmar and includes very little information (if any) on the seven minority States made up of largely ethnic minority populations. The little data available from government health centers in minority States such as Kachin, Kayah, Chin and Mon division shows admissions of women for delivery equal to those seeking treatment for abortion complications (Ba Thike, 1997).

2.5.4. Violence against Women

Due largely to the GOM's policies and the ongoing war with minority and opposition groups, nearly five million people in Myanmar are on the move. The majority has been forcibly relocated with little or no notice into areas that have not been prepared for their arrival, thus find themselves without any facilities or services available. While migration disrupts the entire community, women are particularly vulnerable as they

typically carry the domestic responsibilities and face an entirely new environment with few resources and limited security available. In addition, forced labor and conscription, particularly in border areas, results in males living outside of the village to avoid duty, as a result women are left to care and protect their children often at great personal risk.

Violence against women in Myanmar is documented largely by the extent of rape and physical violence consistently reported by victims in Myanmar, again particularly in the border areas (Earthrights International, 1998; Amnesty International, 1998; Smith, 1996; Asia Watch; 1992). The numbers of rapes reported are likely to be in the thousands and given the likelihood of underreporting the realities could easily be many times more. The perpetrators are predominantly military personnel and as a consequence very few of the women reporting rapes have been able to seek recourse for the abuse they encounter (Earthrights International, 1998; Amnesty International, 1998; Asia Watch, 1992). This places the entire responsibility of protection on the women themselves often in a hostile or unfamiliar environment.

2.5.5. Reproductive health risks of migrants within and from Myanmar

Unfortunately, there is an extremely limited amount of information available on reproductive health realities and needs of migrant populations from Myanmar. This in itself highlights a need for exploratory and descriptive research of the issues and needs of this population including their reproductive health needs in the context of their health realities and concerns in general.

Of the five critical migrant reproductive health issues noted earlier (Population Reports, 1996), extremely limited information is available in the Myanmar context and that which largely focuses on the HIV/AIDS epidemic. There is no available data on abortion or safe motherhood and limited knowledge of the extent of violence encountered. Therefore, the following will present the vulnerabilities of migrants to HIV/AIDS as an indicator of some of the risks faced by migrant populations within and from Myanmar and some of the issues of violence that have been documented.

HIV/AIDS

Myanmar is positioned in between Thailand and India where the estimated rates of HIV infection in 1993 were 400,000 and 1.8 million respectively. Given the reality of migration and the opening of trade and transport between Myanmar and it's neighbors it is not surprising that Myanmar is already facing alarming rates of HIV/AIDS infections (Portor, 1995). In addition, in neighboring countries the most alarming rates are found on their borders with Myanmar. For example, some of the highest rates of infection in Thailand are found along its border with Myanmar (PATH, 1992). Yunnan province of China (which borders with Burma's Kachin and Shan States as well as Laos) is the area with the highest prevalence of HIV infection in China. The Chinese Ministry of Health reported in 1995 that 80.4 percent of all HIV infections in China were detected in Yunnan and 60 percent of all confirmed AIDS cases (Zeng Yi, 1995). The State of Manipur

(across from the Chin State of Myanmar) has the highest percentage of HIV positive cases in all of India (Department of Health, 1995).[12]

In the areas where there has been HIV/AIDS sentinel surveillance data available within Myanmar, the border towns have shown extremely high prevalence rates (in comparison to other areas of Myanmar). In HIV sentinel Surveillance of high-risk groups, the highest rates of infection were found in Myanmar's cross-border points with Thailand, and Mandalay (Min Thwe, Bo Kywe, & Goodwin, 1995). Unfortunately, data is only available for several border areas, leaving little known about HIV/AIDS prevalence (and other health realities) in most migrant and border communities.

Given the profile of migrants within and from Myanmar, they are likely to be relocated into areas where health services are unavailable or find themselves unable to access them. This may be due to a variety of realities that go beyond availability and include factors such as lack of documentation (in that township or country), language skills, limited resources for transportation or health care costs and/or trust of health care providers. In addition, issues of discrimination, violence and fear also influence reproductive health risks that have not adequately addressed.

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[12] According to India's Department of Health, (1995), *National AIDS Control Programme in Manipur*, Manipur, India: "Manipur ranks second highest in regarding the total number of HIV cases next to only the Maharastra State. However if we calculated the sero-positivity rate per 1 million population, the sero-positivity rate of Manipur is 16 times higher than that of Maharastra State and 24 times than that of Tamilnadu."

Violence against Women

Gender-based violence, both within and outside formal relationships, has a direct and serious impact on reproductive health (National Research Council, 1997). Migrants within and from Myanmar are extremely vulnerable to exploitation and deprivation of their rights at every stage of their flight including relocation sites or camps. Many girls and women have reported having been physically beaten and/or raped in Myanmar, during their migration and/or after their relocation (Earthrights International, 1998; Amnesty International, 1998; Smith, 1996; Asia Watch; 1992). More than 80 percent of the refugees are women and children (ALTASEAN, 1997) and in addition to the physical violence, these women have been left alone to struggle for the survival of the family in a strange place and an economy distorted by violence (ALTASEAN, 1997).

Trafficking of girls and women from Myanmar is another form of violence that has directly affected the reproductive health of the victims. Reports of up to 10,000 girls and women from Myanmar have been trafficked each year into brothels in Thailand (Asia Watch, 1993). Reports of girls and women trafficked into sex work in China and India have also been made, but with no detailed research of the phenomena. Traffickers have also been reported to have recruited women in Yangon to migrate to Japan as classical dancers and forced into prostitution (Smith, 1996). As noted earlier the GOM response to trafficking has been to prohibit cross-border migration of all females 16-25 years of age, placing an infringement on their basic freedoms. Unfortunately, this has resulted in more

and more young women moving in unregulated manners and increasing their vulnerability to violence without recourse (Smith, 1996).

2.6. Reproductive Health Concerns of Migrants within and from Myanmar

While acknowledging these specific reproductive health risks to migrant populations (noted in section 2.5.), it is critical to address the underlying issues that interfere with migrant's ability to meet their reproductive health needs. This is referred to as the adaptation process of migrants to their new environments and in overcoming obstacles to obtaining reproductive health commodities, services and information (as noted in section 2.1.4.). This section will look at the obstacles to adaptation, that should also be included in strategies for meeting the reproductive health needs of migrant populations of Myanmar.

There are three broader concerns that emerge from this analysis that should be included in strategies for addressing the reproductive health needs of migrants within and from Myanmar. These are:

- constraints placed on basic freedoms of information, expression and association.
- limited provision and access to contraceptives and reproductive health commodities and services.
- discrimination in the framing and delivery of reproductive health services

These three issues will be discussed in more detail in this section and provide the backdrop for the recommendations presented afterwards (section 2.7).

2.6.1. Constraints on Basic Freedoms

The denial of basic freedoms of information, expression and association (noted in section 2.3.2.) have impacted reproductive policies, health providers, researchers and clients, particularly women (noted in section 2.4.). Denial of these basic freedoms has also limited the discussions and ultimately the recognition of large numbers of migrant populations due to its political sensitivities. As a result, a wide range of reproductive health issues and the presence and special needs of migrant populations within and from Myanmar have not been acknowledged or addressed.

Health professionals in Myanmar have faced severe restrictions in addressing health issues, which for many have resulted in harassment, demotion or loss of job, arrest and even imprisonment (Smith, 1996). In addition, reproductive health issues have been known to be particularly sensitive, for example HIV/AIDS, abortion, adolescent sexuality and violence against women. As a result, national research and information on these issues have been carefully worded and published only with consent from the GOM.

Migration is also an extremely sensitive issue within Myanmar as well as in neighboring countries. This has resulted in limited access to migrant populations. In

Myanmar, the limited access together with constraints on basic freedoms of information, expression and association further restricts knowledge and recognition of migrant populations and their needs.

2.6.2. Limited Commodities and Services

Given the limited reproductive health care services available to those in Myanmar (as noted in section 2.4.1.), migrants are even less likely to be able to access these services. This is a result both of the discrimination found in service delivery (noted in section 2.4.3) and the undocumented status, limited resources, age, isolation and language differences among migrants (noted in section 2.3.1). For many migrants, particularly female, the issues surrounding violence and fear also impact their reproductive health and ability to access services.

The vast majority of migrants from Myanmar in neighboring countries have also been difficult to access. They are either kept in closed camps with strictly controlled access or living and working illegally in fear of arrest. As a result, contact with these populations is extremely limited and sensitive. For those living in camps all contacts require the approval of the authorities and any problems may likely result in additional restrictions or denial of access. Illegal migrants from Myanmar in neighboring countries are well aware of the risks of drawing attention to themselves that may lead to their arrest, detention and deportation, making it often difficult to contact them. These issues greatly restrict their ability to obtain reproductive health commodities and services.

2.6.3. Discrimination in Services

Finally, migrants are often from marginalized populations and in the context of Myanmar have a predominant profile of being poor, from ethnic minority populations, young and in many instances largely female (noted in section 2.3.1.). These are populations that have often already faced discrimination in the framing and delivery of reproductive health services in Myanmar (noted in section 2.4.) and will be likely to encounter further isolation and difficulties in meeting their needs. In addition, the obvious differences they face as outsiders in a new country potentially leads to discrimination in seeking reproductive health commodities, services or information.

These three areas identified here will provide the basis for considering recommendations for addressing the reproductive health needs of migrant populations within and from Myanmar.

2.7. Recommendations for Change

This essay will conclude with a recommended strategy focused on raising awareness of migrant populations of Myanmar and their reproductive health. The strategy presented here will focus on practical interventions that are possible given the many constraints faced in dealing with migrant populations and reproductive health issues in the Myanmar context.

Given the constraints of basic freedoms in Myanmar international and non-governmental organizations can play a critical role in moving discourse and encouraging responsiveness of governments. Farrington & Lewis (1993) emphasize the important position international and non-governmental organizations can have in addressing the needs of those under-represented. The GOM and those in neighboring countries have yet to consider migrant populations in their reproductive health research, policies and programs. In addition, the denial of basic freedoms restrains many nationals (primarily in Myanmar, but also in neighboring countries) from documenting, publishing and intervening on behalf of migrant populations and their reproductive health needs. Therefore, international and non-governmental organizations are often in a better position to take the lead in identifying migrant populations and their particular reproductive health needs, in the context of their lives and environment. This is seen as a critical first step.

The four recommendations below emphasize the role of international and non-governmental organizations and possible interventions they can take in raising the issues of surrounding migration and reproductive health and bringing them to the attention of the GOM and those in neighboring countries. The documentation and dissemination information on the reproductive health issues of migrants through research and outreach initiatives would provide a knowledge base with which to approach the GOM and those of neighboring countries. Given the many constraints in dealing with the GOM and working in the country, it may be easier to begin research and outreach in neighboring countries as these governments have been relatively more receptive in allowing access to migrant populations. The documentation and

information obtained can be used to raise and discuss the issues with the GOM and ultimately negotiating opportunities for research and outreach among migrant populations within the country. This would potentially provide more opportunities for information to encourage discourse and response from the GOM and other governments, international and non-governmental agencies to collaborate in their response to the reproductive health needs of migrant populations of Myanmar.

Based on the strategy outlined above, the following interventions are suggested:

- Identify migrant populations within and from Myanmar (in neighboring countries) and document their situation, and explore their reproductive health needs in the broader context of their lives together with community members and service providers. When direct research with migrant populations is not possible, aspects of migration could be included in other reproductive health research as a means of acknowledging the phenomena and exploring its impact.

- Disseminate information and encourage a discourse among other international and non-governmental organizations on the reproductive health realities, vulnerabilities and needs of migrant populations within and from Myanmar. This would help to build a broad-based awareness and expand opportunities for responding to their reproductive health issues.

- Undertake pilot interventions with migrants from Myanmar in neighboring countries as possible to address their reproductive health concerns and needs

through information and other outreach services. Conduct on-going documentation and evaluation of these initiatives to share with others (including international, non-governmental and government bodies as well as community members and service providers) offering insight on effective interventions in addressing the vulnerabilities and improving migrant's reproductive health.

- Build a consensus of information, interventions and issues among the international and non-governmental organizations to use in discussions with the GOM and the governments of its neighbors to encourage their response to the reproductive health realities, vulnerabilities and needs of migrants within and from Myanmar.

More information is needed to identify the magnitude and vulnerabilities of migrant populations within and from Myanmar in order to increase their visibility and acknowledge their particular needs. Reproductive health is one of the critical issues to be recognized and addressed among migrant populations, especially within and from Myanmar given the high rates of HIV/AIDS infection and violence against women already known among this population. The international and non-governmental organizations have a critical role to play in identifying migrant populations and their particular reproductive health needs, in the context of their lives and environment with the GOM and other governments involved. With the acknowledgement of the reproductive health vulnerabilities of migrant populations, governments can begin to incorporate their needs in future research, policies and programs. Ultimately, this will improve the reproductive health of migrants and the larger communities in which they live both within Myanmar and its neighboring countries.

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