ปัญหาหลักของการเลี้ยงดูเด็กในค่ายผู้อพยพบริเวณชายแดนไทย-พม่า

นายเมียว ซอ อู

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาศิลปศาสตรมหาบัณฑิต
สาขาวิชาเอเชียตะวันออกเฉียงใต้ศึกษา (สหสาขาวิชา)
บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2551

MAJOR DIFFICULTIES OF CHILD CARE PRACTICES IN REFUGEE CAMPS ON THAI-BURMA BORDER

Mr. Moe Zaw Oo

A Thesis Submitted in Partial Fulfillment of the Requirements
for the Degree of Master of Arts Program in Southeast Asian Studies
(Interdisciplinary Program)
Graduate School
Chulalongkorn University
Academic Year 2008

Thesis Title	MAJOR DIFFICULTIES OF CHILD CARE PRACTICES IN REFUGEE CAMPS ON THAI-BURMA BORDER
By	Mr. Moe Zaw Oo
Field of Study	Southeast Asian Studies
Thesis Principal Advisor	Assistant Professor Theera Nuchpiam, Ph.D.
Thesis Co-advisor	Miss Pornpimon Trichot

Accepted by the Graduate School, Chulalongkorn University in Partial Fulfillment of the Requirements for the Master's Degree

..... Dean of the Graduate School
(Associate Professor Pornpote Piumsomboon, Ph.D.)

THESIS COMMITTEE

..... Chairman
(Sunait Chutintaranond, Ph.D.)

..... Thesis Principal Advisor
(Assistant Professor Theera Nuchpiam, Ph.D.)

..... Thesis Co-advisor
(Miss Pornpimon Trichot)

..... External Member
(Assistant Professor Suvajee Good, Ph.D.)

เมียว ซอ อู: ปัญหาหลักของการเลี้ยงดูเด็กในค่ายผู้อพยพบริเวณชายแดนไทย-พม่า (MAJOR DIFFICULTIES OF CHILD CARE PRACTICES IN REFUGEE CAMPS ON THAI-BURMA BORDER) อ.ที่ปรึกษาหลัก: ผศ.ดร.ธีระ นุชเปี่ยม, อ.ที่ปรึกษาร่วม: พรพิมล ตรีโชติ, 115 หน้า.

งานวิจัยครั้งนี้มีวัตถุประสงค์เพื่อตรวจสอบ วิธีการดูแลบุตรของมารดาในค่ายผู้อพยพแม่ลาและการแยกแยะข้อจำกัดหลักต่างๆ ของมารดาในการดูแลบุตรในค่ายผู้อพยพ จากการศึกษารายละเอียดในค่ายผู้อพยพแม่ลา ผู้วิจัยพบว่าบรรดาคุณแม่ทั้งหลายมีปัญหายุ่งยากในการดูแลบุตรที่มีอายุต่ำกว่า 5 ปี เนื่องจากในค่ายผู้อพยพมีข้อจำกัดด้านทุนทรัพย์และสภาพแวดล้อม งานวิจัยนี้เน้นที่ค่ายผู้อพยพแม่ลาเขตบี ซึ่งมีทั้งหมด 3 เขต ตามแนวชายแดนไทย-พม่า มีค่ายผู้อพยพ 9 แห่ง การศึกษาเน้น เรื่องการอบรมให้มารดามีความรู้แบบสมัยใหม่ในการดูแลบุตร เรื่องพื้นฐานทางเศรษฐกิจและสังคมของเขา และเรื่องบริการต่างๆ สำหรับเด็กในค่ายผู้อพยพ

งานวิจัยครั้งนี้ เน้นวิธีการวิจัยเชิงคุณภาพ กับการใช้ข้อมูลปฐมภูมิและทุติยภูมิ ซึ่งข้อมูลทุติยภูมิได้จากแหล่งข้อมูลในอินเตอร์เน็ตเว็บไซด์ ตำรา และวารสารต่างๆ ซึ่งแม้ว่าจะมีข้อมูลจำกัด แต่เพื่อให้บรรลุวัตถุประสงค์ จึงมีการใช้เครื่องมือวิจัยอื่นเช่น ข้อมูลจากการสัมภาษณ์ การสังเกตุการณ์ (ไปที่ค่ายผู้อพยพ) และการสอบถามทั่วไป มาใช้ประกอบเพื่อให้เข้าใจข้อจำกัดหลักต่างๆ และปัญหาของมารดาในค่ายผู้อพยพ

งานวิจัยครั้งนี้ส่วนใหญ่ถกเถียงถึงข้อมูล ที่ว่ามารดามีปัญหายุ่งยากในการดูแลบุตรเพราะขาดความรู้ความเข้าใจ ขาดแคลนสิ่งของและทุนทรัพย์ที่ต้องสนองต่อความต้องการประจำวัน สภาพแวดล้อมที่ไม่ปลอดภัย และข้อจำกัดในการบริการ รวมถึงพื้นฐานสังคมและจิตใจของมารดา ได้เน้นเรื่องการดิ้นรนในแต่ละวันของมารดาเพื่อให้มีอาหารและของใช้จำเป็นซึ่งต้องไปรับจ้างทำงานด้วยค่าแรงต่ำทั้งในและนอกค่ายผู้อพยพ สำหรับมารดาที่มีสามีทำงานทั้งในและนอกค่ายผู้อพยพก็มีความกังวลว่าสามีจะทำอะไรที่ไม่ดี ผิดกฎหมาย ซึ่งมีผลต่อการเลี้ยงดูบุตรต่อไป

สาขาวิชา: เอเชียตะวันออกเฉียงใต้ศึกษา ลายมือชื่อนิสิต .....

ปีการศึกษา: 2551 ลายมือชื่อ อ.ที่ปรึกษาหลัก.....

ลายมือชื่อ อ.ที่ปรึกษาร่วม.....

508 75942 20: MAJOR: SOUTHEAST ASIAN STUDIES
KEY WORD: CHILD CARE PRACTICE / MAE LA REFUGEE CAMP / THAI-BURMA BORDER

MOE ZAW OO: MAJOR DIFFICULTIES OF CHILD CARE PRACTICES IN REFUGEE CAMPS ON THAI-BURMA BORDER. THESIS PRINCIPAL ADVISOR: ASST. PROF. THEERA NUCHPIAM, Ph.D., THESIS CO-ADVISOR: PORNPIMON TRICHOT, 115 pp.

This thesis examines how mothers take care of their children in the Mae La refugee camp and identifies major constraints faced by mothers in taking care of their children in the refugee camp. By examining this case study of Mae La camp, the researcher clarifies how difficult it is for mothers to take care of their under 5 year old children in the refugee camp given the limited resources and situation. The focal area of studies is in Zone B out of three Zones of the Mae La refugee camp which is one of the nine refugee camps located alongside the Thai-Burma border line. The study mainly focuses on current child care practices of mothers in the camp, their socio-economic background and available services for their children in the camp.

In this study, the major approach is qualitative research methodology with both primary and secondary data. Secondary data are retrieved from sources of internet websites, academic books, articles and paper, although there have been a scarcity of sources in this area. In order to meet the objectives, different tools such as key informant interviews, direct observation (home visits) and in-depth interview, are used in order to understand major constraints and difficulties facing mothers in the setting of refugee camp. This thesis mainly argues that mothers have difficulties to take care of their children due to lack of knowledge, insufficient supply and income to meet their daily needs, unsafe environment and limitation of available services for their children as well as mothers' psycho social background. It also emphasizes the daily struggles of mothers to supplement their insufficient food and other needs by working inside or outside the camp in low-paid jobs in risky situation. Mothers whose husbands are working outside or inside the camp also have worries about their husbands' social misconduct which affect way of raising their children.

Field of study: Southeast Asian Studies Student's Signature.....

Academic Year: 2008 Principal Advisor's signature.....

Co-advisor's signature. Pornpimon Trichot

ACKNOWLEDGEMENTS

First of all, I would like to express my gratitude to my Scholarship Institutes; Open Society Institute and Prospect Burma. Without their financial support, I would not be able to study in Thailand. And my thanks also go to my principal advisor, Assistant Professor Dr. Theera Nuchpiam and co-advisor, Miss Pornpimon Trichot for their help and support throughout my research and while writing the thesis.

My special gratitude also goes to Southeast Asian Studies Center and all of the staffs for their administrative as well as formal and non formal advices throughout the course. I also thank to fellow students with whom I have been experiencing my master student life both in the class and outside the class especially in the traveling classroom.

I also wish to thank all of my friends in Mae La refugee camp who provided me place to stay and arranged me interviews with key informants during my research. My gratitude is not spared to mothers and other key informants who allowed me to ask questions to extract necessary data and information for my thesis. Finally, special thanks to Ms. Hteik Tin Khine who helped me throughout the research by acting as my assistant while making interviews and during home visits. My last thanks go to my parents for their warm wish and support from far away place.

CONTENTS

LIST OF TABLES

Page

LIST OF FIGURES

Page

ABBREVIATIONS

ANC	Antenatal Clinic
AMI	Aide Medicale Internationale
ARC	American Refugee Committee
BMA	Burma Medical Association
BSPP	Burma Socialist Programme Party
CRC	United Nations Convention on the Rights of the Child (1989)
CEAB	Community Elder's Advisory Boards
CCSDPT	Committee for Coordination of Services to Displaced Persons in Thailand
CBO	Community based organization
COERR	Catholic Office for Emergency Relief and Refugees
CIDKP	Committee for Internally Displaced Karen People
DfID	United Kingdom Department for International Development
DKBA	Democratic Karen Buddhist Army; Karen armed group allied with the
SPDC	State Peace and Development Council
ECHO	European Commission Humanitarian Office
H/A	height-for-age
HI	Handicap International
ICRC	International Committee of the Red Cross
ICS-Asia	International Child Support
IDP	Internally Displaced Person
ILO	International Labour Organisation
KDHW	Karen Department of Health and Welfare
KNLA	Karen National Liberation Army
KNU	Karen National Union
KPF	Karen Peace Force; Karen armed group allied with the SPDC
KRC	Karen Refugee Committee
KTWG	Karen Teachers Working Group

KWO	Karen Women's Organisation
KYO	Karen Youth Organisation
LIB	Light Infantry Battalion of the SPDC Army
MOI	Royal Thai Government Ministry of Interior
MSF	Medicins Sans Frontiers
MUAC	Middle Upper Arm Circumference
NGO	Non-governmental Organization
PPAT	Planned Parenthood Association of Thailand
RTG	Royal Thai Government
SLORC	State Law and Order Restoration Council
SMRU	Profile of the Shoklo Malaria Research Unit
SPDC	State Peace and Development Council
SVA	Shanti Volunteer Association
TBBC	Thailand Burma Border Consortium
TPDC	Township Peace and Development Council
TBA	Traditional Birth Attendant
TOPS	Taipei Overseas Peace Service
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
UNHCR	United Nations High Commissioner for Refugees
USDA	Union Solidarity and Development Association
WEAVE	Women's Education for Advancement and Empowerment
W/H	weight-for-height
WHO	World Health Organisation of the United Nations
ZOA	Zuid Oost Azie Refugees Care of the Netherlands
kyat	Burmese currency; US $1 equals 5.8 kyat at official rate, approx. 1110 kyat at current market rate
baht	Thai currency; US $1 equals 31.5 baht at current market rate
viss	Unit of weight measure; one viss equals 1.6 kg / 3.6 lb

CHAPTER I

INTRODUCTION

1. Rationale

The Karen National Union (KNU) has been rebelling against the central government for 35 years and since the mid-1970s it has been increasingly pushed towards the Thai border. In 1984 the Burmese launched a major offensive, which broke up the Karen front lines opposite Tak Province, sending about 10,000 refugees into Thailand. Over the next ten years the Burmese Army launched annual dry season offensives, taking control of new areas, building supply routes and establishing new bases. As territory was lost, new refugees fled to Thailand, increasing the total number of refugees to about 80,000 by 1994.

In 1988 the people of Burma rose up against the military regime with millions taking part in mass demonstrations. The uprising was crushed by the army on 18 September with thousands killed on the streets. Around 10,000 ‘student’ activists fled to the Thailand/ Burma border. Over 30 small ‘student’ camps were established along the border. In January 1995, the Burmese Army attacked and overran Manerplaw, a major blow for both the KNU and all the democratic and ethnic alliances. In 1997, the Burmese Army launched a huge dry season offensive and in three years the Burmese army effectively overran the entire border. The ethnic nationalities no longer controlled any significant territory and the number of refugees had increased to around 115,000.

Once the Burmese Army began taking control of former ethnic territory, it launched a massive village relocation plan and at least 3,000 ethnic villages have been destroyed since 1996. This measure has affected over one million people. Probably more than 300,000 have fled to Thailand as refugees (the majority being Shan and not recognized by the Thai government). In 2006, it was conservatively estimated that there were still some 500,000 IDPs in the Eastern states and divisions of Burma bordering Thailand. Meanwhile the population in the border refugee camps has increased to around 156,000 in 2007.

1. 1. Situation of children in Burma

Children's environment and experiences, especially in the first years of their lives, have a profound impact on their overall growth, setting lifelong patterns for physical, cognitive, emotional and social development. These aspects are closely interrelated and during the first years of their life, children require protection, a nutritious diet and health care as well as affection, a sense of security, interaction with others, and psychosocial stimulation through exploration and play.

Myanmar, or Burma* as it was formerly known, is a state party to the Convention on the Rights of the Child (CRC). As such, it has committed to ensuring the right of all children to some extent, but much remains to be done for the children to fully enjoy their rights. Moreover, disparities remain pronounced with children in remote or inaccessible areas remaining disadvantaged across numerous social indicators, especially in the areas of ethnic minorities living on Thai-Burma border. Disparities exist between States (where ethnic minorities are living) and Division (where Burmans, who comprise the major ethnic community, are living); between townships within State/Division; and between villages within a township. Border States continue to be generally characterized by remoteness, isolation, a long history of civil and political instability and low socio-economic development.

Children of Burma continue to experience malnutrition, high morbidity and mortality, low-birth weight, wasting and stunting. Available data show that the problem of malnutrition is most serious in rural and remote areas like in Thai-Burma border. More than one in three children under the age of five is malnourished[1]. The under five-

* Since the 1989 the English name from "Burma" was decided to change to "Myanmar" by the then military junta. However, use of "Burma" has remained widespread, largely based on the question of whether the military regime, not democratically elected, has the legitimacy to change the country's name. Governments of many English speaking countries still refer to the country as "Burma". Others, including the Association of Southeast Asian Nations recognize "Myanmar" as the official name. The United Nations, of which Myanmar is a member, endorsed

mortality rate and the infant mortality rate remain high, the estimated numbers being 107 and 71 (per 1000 live births) respectively[2]. Child malnutrition is widespread in Burma, with over one-third of children under the age of five being severely or moderately malnourished (35%) and 24% of babies born with a low-birth weight[3]. Only 16% of children are exclusively breastfed for the first three months[4].

The high levels of poverty, which have been exacerbated by the current state of the economy, result in households having greater difficulty in meeting their most basic nutritional requirements. This is compounded by the fact that about 3.6 million children under 5 and 1.1 million pregnant women live in areas at a high or moderate risk of malaria transmission. In addition, there are nutritional and dietary practices that aggravate the impact of these trends. Children, even when there appears to be adequate food within the family, are not getting enough food.[5] Anemia remains a challenge, with the national prevalence of reproductive age reported at 45%.[*]

---

the name change five days after its announcement by the junta. The European Union uses "Burma/Myanmar". Media usage is also mixed. However, throughout this thesis, Burma will be used to refer the official name "Myarmar" taking the fact that the country's legitimacy to rename the country remain in the hand of democratically elected parliament.

[1] UNICEF. Multiple Indicator Cluster Survey, National Nutrition Planning Consultant Report. UNICEF Myanmar, 2002 : 38

[2] UNICEF. Fertility and Reproductive Health Survey. Yangon: Department of Health Planning, Ministry of Health, Myanmar, 2003.

[3] UNICEF. Multiple Indicator Cluster Survey, National Nutrition Planning Consultant Report. UNICEF Myanmar, 2002 : 42

[4] Ibid

[5] UNICEF. National Nutrition Planning, Consultant Report. Yangon: November, 2002

[*] Anemia among non-pregnant women of reproductive age ranges from 55.6% in the delta area to 31.3% in the hilly areas according to National Nutrition Centre, 2001.

In spite of its important and long-lasting effects, such aspects of early childhood development are not quite widely recognized in Burma and have only recently become part of basic education. Moreover a large number of families are not aware that the first years of the child's life have a deep impact on his/her development. Lack of time aggravated by poverty may well be a determinant factor: in 92% of all households, women are primary caretakers of children under 5; yet 48% of women of reproductive age are economically active.

As of 2002 there are estimated 6.1 million children in the 0-4 age group in Burma. The majority of 0-5 year olds have no access to adequate childcare services. Only 8% of those aged 3-5, mostly in urban areas, attend a form of pre-schooling. There are virtually no childcare facilities outside the family for the 0-3 year old group. A public day-care service exists for around 10% of children in the 3-5 age group.

1.2. Situation of children in Thailand

Now ranked 74th on the UN Development Programme's Human Development Index, Thailand has been firmly established as a middle-income country. However, huge disparities remain, and the benefits of economic progress have not been shared by all children in Thailand. This is particularly true for the children of ethnic minorities, migrants, refugees and the very poor. These children are still denied many of their basic rights to survival, protection and development.

In 1992, the government made itself accountable for progress towards achieving child rights by ratifying the United Nations Convention on the Rights of the Child. Since then, there have been major improvements for children. For example, the number of child deaths and the incidence of diseases that commonly affect children have fallen dramatically. Literacy rates have soared, far fewer children are malnourished and far more are in schools and not working.

Nonetheless, some of the problems such as malnutrition, exclusion from education, child trafficking and labor, and other forms of exploitation remain. New challenges for children and young people came together with development. These include

the spread of HIV/AIDS, the break up of traditional family systems and a rising toll of child deaths from road traffic and other accidents.

The trafficking of children continues both within Thailand and from Thailand to industrialized countries. In addition, trafficking networks have expanded to draw in children from more isolated communities in nearby countries for exploitation here and abroad. There are also signs that more children in Thailand who are not in desperate poverty become involved in commercial sexual exploitation in response to growing materialism. In some border areas, children are still at risk of being killed by landmines or being recruited as soldiers.

Although national HIV infection rates plummeted during the 1990s, it is estimated that some 290,000 children have been orphaned by the AIDS epidemic, placing a considerable burden on grandparents and other caregivers, who are not always able to provide the financial and emotional support the children need. Some 2,000 children are estimated to be born HIV-positive each year. These children and other infected young people require anti-retroviral medicines.

Access to education is still a concern. An estimated 1 million primary-school aged children are either not in school or are not enrolled in school at the right age, and even more children are missing out on a secondary school education. These concerns are particularly acute for the children of minority groups, who live in the remotest and most deprived areas, and who may require bilingual education that would enable them to benefit fully from schooling.

An estimated 1 million children have no birth registration documents, without which it is much harder for them to claim their rights to education, healthcare and legal protection from abuse. Again, it is the children of minorities, migrants and refugees that are most affected.

In 2004, Thailand reported a progress towards the Millennium Development Goals, many of which include targets relevant to children. This report noted that more must be done at the sub-national level if rights are to be safeguarded for all children,

including the children of marginalized, isolated and minority groups. Reaching these groups is a serious challenge; but it is a challenge that the government committed itself to meeting when it ratified the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women.

Concerning the early childhood care and development, there are public and private childcare services available for mostly for employed parents, although most of the under-three children are cared by their parents and relatives. Various childcare providers operate the services; these include the Ministry of Social Development and Human Security, the Ministry of Public Health, the Ministry of Labor, the Ministry of Defense and certain private-sector organizations and foundations. The National Institute for Child and Family Development (Ministry of Education) also operates a day-care service for research and development.

There are three categories of child care and development services for 3-5 age group: (1) kindergarten (2 and 3 years); (2) preschool classes (in normal primary schools, just one year prior to Grade 1); and child development center (receiving children aged 2-5 years). The kindergarten and pre-school children classes are mostly organized by the Ministry of Education, as well as some public and private sectors/foundations. The majority of child development centers are organized by SAOs (Sub-district Administration Organization) throughout the country.

Formerly most of these child development centers were under the supervision of the Community Development Department, then under Ministry of Social Development and Human Security, and some of them were affiliated with other ministries. Since 1999, when the Decentralization Act was promulgated, they were placed under the formal responsibility of elected local administration organizations in all sub-districts throughout Thailand. And now the Department of Local Administration of the Ministry of Interior is assigned to supervise these 19,000 child development centers.[6]

[6] UNESCO. Strong Foundations: Early Childhood Care and Education. Place de Fontenoy: the United Nations Educational, Scientific and Cultural Organization, 2006. 11-17.

1.3. Children in Refugee Camps

Refugee communities face huge constraints on their efforts to meet the needs of very young children due to the lack of overall awareness of early childhood issues. In refugee situations, very young children are particularly vulnerable. They are often more exposed to health and safety risks, and are prone to being abandoned by their families who may not be able to cope with their demands as normal societal support structures become eroded.

According to the Article 22 of the Convention of the Rights of the children:

> States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

But in reality, children in the refugee camps have not received appropriate protection and humanitarian assistance as compared to the adults in the camps. It is true especially for the 8-year old and lower age group – one also known as early childhood. Although there have been a lot of studies on other aspects of refugee camps, including the political, cultural and psychological effects of being refugees especially in adulthood, studies on child care practices of the parents in the refugees camps remain scarce. It is a subject that needs to be more fully understood through systematic research, so that the most vulnerable age group of the whole population in the camps will have more attention and more humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention of the Rights of the Child.

2. Objectives

1) To investigate how mothers take care of their children in the refugee camp.

2) To identify major constraints faced by mothers in taking care of their children in the refugee camp.

3. Major argument/ hypothesis

With the constraints and difficulties faced by the mothers, children in the refugee camp are not properly taken care of.

4. Scope of Study

4.1. Geographic scope

Mae La refugee camp is one of the nine refugee camps located alongside the Thai-Burma border line. The site of the research is Zone B out of three Zones namely Zone A, Zone B and Zone C. Although Mae La is easily accessible as it is not far away from the town, Mae Sot, its geographic areas is so broad that the study could not cover all the areas of the camp.

4.2. Content scope

Content of this study is mainly focused on the difficulties and constraints of mothers in taking care of their children. Difficulties of mothers are studied through different areas such as child care practices, daily routine of mothers, socio-economic background of mothers and available services for mothers which support their children's well being. As the study is implied to mothers' constraints regarding caring their children, mothers are main scope and content of the study.

4.3. Age Group for research

0 to 5 (From birth to 5 year old)

4.4. Time scope

The documentary research of the refugee camp and children started from the individual studies in the second semester of this course. However, data collection and field research started in July through August, 2008.

5. Conceptual Framework

5.1. Concept of refugees in Thailand

In the paragraph (2) of the article (1) of the 1951 convention relating to the status of refugee, it describe as bellows;

> "A refugee is any person who, as a result of events occurring before 1 January 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality or political opinion, is outside the country of his nationality and is unable or, owing to such fear or for reasons other than personal convenience, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear or for reasons other than personal convenience, is unwilling to return to it".

Further, the 1951 Convention and 1967 Protocol relating to the Status of Refugees state that a refugee is any person who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it.

The refugee definition is important because of the universal nature of the Statue which applies in all Member States of the United Nations, including those which are not party to any of the international refugee instruments. In reality, people do not abandon their homes and flee from their places of origin unless they have encountered serious threats to their life, liberty and/or security. Flight from one’s home country to another is often the ultimate means of survival, essentially employed when all other coping mechanisms have been exhausted.

Various forms of human insecurity have forced many refugees out of their countries of origin to seek asylum elsewhere including Thailand. The arrival in the country of tens of thousands of refugees from neighboring countries Burma as early as

1984 is arguably indicative of insecurity in the places origin. For some 140,000 refugees from Burma, this has meant being enclosed in the nine camps for over 20 years without the opportunity to work legally and realize their full human potential. There are similarly asylum-seekers and refugees from countries in Asia and Africa. Their overall situation is far from secure as they continue to contend with risks of arrest for illegal entry or stay and all its logical implications in the absence of a proper asylum system.

In the context of Thailand, on 10 December 1948, the State joined the other 47 Members of the United Nations in voting to adopt the draft Universal Declaration of Human rights. Since 1948, Thailand has become a State party to five out of nine core international human rights instruments. These are the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Elimination of All Forms of Racial Discrimination (CERD). Most recently, Thailand signed the Convention on the Rights of Persons with Disabilities and reportedly, the Cabinet has approved the State's accession to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Further, Thailand is a State-party to the Optional Protocol to CEDAW, by which it has accepted the CEDAW Committee's competence to receive and consider individual complaints regarding alleged violations under this treaty. Thailand also became a State party to the two Optional Protocols to the CRC, namely, that on the sale of children, child prostitution and child pornography and the other on the involvement of children in armed conflict.

As a State party to the aforementioned international human rights instruments and/or treaties and on the occasion of Thailand's submission of candidacy to the Human Rights Council in 2006, the Permanent Representative of Thailand to the United Nations has pledged Thailand's firm commitment to respect human dignity, justice, compassion,

non-discrimination and a sense of mutual obligations to fellow human beings, which together constitute core human rights principles.*

In Thailand, the Human Rights Committee, which is a treaty body in regard to the International Covenant of Civil and Political Rights (ICCPR), expressed its concerns on the treatment of refugees and asylum seekers in Thailand. ** Although Thailand is not a State party to the 1951 Convention of the Status of Refugees, the Committee was concerned that the State lacked a systematic adjudication procedure for asylum-seekers. The Committee also expressed concern about the plan to relocate all refugees from Burma to the camps along the border and that those who failed to comply would be considered illegal migrants and subject to forcible deportation to Burma. The Committee was particularly concerned on the situation of Hmong refugees in Petchabun province, majority of whom are women and children, as well as the risk of deportation to a country where they fear persecution. The Committee noted that the current screening and expulsion procedures contain no provisions guaranteeing respect for the rights protected by the ICCPR.

Similar concern was raised by the Committee on the Elimination of Discrimination against Women at its concluding comments in relation to Thailand's fourth and fifth periodic CEDAW reports.*** Of some 140,000 refugees in Thailand, the Committee was concerned that refugee women do not have legal status in the country. This has made them even more vulnerable to various forms of abuses and exploitation and has caused them greater insecurity.

In the case of refugee children, the Committee on the Rights of the Child, which is the treaty-body in regard to the Convention on the Rights of the Child (CRC),

---

* Letter from the Permanent Mission of Thailand to the United Nations to the Secretary-General of the United Nations, ref. no. 56101/643, 24 April, 2006.

**The Human Rights Committee Thailand submitted the report "Consideration of Reports Submitted by States Parties" under Article 40 of the Covenant, Concluding observations of the Human Rights Committee: Thailand, ref. CCPR/CO/84/THA, distributed on 8 July, 2005.

*** Please see for more details at the Committee on the Elimination of Discrimination against Women, thirty-fourth session, ref. CEDAW/C/THA/CO/5, distributed on 3 February, 2006.

expressed its concerns regarding birth registration and nationality as well as the rights to non-discrimination and the best interests of the child.

From the early days of an emergency or influx, when refuges flee from their country of origin to the country of asylum, UNHCR in cooperation with the host State, monitors borders to ensure that they remain open to refugees who cross and that they are not forced to return to the country where they would face persecution. Basic assistance such food, medical assistance and shelter will be provided. Registration is conducted and basic documentation is issued to refugees.

When refugees have already settled in the camps or settlements, UNHCR in cooperation with the host State, international humanitarian organizations and non-governmental organizations provides services in such areas as education, vocational training, family tracing, legal and psycho-social counseling and others. The presence of combatants or former combatants among in the camps is seen as possibly detrimental and affects the humanitarian and non-political character of asylum. Security threats could take many forms, ranging from sexual violence against women to armed conflict and active combat. Military recruitment of refugees, in camps or otherwise, especially of children would be unacceptable and have serious implications on refugee status.

UNHCR found some durable solutions for refugees, namely, voluntary repatriation, local integration and resettlement to third countries. Voluntary repatriation and reintegration of people into their home communities would be the preferred and best combination. As it is generally known, overall conditions in Burma as a country of origin to refugees in Thailand reportedly continue not to be conducive for repatriation at this stage. Fighting between the Government army and armed opposition groups are reportedly going on in some parts of the country, possibly in places where refugees fled from. In short, voluntary repatriation of refugees from Burma is not a reasonably viable solution at this point. However, this does not necessarily mean that repatriation would not happen at a later stage. Local integration is not officially available to refugees in Thailand.

Therefore, the third durable solution becomes refugee resettlement to a third country. To address the protracted refugee camp situation in Thailand, UNHCR has facilitated the commencement of a multilateral refugee resettlement programme involving the participation of some 11 resettlement countries and has currently become the largest resettlement operation in the world. The Royal Thai Government (RTG) issued relevant authorization for resettlement from the camps in 2005 and resettlement has continued vigorously to date.

Indeed, collaboration between the RTG, resettlement countries and the diplomatic community, civil society as well as international organizations and the international community at large, does create some concrete opportunities in addressing insecurity of refugees in Thailand and other countries of asylum. It is notable that resettlement from Thailand to third countries is at its largest numbers since the conclusion of Comprehensive Plan of Action for Indo-Chinese refugees in the mid 1990s. Thousands of refugees have left the country since 2005 to start new lives in countries such as the United States of America, Canada, Australia, New Zealand and those in Europe.

The living conditions in the camps in the mean time are becoming increasingly intolerable. Refugees are not formally allowed to leave the camps and/or work to earn livelihood. Social and economic problems have forced some refugees to risk their lives and security to seek other opportunities elsewhere. Trafficking from the camps, a concern reportedly prevalent in the host country cannot be entirely precluded. There are naturally other concerns arising from the camp situation. These require concrete remedial measures and reasonable solutions that would alleviate the conditions, protection and well being of refugees who are first and foremost, human beings. One longstanding proposal from UNHCR has been to allow refugees to work outside the camps, with fair and just regulations, pending the achievement of durable solutions for all. Legal employment for refugees would offer mutual social and economic benefits to the host country and refugees alike and could only reinforce the broader human security concern. Nevertheless, refugees continue to live in Thailand, a country which is historically and

traditionally known to be humanitarian and generous. The general situation of every male, female, child refugee therein can only be reasonably assured through collective, concerted and comprehensive efforts.

5.2. Concept of child care study

The study of children has occurred in one form or another for thousands of years. Philosophers, religious scholars, and early educators have all offered explanations of child behavior based on informal observations and recordings. It is only in the past century, however, that a truly systematic approach has been attempted. Only with the emergence of psychology as a separate scientific discipline in the late nineteenth century did the study of children begin to acquire an objective, orderly character.

In addition to observing particular theories, it is useful to recognize trends in develop mentalists' general interests from one period to another. For example, the collection and description of empirical evidence about how children grow was of primary concern in the 1920s. Subsequently, debates over nature-nurture issues highlighted the 1930s, and an expanded diversity of ways to explain the process of development became a hallmark of the 1980s and 1990s. Recent times have witnessed far greater attention to (1) how physical and social contexts affect development, (2) how the structures and operations of the mind influence the way encounters with environments influence development, and (3) how children's genetic endowment provides a maturational foundation for development.

> In the past 25-30 years, the degree of specialization has increased sharply; in place of grand theories, a variety of mini-theories aimed and specific aspects of development have emerged. However, there is evidence of an attempt to link together these minitheories. The idea of general processes as explanations of development has been given up because we have learned that they are not so

general; instead, it is increasingly evident that they depend on the specifics of the situation.[7]

Trends have also been identified among methods of investigation. In the early twentieth century, the dominant approach was cross-sectional-studying children of different age levels and, on the basis of such evidence, drawing, conclusions about how children change from on age period to another. Then in the 1920s and 1930s important longitudinal programs were launched, with investigators following the same children year after year to chart their progress in intelligence at many universities in America. But by the 1960s cross-sectional approaches became paramount and longitudinal studies increased, aimed at discovering more about the nature of the developmental stability and change over time (Parke et al., 1994, p. 36). Furthermore, a marked expansion in the incidence of cross-cultural studies over recent decades has been accompanied by the revision of theories to accommodate for the cross-cultural findings (Garcia Coll et al., 1996). [8]

The study of children has occurred in one form or another for thousands of years. Philosophers, religious scholars, and early educators have all offered explanations of child behavior based on informal observations and recordings. It is only in the past century, however, that a truly systematic approach to this effort has been attempted. Only with the emergence of psychology as a separate scientific discipline in the late nineteenth century did the study of children begin to acquire an objective, orderly character.

---

[7] Parke, R. D., Ornstein, P. A., Rieser, J. J., & Zahn-Waxler, C. The past as prologue: An overview of a century of developmental psychology. In R. D Parke, P. A. Ornstein, J. J. Rieser, & C. Zahn-Waxler (Eds.), A century of developmental psychology. Washington, DC: American Psychological Association, 1994.

[8] Garcia Coll, C., Lamberty, G., Jenkins, R., McAdoo, H. P., Crnic, K., Wasik, B. H., & Garcia, H. V. (1996). An integrative model for the study of developmental competencies in minority children. Child Development, 1891-1914.

6. Key Words and Terminology Definition

6.1. Refugee

According to UNHCR's Statute, a refugee is any person who, as a result of events occurring before 1 January 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality or political opinion, is outside the country of his nationality and is unable or, owing to such fear or for reasons other than personal convenience, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear or for reasons other than personal convenience, is unwilling to return to it.

Further, the 1951 Convention and 1967 Protocol relating to the Status of Refugees state that a refugee is any person who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it.

6.2. Refugee Camps in Thailand

Defining refugees in Thailand is a delicate matter. The Royal Thai Government (RTG) is not a signatory to the 1951 Convention on Refugees and its companion 1967 Protocol, and under national law asylum seekers in Thailand are technically 'illegal immigrants'. Also, in strictly formal terms, the concept of 'refugee' does not exist, and so does the legal refugee protection. Since the late 1990s, the official speeches of Thai policy has been expressed in terms of "displaced people fleeing fighting" (rather than 'refugees'), "temporary shelters" (rather than 'refugee camps'), and their official status as illegal entrants under Thai law.

In this respect, the Thai authorities fear an influx of refugees into the camps from inside Myanmar as well as from unofficial refugees and migrant workers communities. In addition, the authorities are wary of growing links between refugees and the Thai

economy, both official (the growing migrant worker community) and illegal (the drug trade). As the Thai government seeks to expel all undocumented migrants with little distinction between refugees and migrants,[9] a close examination reveals that the definitions employed to classify the people from Burma in Thailand are not clear-cut, but in fact, often blur one into the other. Indeed, there is an arbitrary line between the groups that have been designated 'temporarily displaced', 'students and political dissidents' and 'migrants'. Throughout this thesis, the term refugee camp is used to express the genuine status of the people in the camps despite the words of RTG's terms such as "displaced people fleeing fighting" (rather than 'refugees'), "temporary shelters" (rather than 'refugee camps').

6.4. Early Childhood Care for Development: A Definition[10]

Early Childhood

As it is currently used internationally, early childhood is defined as the period of a child's life from conception to age eight. There are two reasons for including this age range within a definition of ECCD. First, this time frame is consistent with developmental psychology's view of the continuum of children's development. Children below the age of eight learn best when they have objects they can manipulate; when they have chances to explore the world around them; when they can experiment and learn from trial-and-error within a safe and stimulating environment. At about the age of nine they begin to view the world differently. They can manipulate ideas and learn concepts mentally and are less dependent on objects. Thus in terms of learning theory, the birth through age eight time period presents a developmental continuum.

Care

In the 1980s, the term care was added to the phrase early childhood development. This was in recognition of the fact that young children need care and nurturing. They need attention to their health and nutrition, their evolving emotional and social abilities, as

[9] Lay T., Where You're Not Welcome. Burma Issues. Vol. 13(1) (January, 2003) : 33

[10] UNICEF. Facts on children. Retrieved from the UNICEF website; http://www.unicef.org/earlychildhood/index.html (24 December, 2007)

well as their minds. The term care was chosen, rather than education, to move policy makers and program providers away from thinking exclusively in terms of pre-schooling.

7. Methodology

In this study, the major approach is qualitative research methodology with both primary and secondary data. Secondary data are also important sources although there have been a scarcity of sources in this area. In order to meet the objectives, different tools will be used to understand major constraints and difficulties facing mothers in the setting of refugee camp. The study of difficulties and constraints facing mothers to take care of their children is mainly focused on child care practices, socio-economic background, available services and supply materials for children.

7.1. Research Site and criteria for choosing research site

Mae La refugee camp which is one of the nine refugee camps located alongside the Thai-Burma border line. Zone B was chosen as the sit of research because Zone B is situated the middle of the camp from where characteristics of the camp such as schools, hospital, NGOs, markets, and other public places are easily accessible and Karen nationalities who are focused population of the research are particularly living in Zone B. There are approximately 2,219 children under 5 years old among total population of 16,910. (See the table 1).

Table 1. Population in the camp

Camp	No. of families	Over 12 years		6 - 12 years		Under 5 years		Total
		M	F	M	F	M	F	
Mae La	8,781	13,302	13,204	4526	4201	3438	3271	41,942
Zone B	2,893	4,426	4,318	1,612	1,442	1,151	1,068	16,910

Source: KRC monthly report, June, 2008

7.2. The tools and techniques for the study

7.2.1. Key Informant Interviews

Key informants for the research are from hospitals, NGOs, nursery schools, administrative units and elder people who have a wealth of good knowledge and experience not only about the child but also about the general background of the camp. 10 key informants were interviewed for the research. Necessary information, data and documents were extracted from key informants, which could be used for further investigation of my study.

7.2.2. Direct observation (Home Visit)

Some care giving practices were studied through direct observation by visiting mothers' homes when certain activities were taken places. Semi-structured interviews were made during these visits. Hygiene practices, feeding and indoor playing were observed through home visits. Homes were visited randomly and altogether 25 home were visited based on the following criteria;

a. Home of mothers who have children under 5 year- old children

b. Home of mothers who have lived in the camp for at least 3 consecutive years.

c. Home of mothers who are Karen nationality regardless of their religion.

7.2.3. In-depth Interviews

In-depth Interviews were conducted mainly with mothers who are primary caregivers. The researcher asked a set of carefully chosen key issues and problems that were extracted from the key informants. There are 5 quarters in Zone B; one, two, three, four and five. 3 mothers from each quarter of Zone B were randomly chosen for in-depth interviews. Mothers were encouraged to voice not only their daily routine of child cares but also their ideas and opinions regarding problems and issues they are facing.

With criteria described below, mothers are chosen to make in depth interviews in zone B of the camp;

a) Mothers who have children under 5 years old.

b) Mothers who are widow or separated with their husbands

c) Mothers whose husbands are working (outside the camp or inside the camp)
d) Mothers who are working (outside or inside the camp)
e) Mothers who are not working but taking care of their children at home.
f) Lactating mothers who have one year old or younger children
g) Mothers who have 3 to 5 year old children who are sent to nursery schools.
h) Mothers who children are not sent to the nursery schools.
i) Mothers who have at least primary level education
j) Mothers who are illiterate or just know how to read and write

7.3. Limitations of the research

- Most of mothers in the camp are working so have to wait for their available time.
- Research site covered only one third of the whole camp.
- Some NGOs are not willing to provide their data and information due to their own regulations and worry about unnecessary consequences
- Time for research was limited due to allowance and security of the camp
- Most of Karen mothers cannot speak nor understand Burmese language so that have to be communicated through interpreter.

8. Significance of study

Systematic study about difficulties of mothers in taking care of their children in the refugee camp especially in Thai Burma border is still a scarce literature. This study provides some systematic information about the practices of child care given by mothers in the refugee camps. This kind of information will contribute to the organizations which are planning to provide humanitarian assistance to refugee camps, especially for organizations that want to make programs with community based child care activities or parenting education program in order to provide necessary knowledge and information. Awareness of the situations of the children in the refugee camps will entice more assistance for the children.

CHAPTER II

LITERATURE REVIEW AND HISTORICAL BACKGROUND

1. Literature Review

1.1. Early Childhood Care for Development

Research results indicate that "most rapid mental growth occurs during infancy and early childhood and that a child's early years are critical for forming and developing intelligence, personality and social behavior"[1]

UNESCO (1995)[2] defined Child Development as "...a process of change in which the child learns to handle more complex levels of moving, thinking, feeling and interacting with people and objects in the environment." Holt (1993)[3] added that "The term applies to a global impression of the child and encompasses growth, increase in understanding, acquisition of new skills and more sophisticated response and behavior".

Child development has been defined by many scholars from different discipline. The literature for early childhood can be observed well in UNICEF's paper and documentation. In the Facts on children of UNICEF[4], it explains the definition of early childhood care for development as follows;

> '*Children do not just grow in size. They develop, evolve, and mature, mastering ever more complex understandings of the people, objects and challenges in their environment. There is a general pattern or sequence for development that is true of most children. However, the rate, character, and quality of development vary from child to child. Culture influences development in different ways, and the goals for children differ from culture to culture.*

---

[1] Young, M. Early childhood development. Netherlands: Elsevier science B.V., 1997.

[2] UNESCO. Enhancing the skills of early childhood trainers. Bernard Van Leer Foundation, France, 1998.

[3] Holt, K.S. Child development: Diagnosis and assessment. London: Butterworth-Heinemann Ltd, 1993.

[4] Facts on Children. UNICEF. Retrieved from the website: http://www.unicef.org/earlychildhood/index.html (24 December, 2007)

Early Childhood Care for Development (ECCD) refers not only to what is happening within the child, but also to the care that child requires in order to thrive. For a child to develop and learn in a healthy and normal way, it is important not only to meet the basic needs for protection, food and health care, but also to meet the basic needs for interaction and stimulation, affection, security, and learning through exploration and discovery.'

1. 2. Growth and Development

1. 2.1. Milestones

Just as a journey on a road is marked at regular intervals by milestones, so is the child's progress on the path of development marked by certain indicators. These are sometimes called developmental 'milestones'. These milestones indicate broadly the age at which children can be expected to do certain things. For example, we have an idea at what age most children will hold the head erect, roll over, sit without support, smile and respond, babble, crawl, get the first teeth, grasp objects, walk, name objects,, utter two-word sentences, climb steps, and so on. But there are no hard and fast rules. Normal children vary enormously in their rate and style of development. In a group of children, some may walk at eight months, others at 18 months - yet all may be considered normal. The same goes for speech and other developmental learning.

The range of variability in human children is very great. So the milestones should be seen as guideposts for the stages through which every normal child passes. Each child may pass the milestone in her own way and at her own pace. Sometimes, a stage may be compressed or skipped and another one stretched out. All of these are acceptable. Each child's individuality must be respected, for all children are different. But if milestones are unduly delayed, it is a signal that the child should be medically examined for any defect, illness or retardation. For example, a child usually begins to smile and coo between two and three months, though some may do so earlier and some later. But if the child does not respond to human voices and faces till she is four months old, then she should be tested for defects in vision or hearing. For every 'milestone', there is a normal range which

experienced people and specialists can indicate. Only delay beyond this range should cause concern.

1. 2.2. Motor and Mental Development

In the first two years of life, often called the sensory motor stage, the child learns through the senses and motor activity. What does this mean? The five senses are usually taken to mean sight, hearing, touch, taste, and smell. For the young child, touch covers several aspects. It means feeling, not merely with the hands, but also with the skin surface on the whole body, with the mouth, and with all the limbs. Young children like to put things in their mouths at a certain stage. This is part of the process of exploring the world through the body.

Another important sense, sometimes called the sixth or the kinesthetic sense, is concerned with bodily movement. This is of two types: **sensation,** which the child experiences when rocking, swinging, being lifted and carried, rolled, etc. and **movement,** which she initiates herself, such as kicking, bouncing, and moving the limbs at first, and later creeping, crawling, standing, walking and running. In these ways, the child explores the world and acquires experiences; from these experiences grow concepts, language and the sense of self.

1. 2.3 Personal and Social Development

The human infant is born with the innate ability to interact with others. Through this process, which begins soon after birth, the child's personality develops. Social and personal development goes together. By interacting with the environment in general, and with other people in particular, the child becomes aware of herself as a person, and also learns to adjust herself to others and become an accepted member of a social group.

Soon after birth, the baby tries to attract attention to her needs by her cries. She cries out when she is hungry, in pain or in distress, and responds when she is comforted, held or fed. From the sensations associated with being held, picked up, soothed, rocked, cuddled, etc. the baby gets not only a sense of security but her first physical sense of

herself. She also uses several means to express herself - at first through mere aimless movement of limbs, which later develops into eye contact, gestures, grasping, reaching and smiling.

Initially the child responds to the environment in a general way. She asks for satisfaction of her own needs, and responds to stimuli. Around the age of six weeks, she is able to differentiate her mother (or main caregiver) from others, and responds to her by smiling, cooing and initiating physical play. Usually the mother responds, and this strengthens the child's ability to interact and builds her sense of self.

Up to about six months, the child though attached to the mother or principal caregiver can still accept another caregiver who provides the same kind of stimulation and security through loving care. But by six or seven months, special attachment develops to the mother. The child will now show signs of distress when separated from her. A little later, at about eight months, appears the response known as 'stranger anxiety', the fear or avoidance of unfamiliar people.

1. 2.4. Language Development

All of us know that a young child learns language fast. It is so common that we may not think much about it. Yet this is one of the most amazing examples of the speed and complexity of development. At birth, the infant communicates only through cries; in three years the child has learnt the basics of her first language, and can use it for several purposes. This happens to all children reared in all cultures; perhaps it is a natural process.

At about one year of age, most children speak their first words. This is also the time at which most children learn to walk. Talking and walking are the most significant achievements of the first year. In the second year, the child begins to join words and communicate in longer utterances. In the third year, the child's vocabulary and grammar grow by leaps and bounds, and at the end of this period she can skillfully perform the basic functions of language.

1. 3. The child in the family

Most children are reared in homes as part of a family, which provides, sometimes well and sometimes badly, for all the child's basic needs. It also socializes her and helps her to grow and develop into a mature adult. The family exists in all cultures and social groups, but varies widely in its structure. One kind is the nuclear family, which consists of husband and wife, and their children. A child born into such a family is reared by both parents, mainly the mother. Older children may help, if the child is not the eldest. But far more prevalent, almost universal, is the extended family, which includes many people of varying ages, and three or more generations.

In some societies, the young couple lives with the husband's family, and in others with the wife's family. The family then includes the child's grandparents as well as uncles and aunts. A really large extended family may include several kinds of relatives. Other children in the family may include the child's own siblings as well as cousins. In most of Asia and Africa, especially in rural areas, some form of the extended family is to be found. In crowded urban areas a child may be reared in a small home by her father and mother, or by the mother alone.

Exploration, which forms the basis of learning, is through the five senses. The child, like a scientist, is constantly manipulating, experimenting, trying out, exploring, hypothesizing, problem-solving, discovering and learning about her surroundings and the people in it. This need, though present right from birth, becomes most strongly expressed in the second year of life.

It is grounded in the need for security. Research on children's behavior has shown that a secure child tends to be more active, fearless, confident, interested, curious and exploratory; while an insecure child tends to be fearful, dependent and tends to cling to the mother or care-giver. So the two needs are intimately linked, the one resting on the other.

The concept of the family may vary in different cultures, but they are all variations on a theme. Common to all families is the mother-child unit. This central relationship is the most important one for the young child, though it may be found in diverse contexts.

The family has certain basic characteristics which promotes the child's growth and development and meets her basic needs. Of course, families differ widely, and all of them may not have all these qualities in the same degree.

Some families may offer more and some less, and few could be called ideal. But these qualities, which are inherent in the family have little to do with economic status. A family which is very poor in the economic sense may have much to offer in other respects. The larger, extended family may offer more of these qualities than the small nuclear family. But in some way or the other, the following would be found in all families.

The family offers all these characteristics which promote growth and development. These characteristics are not often found in institutions like schools or pre-schools which cater specifically to children. For example, in a school or pre-school, there are usually a large number of children of one age, who rarely mingle with children of other ages. One adult, who may often deal with them as a group rather than as varied and different individuals, is in charge of the group. This may not matter so much in a primary or secondary school, but with children below the age of three such an atmosphere will not foster development.

1. 4. Child rearing

Every society has different child rearing practices. These practices depend on cultures, beliefs, and socio-economic as well as environmental factors. These different

factors influence child development as societies at the same time have different perceptions and expectations on child development. Dr Chancha said[5];

> *In the past, Asian children were mainly perceived as of family value to parents. Often this was on times of economic value. At present, children are viewed as of human value. That means they have been more valued in a qualitative sense. One change resulting from this view point is that parent-child relationships are changing from pattern of respect to a pattern of more companionship. One way pattern of the child showing respect to a child is being overthrown by a two way respect pattern. Hence in socialization the child, parents seem to be more ready to accept their child's viewpoints, ideas and reasonings.*

As far back as 1953, Whiting and Child[6] found that parents living in different cultures "adopt some similar, as well as some different, approaches to childrearing, and that parenting is a principal reason why individuals in different cultures are who they are, and are often so different from one another"[7]. Marc Bornstein introduces an entire textbook on the impact of culture on parenting methods. He argues that "cultural variations in the various domains of childrearing exert significant and differential influences over mental, emotional, and social development of children, just as variation clearly dictates the language children eventually speak"[8] .

Further, Whiting and Whiting (1960) argue that the study of parenting practices in a single culture do not yield as much information as a multi-cultural outlook. They write:

---

[5] Suvannathat, C., Bhanthumnavin, D, Bhuapirom, L., Keats, D. M (Eds). Handbook of Asian Child Development and Child Rearing Practices. Bangkok: Behavioral Research Institute, 1985.

[6] Whiting, J. W. M. and Child, I. L. Child Training and Personality: A H. (Ed.) Cultural Approaches to Parenting. Hilldale, New Jersey: Lawrence Erlbaum Associates, 1953.

[7] Bornstein, M. H. Approaches to parenting in culture. Indo-Canadian Families: Historical constraints and contemporary contradictions. Journal of Comparative Family Studies, Cross-Cultural Study. New Haven: Yale University Press, 1993.

[8] Ibid

> *If children are studied within the confines of a single culture, many events are taken as natural, obvious, or a part of human nature and are therefore not reported and not considered as variables. It is only when it is discovered that other peoples do not follow these practices that have been attributed to human nature that they are adopted as legitimate variables.*[9]

The cultural context is central in parenting styles, parent-parent and parent-child interactions.[10]. These interactions reflect cultural expectations. According to Swick, "parenting is carried on amidst many cultural signals, not all of which are consistent with each other or necessarily 'good' for children. Parenting context often dictates how these style issues are dealt with in the life span".

Foss (1996)[11] calls cultural beliefs and values "internalized script." She states that "when individuals and families move to a new country and culture, they take this internalized script". According to Foss, it is used in its original entirety or in an integrated form that reflects assimilation of some of the new culture in the child-rearing practices of women.

1. 5. Refugee Children

International treaties are important to refugee children because they set standards. When a state ratifies a treaty, the government of the state promises to the international community that it will conduct itself according to the standards in the treaty.

---

[9] Whiting, J. W. M. and Whiting, B.B. Contributions of Anthropology to the methods of studying child rearing. In Mussen, P.H. (Ed.) Handbook of Research Methods in Child Development. New York: Wiley, 1960.

[10] Swick, K. J. Cultural influences on parenting: Implications for parent educators. Journal of Instructional Psychology. 12(2) (1985) : 80-85.

[11] Foss, G. F. A conceptual model for studying parenting behaviors in immigrant populations. Advances in Nursing Science 19(2) (1996) : 74-87.

The 1951 Refugee Convention and the 1967 Protocol (Relating to the Status of Refugees) set standards that apply to children in the same way as to adults:

(1) A child who has a "well-founded fear of being persecuted" for one of the stated reasons is a "refugee",

(2) A child who holds refugee status cannot be forced to return to the country of origin (the principle of non-refoulement), and

(3) No distinction is made between children and adults in social welfare and legal rights.

The treaty which sets most standards concerning children is the 1989 Convention on the Rights of the Child (CRC). While the CRC is not a refugee treaty, refugee children are covered because all CRC rights are to be granted to all persons under 18 (art. 1) without discrimination of any kind (art. 2). In keeping with the Convention on the Rights of the Child[12], UNHCR considers a child to be a person "below the age of 18 years, unless, under the law applicable to the child, majority is attained earlier"[13].

The Convention on the Rights of the Child is important to refugee children because it sets comprehensive standards. Virtually every aspect of a child's life is covered, from health and education to social and political rights. Some of the standards are specific, for example the articles on juvenile justice (arts. 37 and 40), adoption (art. 21) and family rights (arts. 5, 9 and 14.2). Some social welfare rights are expressly qualified by the state's financial capability. Rights to health (art. 24), education (art. 28), and to an adequate standard of living (art. 27) are called "progressive rights" because they increase along with the State's economic development. However, these social welfare rights are not just principles or abstract goals. Because they are "rights," the prohibition against discrimination (art. 2) means that whatever benefits a state gives to the children who are its citizens it must give to all children, including those who are refugees on its territory. The Convention on the Rights of the Child has gained importance to refugee children because of the near-universal ratification of the treaty (155 State parties by

[12] THE UNITED NATIONS. General Assembly resolution. 44/25.. Article 1.

[13] Ibid.

March 1994).

The CRC standards have been agreed to by countries in every region of the world, countries of every population and geographical size and stage of economic development, and representing every type of political system and religious tradition. The widespread ratification of the CRC is important for other reasons as well. When a state is a party to the CRC but not to any refugee treaty, then the CRC may be used as the primary basis for protecting refugee children. The UNHCR Policy on Refugee Children[14] states in one of the guiding principles, "In all actions taken concerning refugee children, the human rights of the child, in particular his or her best interests, are to be given primary consideration" (Para. 26 (a)).

In 1990, the World Summit for Children adopted a Declaration and Plan of Action in which states are encouraged to develop national plans of action, which should include refugee children under the category of "children in especially difficult circumstances." Although the Declaration and Plan are not treaty standards, their widespread acceptance has been a major step forward.

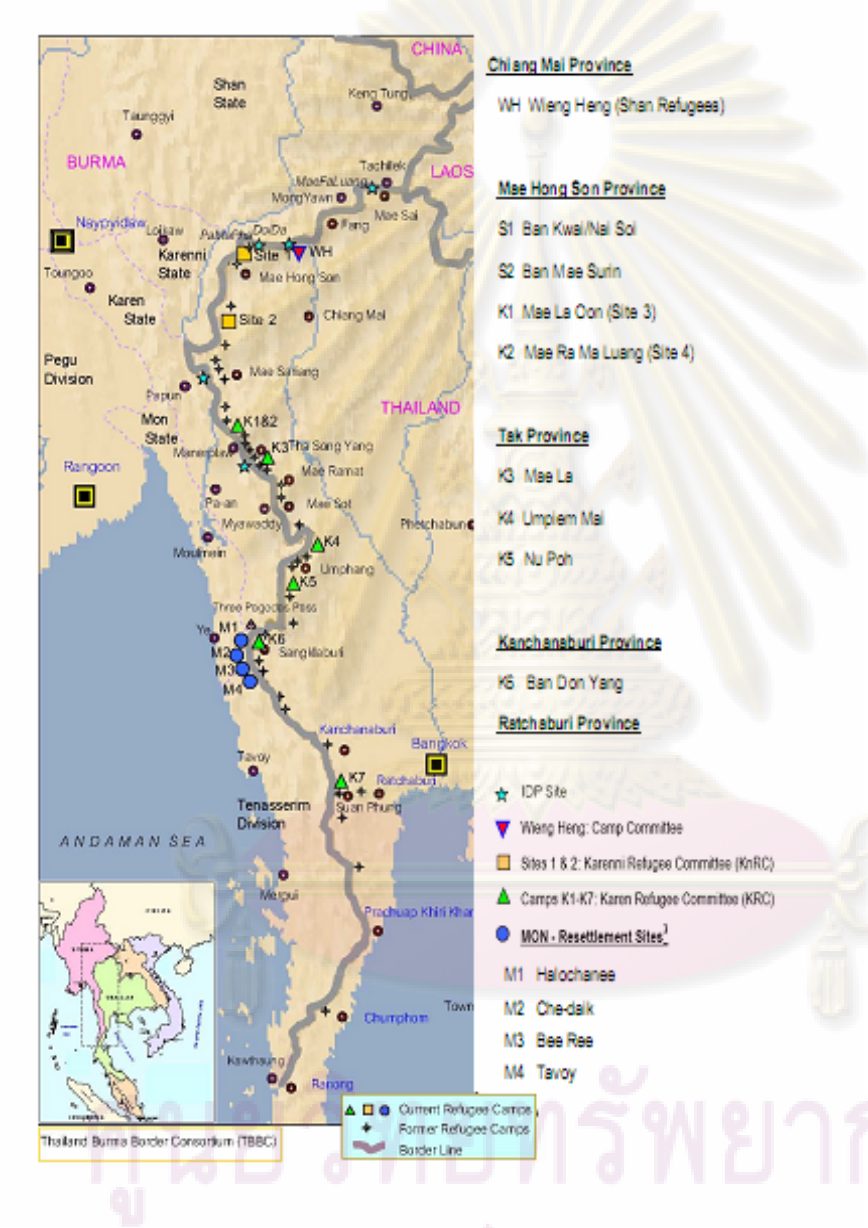
Refugees who flee their native countries for social or political reasons are usually impoverished, arriving in a new country with little assistance. The experience of refugees in the host country greatly differs from that of immigrants. (Basran, 1993)[15] The refugee often leaves his/her home country suddenly and under extreme circumstances, and is less likely to be physically or emotionally prepared for the move. They "often have fewer kin

[14] UNHCR. UNHCR Policy on Refugee Children presented to UNHCR Executive Committee Document EC/SCP/82. October, 1993.

[15] Basran, G.S. Indo-Canadian Families: Historical constraints and contemporary contradictions. Journal of Comparative Family Studies 24 (3) (1993) : 339-352.

and community contacts in the receiving nation to buffer their arrival, and their move is associated with social crisis and personal trauma"[16].

Figure-1 Map of Thai-Burma border



Source: TBBC; Map of Thai Burma border

[16] Opoku-Dapaah, Edward. Somali Refugees in Toronto: A Profile. Toronto: York Lanes Press, 1995.

2. Historical Background

2.1. Ethnic Groups in Burma

Myanmar, formerly Burma, has been in a state of internal armed conflict since it gained independence from the United Kingdom in 1948. For the last 50 years armed opposition groups representing various ethnic minorities have engaged in insurgency activities against the central government in an effort to gain greater autonomy or complete independence. According to the government, there are 135 “national races” in Myanmar, including the dominant ethnic Burman group. Ethnic minority groups comprise approximately one third of the population, who live mostly in the seven ethnic minority states surrounding the central Myanmar plain. The Karen is one of ethnic groups of Sino-Tibetan origin. Among the Karen are practicing Buddhists, Christians and animists.

Figure-2 Map of Burma showing the Ethnic States

Map source: KWO Annual Report, 2005-2006

2.2 The Burmese Border Refugee Camps in 1984

The porous Thai borderland became a temporary home to some people displaced by seasonal fighting. But people typically returned to their villages when situation resettled. At that time, borderlands' forest provided sufficient materials and food for people to sustain themselves. However, from the time of the dry-season of 1983-84, the *tatmadaw* intensified its military operations against Karen National Liberation Army (KNLA). The Burmese army launched offensives and occupied KNLA's base of Mae Tha Waw. They continued their attacks on KNLA camps at Klerday and Maw Pokay on the bank of Moei river, and also Mae La, Wangka and Phalu.[17]

As a result of these offensives, the KNU border economy suffered a lot. This time, Burmese army maintained a presence throughout the rainy season. KNLA launched a wet season counter attack in August 1984 and reoccupied their camps except Mae Tha Waw. In February 1984, some nine thousand Karen refugees fled into Tak province, and started "semi-permanent" refugee camps on Thail-Burma border. In February, the Thai Minister of Interior (MOI) invited the Coordinating Committee for Service to Displaced Persons in Thailand (CCSDPT), to provide emergency assistance to the displaced Karens. Then the Burmese Border Consortium (BBC) was formed with NGOs. The BBC set up a "CCSDPT Karen Subcommittee". The Karens formed the Karen Refugee Committee (KRC) to administer the refugee population. BBC provided assistance through KRC. Within the camps, there were village heads, committees, and section with traditional village management structure.

The Karen refugee leaders gained permission from the Governor of Tak province to establish basic camp facilities, on the agreement of return to Burma when situation

[17] Almerigo Grilz and Gian Micalessin. Letter From Wankha. Far Eastern Economic Review. November, 1984, p. 90

allowed. Until 1990, Thai security arrangements in Burmese refugee camps were not strict but allowed the village style character of traditional life style.[18]

Figure-3 Location of Border Karen Refugee Camps

Map source: 1995; Map adapted from Burmese Border Consortium, Bangkok, 1995

2.3. Transitional Period starting from 1988 on Thai Burma border

In 1988, after the crackdown on pro-democracy uprising, Thailand initiated the relationship with the State Law and Order Restoration Council (the military government after the coup). In accordance with the policy of "constructive engagement", Thai government advocated political coexistence and attempted to exploit the enormous resource and economic potential in the Burmese border region.[19]

[18] MOI Regulations, as of May 31, 1991. Burmese Border Consortium, Appendix B. Burmese Relief Programme Report for Period January to June 1997. Bangkok: Burmese Border Consortium, 1997.

[19] Innes-Brown Mark, and Mark J Valencia, Thailand's Resource Diplomacy in Indochina and Myanmar. Contemporary Southeast Asia. 14/4, 1993.

When the military reasserted power in September 1988 after suppressing a nation-wide pro-democracy movement, they adopted a policy of negotiating cease-fires individually with ethnic minority armed opposition groups rather than engaging with umbrella organizations which grouped them together. Since 1989 they have agreed 17 cease-fires with various armed opposition groups. Although peace talks have taken place between the KNU and the central government, the KNU apparently rejected the government's offer in late March 1999 for the resumption of cease-fire talks. The KNU state that they will only enter negotiations for a full- scale political settlement, rather than a limited military cease-fire agreement. Nevertheless because talks have taken place over the past three and one half years, further discussions between the SPDC and the KNU cannot be ruled out.

2.4. The cross-border raids on the Refugee Camps

In December 1994 the KNU suffered a major setback when a group of disaffected Buddhist Karen troops left the KNU and formed their own group, the Democratic Kayin Buddhist Army (DKBA)[20]. After the split, the then SLORC immediately formed a tactical alliance with the DKBA, providing them with supplies and propaganda support. In early 1995 SPDC and DKBA troops captured Manerplaw and Kawmoora, the KNU's two largest remaining bases. Following the fall of the Manerplaw and Kawmura, security of Karen refugee camps were affected. By early 1997 the KNU had lost the vast majority of its territory to the Burmese army.

The head quarter of the DKBA were set up at Myaing Gyi Ngu on the Salween River. Sayardaw U Thuzana is their spiritual leader. Since 1995, U Thuzana called for Karen villagers and refugees to move to this DKBA settlement. DKBA has been operating in the Pa-an, Papun, Nyaunglebin, and Thaton districts of Karen State. In

[20] The KNU leadership is generally dominated by Christians, and DKBA members claimed that Buddhists were discriminated against on the basis of their religion.

February 1995, DKBA distributed leaflets in the refugee camps demanding refugees to return to Burma. They promised in their leaflets land, rice and peace. In February of that year, armed members of DKBA snaked into the Karen refugee camps in Thai soil. They abducted KNU senior officials and forced refugees to return to Burma. On 9 February, one of the well-known, senior KNU leader and chairman of Pa-an District, Pado Mahn Yein Sein was abducted. During those days, DKBA members attacked and completely destroyed several camps. They just ceased their attack in rainy season and resumed again in dry season in November[21].

"I was arrested by former KNLA members whom I knew very well. I was brought to U Thuzana as I am a Buddhist. I urged U Thuzana to make a talk with KNU leaders but he refused my advice by saying that KNU are relying very much on the US, so he could not cooperate with them. After that, I was turned into the Military Intelligent. I was imprisoned in Myin Chan prison for 5 years. After I was released from the prison, I stayed in Pa-an in monk hood for one year. And I run away to here again."

Pado Mahn Yein Sein, KNU leader

Photo: 1 Photo of Pado Mahn Yein Sein with researcher in his house in Mae La camp (2.8.2008)

[21] Karen Human Rights Group, Inside the DKBA, p.7, 1997.

In January 1997, DKBA forces raided and burned Huay Kaloke, Don Pa Kiang and Mae La camp. On January 4, Sho Klo camp was shelled[22]. As a result of shelling, Sho Klo camp was closed down in February and its more than seven thousand refugees moved to Mae La camp.Mau Kur and Mae Kong Kha camp were also threatened and people living in these camps had to run and hide in nearby jungles. In March 1998, Huay Kaloke, Maw Ker and Mae La camps were raided and attacked.

Thai authorities managed immediately to consolidate many small camps into larger camp. As a result, Mae La camp became the largest one with population around 25,000 by 1996. In 2000, there were only 12 camps in Thai-Burma border in contrast to more than thirty at the beginning of 1995[23]. Since 1995, cross-border raids have threatened peace along the border. The refuges of displaced Karen people were affected greatly. Burmese army as well as the DKBA recognized refugees in the Thailand as rebel sympathizers.

Figure-4 Location of Border Karen Refugee Camps, 2000

[22] Karen Refugee Committee press release, Mae Sot, January 29, 1997; Karen Human Rights Group, "Attacks on Karen Refugee Camps", KHRG No. 97-05, March 18, 1997, pp. 1-16

[23] Burmese Border Consortium, Refugee Relief Programme: Programme Report for the Period January to June 2000. Bangkok: Burmese Border Consortium, August 2000.

Source: Map adapted from Burmese Border Consortium, Bangkok, 2000

2.5. Causes of displacements

Causes of displacements primarily rooted from widespread counter- insurgency activities of the State Peace and Development Council (SPDC)*, Myanmar's military government) against the Karen National Union (KNU) and its armed wing Karen National Liberation Army (KNLA). These widespread and systematic human rights violations by the *Tatmadaw*, and to a lesser extent, by government-allied paramilitary forces are the primary cause of the displacement of thousands of civilians[24]. Guerrilla fighting between the two groups continues, but the primary victims are Karen civilians. Civilians are at risk of torture and extrajudicial executions by the military, who appear to automatically assume that they supported or were even members of the KNU. Civilians

* The State Law and Order Restoration Council (SLORC) changed its name to SPDC in November 1997. Several SLORC members who were alleged to be involved in large-scale corruption were sidelined but otherwise the SLORC's policies have remained unchanged

[24] Amnesty International. Crimes against humanity in eastern Myanmar. Amnesty International Report. ASA 16/011/20085, June, 2008.

also became sitting targets for constant demands by the *Tatmadaw* for forced labor and portering duties.

Further, the offensive is not a security or counterinsurgency measure against the KNLA, but rather an operation primarily targeted at civilians. Individuals have been forced out of their homes as a direct result of the *Tatmadaw*'s decades-old "Four Cuts" strategy, designed to break down armed opposition groups' links to food, financial support, recruits, and information, or have been forced to leave after repeated demands by the *Tatmadaw*. These demands, including forced labor and excessive food requisitioning, have made it extremely difficult for civilian villagers to survive.

SPDC and DKBA troops have accused villagers of helping the KNU in various ways, and punished them for their purported actions. In addition, DKBA and SPDC troops stole villagers' rice, livestock, and other possessions, adding yet another hardship. *Tatmadaw* officers do not provide their troops with adequate supplies, so troops in effect live off the villagers. Villagers were also frequently required to pay various forms of arbitrary taxes, including fees to avoid forced portering and labor and fines if the SPDC claimed there was KNU activity in the area[25]. Villages were attacked and destroyed by the *Tatmadaw*, and villagers were ordered to relocate.

Another hardship suffered by Karen is forcible relocation, which the *Tatmadaw* uses as a means of breaking up alleged support or links between civilians and armed ethnic minority groups[*]. Forcible relocations are part of the army's "Four Cuts" counter-insurgency strategy, which entails cutting alleged links of intelligence, food, money and recruits between armed opposition groups and local civilians. Since 1996 hundreds of thousands of ethnic minority civilians have been pushed off their land and homes by the *Tatmadaw* in the Karen, Karenni, and Shan States. Such disruption has caused tens of thousands of internally displaced people to seek refuge across the border in Thailand. The KNU is active in Papun District, and regularly engages SPDC units in skirmishes.

---

[25] Amnesty International Report. Myanmar: Crimes against humanity in eastern Myanmar. ASA 16/011/20085. June, 2008.

[*] Since early 1996 the *Tatmadaw* has forcibly relocated 20,000 - 30,000 Karenni civilians in the Kayah State and over 300,000 Shan civilians in the Shan State.

Villages were destroyed by the army. As a result people living in war affected areas were believed to have been displaced; some fled to Thailand, others went to SPDC- designated relocation sites, and still others hid in the forest[26]. All of these groups have lost their land, homes, and most of their possessions.

Karen refugees in Thailand had fled mostly from Papun, Hpa'an, and Nyaunglebin Districts in the Kayin State for several reasons for leaving their homes. Some had been forced out of their villages by the *Tatmadaw*, and had been hiding in the forest. Conditions there were poor, as it was almost impossible for them to farm. They also feared being shot on sight by the military because they occupied "black areas", where the insurgents were allegedly active. Many others fled directly from their home villages in the face of village burnings, constant demands for forced labor, looting of food and supplies, and extrajudicial killings at the hands of the military. All of these people were farmers who typically grew small plots of rice on a semi-subsistence level.

The continuing economic downturn throughout Asia makes it even more difficult for these countries to cope with more refugees, as they are faced with widespread unemployment and other problems. An estimated 147,800 persons are reported to have been, and remain, internally displaced in Kayin State and eastern Bago Division as a result of the continuous offensive and its attendant human rights violations. People who fled the conflict described an increased military presence in Hpa'an and Papun Districts in Kayin State, and Nyaunglebin District in Bago Division*.

---

[26] Burma Ethnic Research Group and Friedrich Naumann Foundation. Forgotten Victims of a Hidden War: Internally Displaced Karen in Burma. Chiangmai: Nopburee Press, April, 1998 : 35-49.

* The KNU demarcates territory differently from the SPDC. Administrative areas bordering Karen State are demarcated by the KNU as part of Karen State, rather than Bago Division. The KNU also refers to both Thandaung townships in Hpa'an District, Karen State and Tantabin Township in Nyaunglebin District, Bago Division, as being in "Taungoo District", Karen State.

CHAPTER III

SOCIO-ECONOMIC SITUATION

In this chapter, a brief background of Mae La camp is presented to provide the general scenario and setting of refugee camp in order to have a brief overview of how the camp is organized and operating. Then occupation of mothers in the camp with general socio-economic situation is investigated following the brief background of Mea La camp. Mothers' living style and child care practices is dependent on how mothers have to live in the camp and how they struggle for their living. Mothers have to work to keep their house or to earn income for living or both. Anyway, living and working situation affect how they take care of their children.

Despite some supply and services for both mothers and children, mothers need income for extra expenses for their children in a camp where they have been living for years. Despite the fact that the camp is titled as 'temporary shelter' for 'displaced persons', it has been no longer temporary and people living in the camp are not just displaced for short period but refugees settled in a small society for decades. Mothers who have been struggling for their survival are among those considerably affected by the long term settlement in the camp. The following historical background and socio-economic situation will testify it.

3.1. A brief background of Mae La Refugee Camp

Before current child care practices in the camp are studied, profile of the Mae La refugee camp should be overviewed. Mae La camp, located in Mae Sot District, Tha Song Yang District, Tak Province, on the northern border between Thailand and Burma, has been in existence since 1995. Its area is approximately 1,148 rai wide according to Ministry of Interior (MOI). It is only 8 kilometer in straight line away form Burma border. It can be easily accessed from Mae Sot, just an hour drive away and all year round with good road condition. Mae La camp is the largest in both size and population among 9 camps along the Thai-Burma border.

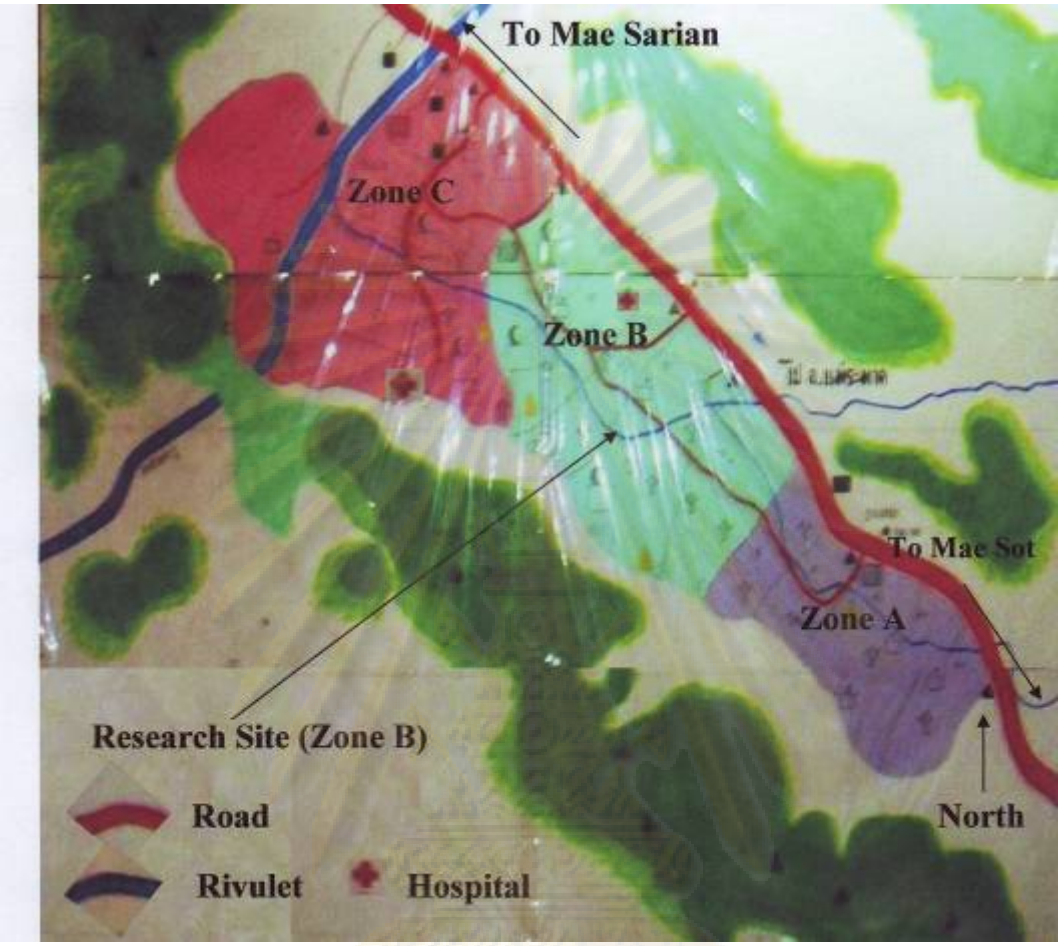
This camp was originally established closer to the border in 1984 with a population of 1,100. Then it was moved to the present zone C shortly afterward. After the

fall of Manerplaw in January 1995, a number of camps were attacked in cross border raids. The Thai authorities then began to consolidate camps to improve their security. In April 1995, Mae La increased in size from 6,969 to 13,195 due to the closure of five camps in the north (Mae Ta Waw, Mae Salit, Mae Plu So, Kler Kho and Kamaw Lay Kho) and the move of Huat Henh later in the same year. Over the following months, the camp doubled in size again to 26,629 in may 1996 as those lost in the move came back into the camp. In March 1997 some people were relocated here following the closure of Dong PaKiang camp and again in February 1998 when Shoklo camp was closed. Mae La is also known as 'Beh Klaw' in Karen, which means 'cotton field' due to the agricultural activities for which Karen leaders first negotiated permission for refugees to cross into the area in 1984.

The majority of residents are members of ethnic groups from border States in Burma, mainly Sgaw Karen, with some Pwo Karen, Burmese, and Mon scattered throughout. The shelters in Mae La camp are made mostly of bamboo provided by ther BBC (walls and floors) and thatched roofs, with only some structural supports made of wood. Space and water are very limited within the confines of the camp.

The camp is divided into three zones and is administered by an elected camp committee. The camp is located along a main thoroughfare, and some camp residents find day labor in neighboring farms, although the movement of refugees in and out of the camp is increasingly restricted by Thai border officials. Nonetheless, the camp has a lively economy. Zone C has a large market, with over 100 small shops that sell food and goods daily. Zones A and B have a few small shops selling some dry and some fresh foods. Camp residents are free to travel between zones to access markets, health services, churches, etc.

Figure-5 Mae La camp; Location Map of Zone A, Zone B and Zone C



Source: Adapted from the photo taken at the administration office of Mae La camp

3.2. Demographics

Population of Mae La refugee camp is monthly reported by Karen Refugee Committee. But real figure of population is subject to the transient flow of refugees coming and going quickly. A large number of populations are not in the registered list of the camp and there are also a large number of new arrivals.

Table 1. Overall Population: 41,924 (June 2008)

Camp	No. of families	Over 12 years		6 - 12 years		Under 5 years		Total
		M	F	M	F	M	F	
Mae La	8,781	13,302	13,204	4526	4201	3438	3271	41,942

Source: KRC, Monthly Report, June, 2008

3.3. Non-Governmental Organizations/UN Agencies

Table 2. Non-Governmental Organization and UN Agencies

SECTOR	**ORGANISATION**
Food, shelter and non food items	Thailand Burma Border Consortium (TBBC)
Health and sanitation services	Aide Medicale Internationale, Solidarities
Reproductive health	Planned Parenthood Association of Thailand (PPAT)
Malaria research	Shoklo Malaria Research Unit (SMRU)
Primary and Secondary Education	ZOA Refugee Care / Internationaal Christelijk Steunfonds Asia (ICS-Asia)
Nursery schools	Taipei Overseas Peace Service (TOPS)
Special education	World Education / Consortium (WE/C)
Mine risk education	Handicap International (HI)
Social services	Catholic Office for Emergency Relief and Refugees (COERR) Taipei Overseas Peace Service (TOPS)
Rehabilitation	Handicap International (HI)
Libraries	Shanti Volunteer Association (SVA)
Protection	United Nations High Commissioner for Refugees (UNHCR)

Source: TBBC

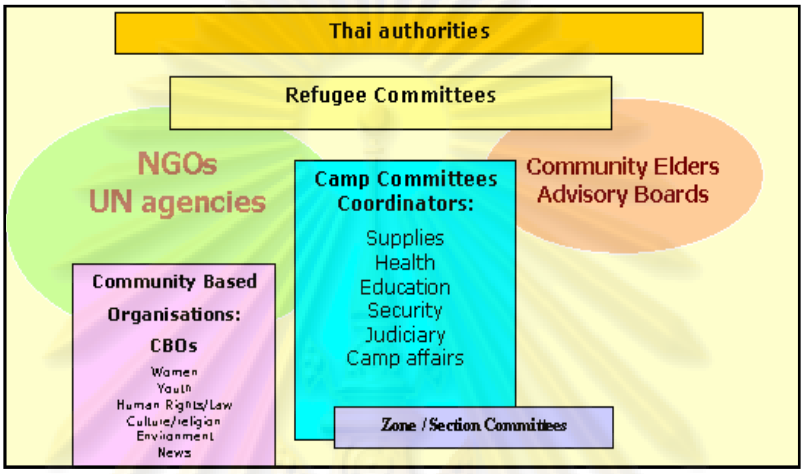
3.4. The organizational structure for administration of the refugee camps

3.4.1. Thai Authorities

The Royal Thai Government (RTG) maintains ultimate authority over the Karen refugee camps in Thailand. The MOI, through provincial and district authorities, enforces refugee policy and controls the day-to-day running of the camps in collaboration with refugee and camp committees. Various other government agencies, including the Royal Thai Army Paramilitary Rangers and the Border Patrol Police also assist in implementing policy and providing security. Usually a MOI local District Officer (‘Palat’) is assigned

as the Camp Commander in each camp, with Territorial Defense Volunteer Corps (‘Or Sor’) personnel providing internal security under his jurisdiction.

Figure. 6 The organizational structure for administration chart



Source: TBBC

3.4.2. Community Elder’s Advisory Boards (CEABs)

Community Elder’s Advisory Boards are set up to provide guidance for refugee committees and camp committees in their work. They are made up of elders appointed from the local community and in theory consist of 15 members. In reality, a lot fewer than this actively make up each board. Specific aspects of their work include the organizing and overseeing of refugee committee and camp committee elections, and assisting in solving conflict.

CEAB members are appointed by senior elders from the local community in which the CEAB operates. There is rarely a fixed term of office, although in some camps they are reassigned every two years. However, members can be reappointed by the senior elders. The central Karen CEAB is based in Mae Sot, with camp-based boards present in each Karen camp made up from the local population. Members of these are also made up from the local population.

3.2. Occupations of mothers

Socio-economic situation is one of the important factors that affect the child care practices of mothers in the refugee camps. In the camps, although food and other non food items for construction, cooking and health care are supplied, mothers have to fulfill other needs by working or foraging for food. They need to buy some food items or snacks at the markets. Mothers need to buy things than other people in the camp as they have to fulfill the needs of their children.

Out of 25 mothers interviewed, 14 mothers do not work as their husbands work. Their husbands are working in outside plantation or work inside the camp such as carrier, carpenter, and security man or in NGOs like legal assistants. Their husbands who are working outside the camps can be easily arrested by immigration or police or forest guards. Although their husbands are working, mothers are busy with house keeping and caring their children. Sometimes, they are foraging foods such as collecting bamboo shoots or finding small fish in the stream.

Out of 25 mothers interviewed, 9 mothers are widow or separated with their husbands who have mostly married to other women. Most of them work outside the camp in plantation where as some works inside the camp as vender or random workers. They are in the category of the mothers who have to take care of their children in the most difficult situation due to lack of time and resources. They have to work all day and have to take care of their children just in the morning and at night time. One mother who is separated with her husband cannot work as her children is just months old so have to live together with her aunt and rely on her for everything.

There are also mothers who work also although their husbands are working like a couple who are working at their home shop and another couple who are working as legal assistants in an NGO. Depending on mothers' work and their marital status, how much they can take care of their children differ. Although it can be said that non working mothers have more time than working mothers so that they can take care of their children better, it also depends on their social status as non working mothers also have their own social difficulties like in the case study (2). In the case study two, although she is not

working as her husband works as a security person in the camp, she has to take care of her children's every matter. One of her twin child died of the malaria as she does not handle the problem well. And her husband is always drunk so they have quarrels at home all the time which also affect the children psycho-social stimulation.

Working mothers' main difficulties are that they do not have enough time for their children as they are working at day time so that they cannot take care of their children. Most of their works are outside the camp so have to take risk of being arrested. In the case study (1) of working mother, the mother was arrested and had to live in the prison for 3 months leaving her children in her sisters' house without proper care. As a lactating mother, she had to take her children to the workplace and breastfed her child whenever she was free from work. When they are old enough and can be left at her sister's home, children are forced to work and not properly fed.

Only one mother who is the owner of a cloth shop is good in economic situation although she is a widow. Another reason why she is comfortable with her own business is that she is supported by her daughter working in Bangkok. Another couple both of who are working as legal assistants in an NGO called 'International Rescue Committee' has a regular income for their family. As a result, they can take care of their children well although they work all day.

A mother whose husband was arrested by forest guards is collecting bamboo shoots and sells them back for her living. A mother of 5 children who cannot work depends on her aunt who is also collecting bamboo shoots and mushrooms, and sells them back at the market. Collecting bamboo shoots and mushroom is also a popular work among mothers. Other works inside the camp is staffs in NGOs, nurses in hospitals or teachers in schools or nurseries. However, these kind of works need special skill and also skill in English language so that most of mothers cannot approach them.

Table.3. Socio-economic background of 25 mothers interviewed

Sr. No.	Name	Age	Karen		Religion	Education	Family member	Total no. of children	No. of children < 5	Marital Status	Work (if any)	Husband's work (if any)
			S	P								
1	Daw Linn Aung	43	Â		Buddhist	Middle School	6	3	1	Widow	Clothes shop	
2	Khin Ma Ma	32	Â		Christian	Lower Primary	6	4	2	With husband	Not working	Carpenter
3	Naw Wah Htoo	25	Â		Buddhist	Lower Primary	5	3	3	With husband	Not working	Not working
4	Nan Chit Swe	16		Â	Buddhist	Lower Primary	3	1	1	With husband	Not working	Random work
5	La Say Wah	36	Â		Christian	Lower Primary	7	5	2	With husband	Not working	Outside work
6	Muu Kha Le	21	Â		Buddhist	Lower Primary	3	1	1	With husband	Not working	Outside work
7	Naw Tar Tar	26	Â		Buddhist	Illiterate	6	5	2	Widow	Vender	
8	Naw Gay Phe	20	Â		Buddhist	Illiterate	4	2	2	With husband	Not working	Outside work
9	Naw Pe Phaw	43	Â		Buddhist	Lower Primary	6	4	2	With husband	Home shop	The same
10	Naw Thaw	35	Â		Buddhist	Lower Primary	3	2	2	Widow	Outside work	
11	Naw Dar	24	Â		Christian	Lower Primary	3	2	1	Widow	Outside work	
12	Lay Lay Phaw	22	Â		Christian	Lower Primary	4	2	1	Separated	Outside work	
13	April Phaw	29	Â		Christian	Lower Primary	5	3	1	With husband	Not working	
14	Nyan Baw	45	Â		Christian	Lower Primary	9	7	1	With husband	Not working	Random work
15	Mee Mee	38	Â		Christian	Primary	7	5	1	With husband	Not working	Word Admin
16	Naw Day Muu	26	Â		Christian	7th grade	6	3	1	With husband	Legal Assistant	Legal Assistant
17	Naw Phaw Bo	35	Â		Buddhist	Primary	6	5	2	Divorcee	Not working	
18	Ma Ohn Kyi	34	Â		Buddhist	Primary	3	2	1	Separated	Work outside	
19	Naw Che	22	Â		Buddhist	Primary	4	2	2	With husband	Not working	Work outside
20	Naw Snow	28	Â		Christian	Lower Primary	5	3	1	With husband	Not working	Carpenter
21	Naw Pwe Phaw	26	Â		Buddhist	Lower Primary	5	3	2	With husband	Not working	Work outside
22	Naw Bway Baw	30	Â		Animist	Illiterate	10	8	3	With husband	Not working	Work outside
23	Naw Pi Pi	22	Â		Buddhist	Lower Primary	4	2	2	With husband	Not working	Security
24	Naw Phaw Phi Kyi	25	Â		Buddhist	Illiterate	5	3	2	Separated	Random	
25	(Grandmother)	65	Â		Christian	Primary	7	5	1	Widow	Not working	

Table.4. Socio-economic background of 25 mothers interviewed

Sr. No.	Name	Working/non working	Marital Status	Nursery school	Husband's Occupation	Resettlement
1	Daw Linn Aung	Working	Widow	Send		Under process
2	Khin Ma Ma	Not working	With husband	Send	Carpenter	Under process
3	Naw Wah Htoo	Not working	With husband	Send		Under process
4	Nan Chit Swe	Not working	With husband	Don't send	Plantation	No process
5	La Say Wah	Not working	With husband	Send	Plantation	No process
6	Muu Kha Le	Not working	With husband	Don't send	Plantation	No process
7	Naw Tar Tar	Working	Widow	Send		No process
8	Naw Gay Phe	Not working	With husband	Send	Plantation	No process
9	Naw Pe Phaw	Working	With husband	Don't send	Random	No process
10	Naw Thaw	Working	Widow	Don't send		No process
11	Naw Dar	Working	Widow	Send		No process
12	Lay Lay Phaw	Working	Separated	Send		No process
13	April Phaw	Not working	With husband	Send		No process
14	Nyan Baw	Not working	With husband	Send	Random	No process
15	Mee Mee	Not working	With husband	Send	Word Admin	No process
16	Naw Day Muu	Working	With husband	Send	Legal Assistant	Under process
17	Naw Phaw Bo	Not working	Divorcee	Send		No process
18	Ma Ohn Kyi	Working	Separated	Send		No process
19	Naw Che	Not working	With husband	Don't send	Plantation	No process
20	Naw Snow	Not working	With husband	Send	Carpenter	No process
21	Naw Pwe Phaw	Not working	With husband	Send	Plantation	No process
22	Naw Bway Baw	Not working	With husband	Send	Plantation	No process
23	Naw Pi Pi	Not working	With husband	Don't send	Security	No process
24	Naw Phaw	Working	Separated	Send		No process
25	Phi Kyi (Grandmother)	Not working	Widow	Send		No process

3.2.1. Working mothers

Out of 25 mothers interviewed, 10 mothers are working in different kind of works. Most of them are working outside the camp in plantation such as rice or corn fields. Mothers in good living condition open a shop at home or at the road side market. Some mothers do not have regular job so they have to forage bamboo shoots or mushrooms in the nearest forest and sell them back at the market. Some mothers forage fish at small streams in the camp for selling back or eating. Some mothers have their own small vegetable fields. Some raise animal like pig and sell them back when they grow old enough. Nine out of 25 mothers have to work outside the camp. Only two of them are working legally outside the camp in plantation.

A mother working outside plantation legally said, "*I have to go to my work to get there before 9 o'clock. I have to send my children to school teacher early before I go to work. If I am late 5 minutes, they cut half of my daily wage which is 50 baht a day. We are dismissed at about 4: 30 and come back at 5:00 o'clock at the evening. After I come back, I have to sell some vegetable that my supervisor asks me to. Only after I have sold out my share, I go back home. At first we are allowed to rest one hour at lunch time. Now we have to work back as soon as we have finished our lunch. They issue a card to us. Police does not arrest me if I show the card. I only cook my dinner just after I came back from work. As I am a widow, there is nobody except my two children to cook rice for me."*

A mother who works in outside the camp illegally said, *"I have to get up very early from bed. After cooking and having my lunch, I go to work. In the early in the morning, police are not present on the way to my work in Mae Tan. I work in a rice plantation and get 100 baht a day. I have to work all day. I come back home once a week at week ends. I have to send my children to my elder sister while working. My husband got married with another woman in Bangkok and did not come back. So there is nobody to take care of my children while I am away for working."*

A mother who works after her husband died said, *"I sell sticky rice and other snacks made of sticky rice. I have to get up very early in the morning and go to the market to sell my snacks. I don't need to work when my husband was alive. Now if I have*

*many difficulties if I don't work as I have 5 children. I fry '*sar ka lay khway' *(a kind of snack made of lentil powder) and send them to the market at the evening. When I am free, I forage bamboo shoot and sell them at the market."*

A mother who works as a legal assistant said, *"I work as a legal assistant together with my husband. I have to discuss one section a week about Thai law. One section takes 3 days. I have to work in my own Zone. I also have to discuss about child rights. I dare not go outside the camp because I know if I am arrested, I will be charged 'two year prison sentence' plus 20,000 Baht. When I am free, I weave some cloth for my children."*

A mother who opens home shop selling miscellaneous snacks and '*mo hin ghar'* said, *"I don't know how much I got as profit from my shop. But my shop will be dismissed because of my children who are taking snacks from my shop without paying for them. But I am happy to have a small shop. My husband raise pigs and today we sell one pig and got 3400 baht."*

A mother who opens a clothes shop at the road side market said,*" My shop sells man and woman's clothes. My eldest daughter from Bangkok sends clothes for my shop. My daughter works as a sale agent in a travel agency in Bangkok. She also sends me 3000 baht a month. I hire a girl for shop assistant. I used to work as a maid in Bangkok. Now my work here is convenient and not as hard as before."*

A mother whose husband was arrested under forest act said, *"My husband was now in the prison. So I have to work. I forage bamboo shoots in the nearest forest. I got about 30 kilo a day. I sell them back with 2 baht for one kilo. But I cannot go and work everyday."*

Cast study (1)

(A story of working mother with two children)

My name is ……. I am now 31 year old. I have been living in Beclaw for over 10 years. I used to live in Sa Khan Gyi Village of Thaton Township in Burma. I have never attended school. My father and mother are workers in other people's farm. My parents went out of the town as they could not stand against the forced rice paddy provided to the government. When I was 14 year old, I worked as a maid in Rangoon. But my mother called me back to stay together with them in Mae Tan. I got married when I was 22 year old. Then we moved to Beclaw. When I had a pregnancy of second child, my husband went to Bangkok and did not come back. He said he got married with another woman there.

At that time, my first child was suffering from measles. I did not know what to do with him. My child was almost blind. An old lady living near my house told me not to send my son to the hospital. She said, "if you send your child to the hospital, you child will die for sure." My son was getting thinner and thinner. I called my elder sister to come and take care. But she did not come. Then, an Indian lady came and saw my son and bathed my son with boiled water in which she put 7 kinds of leaves. I don't remember what kind of leaves they are. She had my son bathe three or four time a day. Then my son's fever cooled down. I took my son and went to the hospital. The doctor scolded me very much for not coming early. My son's fever was released soon by taking medicines from the hospital. I rubbed dried cucumber seeds on the stone and put it on my son's eyes. Then my son could open his eyes and see. I asked my son to kowtow Indian lady often.

My younger child is a daughter and now she is attending the nursery. I took my children when I worked outside the camp. I breastfed them while working. But I could not concentrate in my work because of them. When my son started to attend school, I left them at home. I worked in rice plantation at Mae Tan. My mother is also living in Mae Tan. I got 100 baht a day. Last year, in January, I worked at a corn plantation at Mae Kya Laung and was arrested by immigration. I had to live in the prison for two months. In the prison, I had to carry boxes, and stick some stickers on boxes. I did not need to work on week ends. When I was released from jail, I could not sleep the whole night as I had to answer my children's so many questions.

I had to go Mae Tan by bus. Sometimes there is checking at check points. If so, I had to get down and walk through the forest. Last week, my two children followed me. They gave 10 baht for each to bus conductor. The conductor did not take money for my younger daughter. But my daughter insisted to take her money. She did not want things for free of charge. They told me that their aunt did not feed me anything so they were very hungry. And they had to get up early in the morning and fetch water for their aunt. So they followed me to my work. They asked me to leave chicken eggs and dried fish this time I go to work so that they could cook and eat food by themselves. I had to stay at least for 10 days at work.

Now I could not go to work as my daughter was low in blood pressure as she was dismissed from the hospital not long time ago due to Typhoid. Therefore I do not go up to Mae Tan, instead I worked in legal plantation near the camp. I could come back daily from work. But I got only 50 baht a day. I have to work from 8:30 in the morning to 5:00 at the evening.

I always admonish my children to learn education. If they are not educated, they will be poor. When they disobey, I threaten them by telling I would send them to their father. My son listed to my words, but my daughter is naughty. Sometimes, they fetch water for me. When I see water fetched by them after I come back from my work, I feel really happy and refreshed. Some time ago, we could eat three times a day, but now we could eat only two times a day.

My mother does not want us to go abroad. She told me to go abroad only after she has passed away. I am really downhearted when my children are sick. My daughter was sick very recently at night with her body trembling. So I went to the hospital with a hand lamp in my hand crying all the way. The doctor treated with injection and told me not to be hospitalized. I came back home at that night. I sometimes cannot sleep at night with a lot of thought. I feel depressed some nights. But I encourage myself because of my two children. I don't want to give up the world.

3.2.2. Non working mothers

Some mothers are not working for living. In this case, most of their husbands are working. Only one mother does not work although she is separated with her husband. She said, *"I cannot work because I have 5 children and the youngest is just 3 month old. My husband got married with another woman and left me alone when I was pregnant with my last child. I sold out my house and live together with my aunt. My aunt has also 5 children. She forage bamboo shoots and collect vegetables, and sell them back at the market. Her husband is a KNU soldier."*

Another mother whose husband cannot work said, *"My husband cannot work as he used to be a KNU soldier and was wounded in a battle with Burmese army. He still has some splinters in his head. But my relatives have gone to the US and they send some money for my family."*

All other non working mothers have husbands. But most of their husbands are working outside the camp except two carpenters, one security man and the one who opens a home shop. One of the mothers whose husband works outside the camp said, *"My husband works outside the camp at Mae La Galu. He's got 80 or 100 baht for a day. He works in corn field or rice field alternately. When I was pregnant with elder child, UN[*] took photo and he is not in photo. So he cannot go abroad. My husband allows me to go abroad but I am worried about my children for they will not have father."*

A mother who has disabled children said, *"I have 7 children. My husband works as random workers in the camp. He dare not work outside the camp. As we are new arrivals, we are not provided with food ration. It is very difficult for us to survive in the camp. My neighbors give me some food."*

A mother who has 8 children said, *"My husband used to be a KNU soldier. Now he is working at Mae Nar Tha in corn field or rice field. He comes back home once in about 10 days. He brings back about 400 or 500 baht each time he comes back home. I don't want any more children. When the youngest child is just some days old, my husband*

[*] They name UN whatever organizations take their photo. If someone is not present when photograph is taken, he or she is not registered as a displaced person of the camp.

was arrested and had to live in the prison for 3 months. Then I was greatly in trouble. But my husband said he welcome every child as they are sent by the God."

A mother whose husband is a security person for the camp said, *"I have three children. One of twins died just recently of malaria. My husband works as a camp security. He got 500 baht a month. He works at night. But his friends call him at day time and drink alcohol. He drinks all the day. Now he is drinking with his chief security at the house before my house. We argue and fight almost all the day. I want to separate with him. But I cannot work for my living."*

A mother who is just 16 year old said, *"My child is just 4 months old so cannot work. My husband works random works. He's got around 100 baht a day. I used to work in Bangkok for two years as a maid. I have to take care of children wash clothes. I got 1,500 baht a month. Now I am going to the US when my child is 6 month old. They allow 6 month old baby to travel."*

Case Study (2)

(A story of a non working mother)

My name is …….. I am 22 year old. I am a Sgaw Karen and a Buddhist. I came here in this camp since I was young together with my brothers and sisters. I used to live in Ka Soe village in Hlaing Bwe Township. My parents were farmers at that time. We faced many difficulties to earn for our living due to Burmese Army's forced labor and porter. My father ran away at first followed by my mother and four of us. When we arrived here, there were just a number of people in the camp. Houses were built far away from one another.

I got married in 2003. My husband is a security person of this camp. He got 500 baht as salary. I have 3 children. The eldest son is 4 year old. The younger two are twins but one of them died last month of malaria. I breastfed my children till one year old. Nurses asked me to breastfed them exclusively till they are six month old. But my children are twins so my breastfeeding is not enough for them. So I started my supplementary feeding when they were 3 months old. My elder one and twins took bath three or four times a day as they played all the day. They know how to use toilet, but I have to clean younger twos when they finished toileting. Sometimes younger twos

defecated on the house floor. If so, I have to clean them and I watered down their feces. My twins had to be hospitalized so often. Older twin had to be hospitalized last year for 20 days as he caught cold.

This time, my older twin had to be hospitalized as he suffered from diarrhea and vomited also. Younger twin did not eat anything too when older twin had suffered from something. Then he did not eat anything at all. When I breastfed my older twin at the hospital, my younger twin dropped down from the bed. When the older felt better, the younger one suffered from diarrhea and vomited. Her weight lost from 7 kilo to 5 kilo. After 4 days, they felt better and discharged from the hospital. The older one got worse at home so had to be hospitalized again. When she was tested, she had malaria positive. After 3 days in the hospital, he died of malaria. The staff from hospital did not test her the first time, but at the second time.

They had suffered from diarrhea several times. They were dewormed at the hospital. Worms even fell out of their mouths. When they were sick, I took them Amoxicillin or Paracetemol. I gave them half a capsule of Amoxicillin. When they felt better, I stopped treating. When they did not sleep, I gave them Burmeton. Sometimes, neighbors gave me *'yay man'* (spiritually treated water) to treat my child. At last, only if I could not treat them at home, I go to the hospital. The child, who had passed away, liked mothers' breast milk. Only after he has passed away, the remaining one could have enough breast milk.

I, sometimes, feel very disappointed to take care of twins. I am just getting fat after the other one has passed away. There is no body to help me to take care of them. I am the only one who is to take care of them. My husband has to go for work as he is a security person. In the morning, he cooks rice for us. But after that, he goes out all the day with his friends and drink alcohol. When I am angry with him, I tell him that I will go back Burma. If so, I ask children whether they are getting along with me or stay here together with their father. The children drag my hands and cries. My husband also cries.

Sometimes I am very downhearted as I have no money. I sometimes play card to have extra money, but I lost even 800 baht and I quarreled with my husband. From that time on, I never play card. My children told me they wanted to be a solider, have a long moustache and drink alcohol. I want to go abroad, but my husband doesn't. My parents

do not also allow me to go. I have many things to think about our future. I have no hope but education for my children.

Case Study 3

(A story of a working widow)

My name is Naw……, 23 years old. I am a Sgaw Karen and a Christian. When I arrived here, I was just 10 years old. At first, I lived in *Day Law Phyar* on Myawaddy side. I remember my village but I don't remember the reason why we came here. I just came with my parents who were farmers at that time. My sister remained in the village. I have 7 year old daughter and 3 and half year old son. I got married at 15 and I gave birth to a daughter at 16. As I gave birth to my daughter before the due date, she was born underweight. Now she is abnormal. She does not obey what I say. She is always ready to cry or cross with me. She starts to attend the school just this year. My younger son starts to attend nursery school this year. He is very clever and obeys my words.

My husband passed away one and half years ago. When my husband was alive, he worked in a farm. At that time, I collected vegetable and sold them back. After he died, I worked in a plantation near the camp. I've got 50 baht a day. I have a legal work permit card. Polices do not arrest me when I show the card. I have to work from 8:30 in the morning to 4:30 in the evening. We have to take our own lunch box. We are allowed a few minutes for lunch. In the work, there are two assignments; planting and selling. If I am in planters' shift, I have to get to work on time. If I am late, I will get only half of charge for a day. If I am in the shift of selling, I have to sell my vegetable out. I am responsible to sell all of them. The work is closed on Sunday. We are paid twice a month. I have been working there for one year.

I get up early in the morning and cook lunch. Then, when children wake up, I wash their faces. And we have our lunch together. I send my son to school. My elder daughter goes to school herself. Sometimes, she does not go to school but play at a stream. She does not want to attend the school. After they have come back from school, they have their dinner by themselves. Sometimes the younger son does not have lunch as

he has eaten something in nursery school. I cook dinner after I come back from my work. We have dinner as soon as the meal has been cooked.

I am always worried about my children while working. Recently my son stumbled down out of my house. He had a swollen face but nothing serious happened. Later, it became an abscess. I went to the hospital and consulted with the doctor. Sometimes, an old lady from my neighbor looks after my children. But she lives alone too so she cannot always take care of them.

It is said that my husband was killed by one of his friends. He was working in Wal Lay Khee when he was killed. He came back home once a week. But he did not come back long before he was killed. When I asked him to come back in April for we had to repair roofing, he said he would come back as soon as he was paid. I received the news two months after he called me. My parents also passed away. I don't want to go abroad. One of my sisters is now living abroad and told me not to come as she is not alright there. At the moment, I want to repair my house. I want my children to be educated. My son still thinks any man as his father whenever female stranger visit home.

3.2.3. Differences between working mothers and non working mothers regarding their daily routines

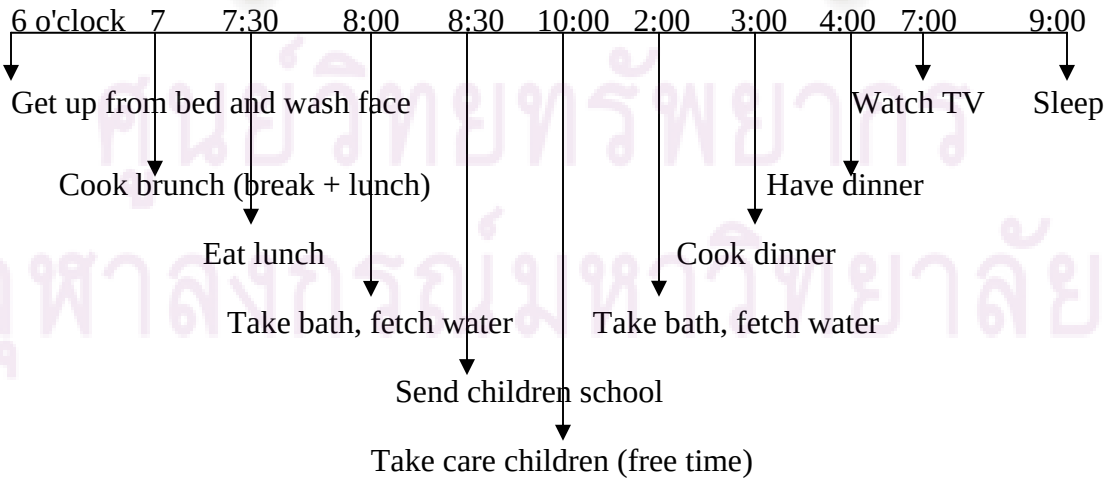
3.2.3.1. Daily routines of working mothers

Depending on the daily routines of mothers, their style of child care practices differs. The common characteristics of mothers' daily routines are based on traditions from their native and nationality background. However, due to their works and socio-economic situation, their daily routings vary from one mother to another. Basically, mothers' daily routines can be generally divided into two categories; daily routine for working mothers and for non working mothers. Most of them get up early in the morning, cook rice and curry, and eat them as soon as it has been cooked in the morning. Their first meal is their breakfast as well as lunch. They also cook their meal early in the evening. They also eat them as soon as it has been cooked. They go to bed early at night.

Non working mothers usually get up about 6 o'clock in the morning. And they cook their meal which is both for breakfast and lunch also. After they have their lunch with their children (sometimes without their children), they fetch water and wash clothes. After that, they have to take care of their children all the whole day time. They take bath and have their children bathe after noon. They cook dinner round about 3 or 4 o'clock and as soon as the dinner has been cooked, they have it. In the late evening, they might go out with their children to neighbors or relatives. At night, like working mothers, they might watch TV at other people's house. Or they go to bed early at night. Illegal source of electricity also stop at about 9 o'clock. Therefore most of family members including children gather at home before 9 o'clock and go to bed.

Non working mothers have some difficulties such as worries about their husbands as their husbands are working outside the camp and might be arrested at any time. Some of their husbands are not even registered in the camp because they were not present in the camp when registration group such as the UNHCR or TBBC came to the camp for registration processes. As a result, they do not receive food ration. And some of their husbands are married with another women in another places where as they are fathers of children in camp. Some came back only once in two months or so. They are prone to outside pressures and political complication too. A non working mother's husband was killed by a former KNU leader who now worked with some local drug traders. She only knew about her husband only three months after her husband was killed.

Time Line for non working mothers

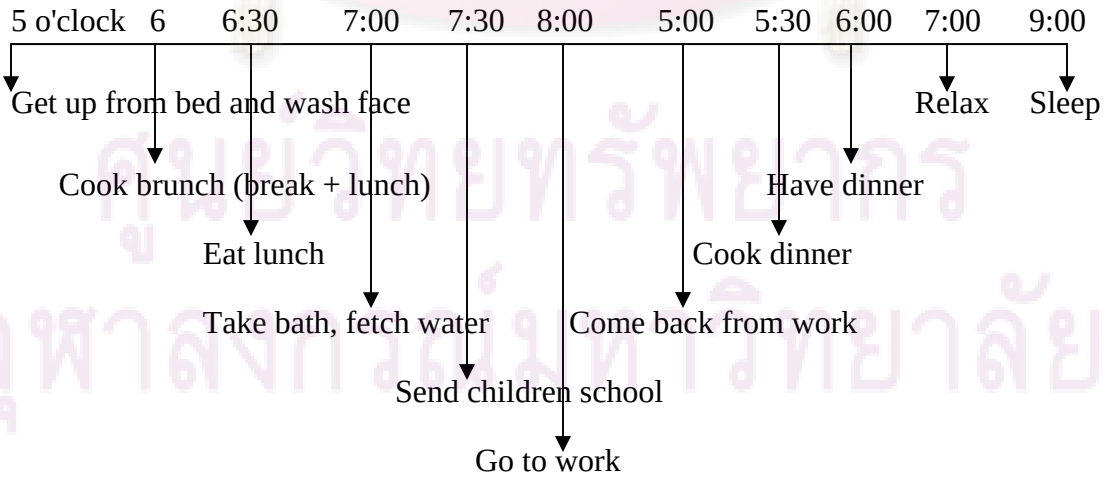


3.2.3.2. Daily routines of working mothers

For working mothers, they have to get up very early in the morning. And they cook their lunch and eat lunch together with their children. Then they send their children to school if the children is attending nursery. After that, they go to work. Normally they came back from work in the early evening. They fetch water for using and might take a bath. They cook dinner after they come back from their work. After they have had their dinner, they go to bed early at night. As most of the houses can not afford to have access to electricity, they sleep as soon as the dark falls. Some mothers go and watch TV at houses where electricity is legally or illegally accessible. Generally they go to bed about 9 o'clock at night.

The most significant difficulties of working mothers concerning their daily routines are that they don't have enough time to take care of their children. They have to work in other places bringing their very young children if they are lactating mothers. Or they leave their children with their relatives or neighbors. Sometimes children have to eat their lunch when they come back from the nursery school before their mothers came back from work. Some mothers who forage food inside the camp bring their children to fishing or collecting mushroom or bamboo shoots. As a result, their children suffer from malaria, respiratory infection or hemorrhagic dengue influenza.

Time Line for working mothers



3.3. Available Services and Materials

Mothers in the camp have access to some NGOs' services for them and their children. They have services for health care, water and sanitation, nursery school, food and nutritional supply and other non food items. Although they can have access to services available for them and their children, it is always a problem to use and have the services provided by international NGOs appropriately and timely. There are also problems for NGOs to adequately provide the services for all of mothers and children in the camp as they have to prioritize the most important assistance to the neediest audience in the camp.

Services available in the camp support mothers in taking care of their children in one way or another. According to some mothers, the services are not even available in their native places. However, they have only limited access to these services especially for health care. Due to lack of skilled staffs and professionals in the camp to provide all necessary services, some services are low in quality. Some services like water and sanitation need certain facilities and the camp environment cannot fulfill necessary infrastructure for these services. Lack of mothers' knowledge and awareness concerning health care and child development also make child care services difficult to be fully effective.

3.3.1. Health care services

The primary health care services providers are the Aide Medicale Internationale (AMI) and the Shoklo Malaria Research Unit (SMRU). AMI hospital is situated in Zone C and SMRU center is situated in Zone B. Most of mothers in Zone B go to SMRU for prenatal and postnatal care. But AMI take responsibility for immunization for children in the whole camp. Only children who are delivered in SMRU are immunized at the hospital for the first round but later course of immunization have to be taken at AMI hospital.

AMI provides Primary Health Cares since mid-2005 in Maela and it is also providing the curative health cares which include: OPD, IPD, and laboratory services, specialized consultations. AMI is providing preventive health cares (demographic data collection, health education, immunizations, growth monitoring and nutrition, post-natal

cares) and water supply to the population. AMI is also organizing various medical trainings for its staff (medics, nurses, lab etc…) and contribute to regular data collection and analysis.

The antenatal clinics of SMRU see new pregnant women in antenatal consultations and 90% of the pregnant women were immunized against tetanus. the majority of pregnant women from Maela camp are seen on a weekly basis. Those who have travelled outside the camp in the previous 2 months get tested for malaria. All cases of malaria were treated according to SMRU protocol. The ANC department of SMRU delivery room has delivered 1753 women with the help of midwives in the previous year.

In the meantime SMRU has continued to provide treatment services in Maela camps and in its clinics for migrants. In its clinics in Maela camp the Chemotherapy department has seen 16,471 patients of which 3,103 were malaria cases for a population of 45,000. This represent a 40% drop when compared to the previous year. The majority of the cases (82%) were in patients who had left the camp area in the previous 2 months and most likely acquired their infection while working outside the camp.

3.3.2. Water and sanitation

AMI is taking care of water supply and a few sanitation programme after Medicins Sans Frontiers (MSF) handed over their programme in 2005. However, from the previous year on, Solidarites took over the responsibility for sanitation programme including hygiene promotion education from AMI. Catholic Office for Emergency Relief and Refugees (COERR) is running waste management and environmental protection called Community Based Waste Management Activity and Environmental Protection Activity Programme.

Solidarites improved access to water and sanitation, and the sanitary conditions in Mae La camp. Solidarites is responsible for sanitation facilities in the Mae La refugee camp including building latrines, distributing hygiene kits, hygiene training, and monitoring epidemics. Solidarites is involved in sanitation in Mae La camp through 4

activities: vector control, latrines construction, drainage construction and hygiene promotion.

3.3.3. Nursery schools

There are altogether 22 nursery schools with 120 teachers, 6 trainers, 3 Managers, 1 Supervisor and 2 KWO teams. There are 7 nursery schools in Zone B and 7 and 8 schools in Zone A and Zone C respectively. In each school, they averagely accept 100 children so there are approximately 700 children of 3 to 5 age group attending in Zone B, and approximately 2200 under 5 children attending in 22 nursery schools at the whole camp.

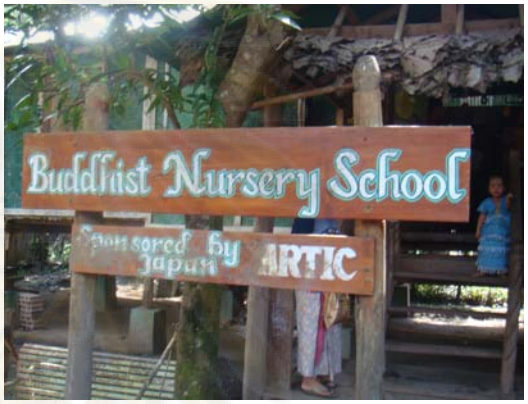
According to the head of one nursery school in Zone B, they have taught Karen and English alphabets, Colors, Shapes, Animals, Fruits, Parts of the body and etc. Although they said they use all languages as medium of instruction, the head of the school interviewed does not understand Burmese language. One of the teachers said, "Although we have time table for daily Activity Lesson Plan, we cannot practice it according to the Lesson Plan. There are a lot of children and we have only 5 teachers to take care of them. We can only teach language alphabet to elder children who are going to school next year."

'TOPS' is main provider for nursery school feeding programme with 3 baht for each children for one meal. They provide teachers' salaries as well. They feed children boiled rice soup or noodle soup or rice and curry. They demand four cups of rice, 10 tickle of edible oil, two cups of lentil, 1 kilo charcoal stick and 22 baht for each of the children from parents. However, all of parents cannot support what the school demand due to their difficulties in insufficient ration. The school head said, "one third of children are from the families who have not received food ration as they are new arrivals. So we have to manage with what we have to feed all children. Some parents provide what they have some months. But they cannot supply every months." ICS provides office materials, play materials and sometimes some building materials.

There is only one Buddhist nursery school in the whole camp located in Zone B. It is supported by ARTIC (Japan) for feeding programme unlike others which are supported by TOPS. It accepts only Buddhist children and teaches Buddhist teachings such as *Mingala sutta* and worshipping. According to the head of the school, they have been discriminated against other nursery schools which are all Christian schools although they are not mentioned so.

Photo: 2. Nursery school supported by TOPS

Photo: 3. Buddhist Nursery School



There is also a 'Special Education' programme for disable children under 5 years old implemented by KWO with assistance from World Education. Trainers from Special Education' programme go to the houses of disabled children and teach, train and practice things appropriate for them. There are 12 disable children in the camp who attending nursery schools and SE teachers go to these nursery schools to train these children. When the schools confront with any problems, Nursery Committee takes responsibility to solve.

Photo: 4. 'SE' trainers visiting disable children's house (Both children are disabled)

3.3.4. Libraries for children

There are libraries for early childhood in the camp mostly attached to the High Schools. Shanti Volunteer Association (SVA) set up libraries and provides assistance and services concerning libraries facilities. Parents from nursery schools are encouraged to hire books for their children from the libraries. However, most of the parents do not know where libraries exist and so do not use the service appropriately for their children.

SVA staff have compiled a series of Karen folk tales and published them as picture books. Moreover, they translated picture books which were published in Japan and overseas into Karen and Burmese. The method SVA used was to write translations on paper, cut them into the appropriate size, and stick them directly on the pages of the book. Other literacy projects include the production of Karen folk tales as picture-story shows. This work is beginning to gain popularity in the camp. SVA produced picture-story shows with the help of some former art teachers and painters in the camp.

3.3.5. Food and Nutritional supply

4.2.5.1. Food rations provided by Thailand Burma Border Consortium[1]

The refugee diet is traditionally rice, salt, and fish paste. Refugees had to supplement it with leaves and roots gathered from the forest, plus any vegetables or livestock that can be cultivated, raised or hunted. For many years the refugees were not entirely dependent on the relief programme for food. Some refugees were also able to get low-paid seasonal work in Thailand, forage in the surrounding forest, keep small kitchen gardens and raise a limited amount of livestock in the camp. At the beginning of the relief programme in 1984, TBBC's aim was to cover only around 50 percent of the staple diet needs. At this level life in the camps remained simple and poor, but not inconsistent with standards in their former villages, or in Thai villages in the area.

Over the years, the refugee camps became subject to tighter controls by the Thai authorities and it became increasingly difficult for the refugees to be self-sufficient. Rations were gradually increased and by the mid-1990's it had become necessary to

[1] TBBC. Food Security Programme: food, nutrition and agriculture. Retrieved from the TBBC website: http://www.tbbc.org/whatwedo/whatwedo.htm#food (14 October, 2007)

supply 100 percent of staple diet needs; rice, salt and fish paste. During 1997 even stricter controls were placed on the camps for security reasons and, in some cases, it became impossible for refugees to leave the camps to forage or get work.

TBBC rations were providing a minimum of 2,100 Kcal per person per day based on an average family, with no differentiation for age. The TBBC food basket was still designed to cover only the basic energy and protein needs of the refugees and did not ensure adequate provision of many important micronutrients. Refugees supplemented TBBC rations by buying, bartering, growing or foraging to make up for any other needs. But as the refugees became more aid-dependent, some segments of the population are at risk for deficiencies.

In 2001/2 TBBC conducted food consumption/ nutrition status surveys in two camps and rapid nutrition surveys in three other camps. The results showed quite consistently that the ration provided was proportionately too high in carbohydrates at the expense of protein and fat, and low in many micronutrients. It was concluded that the refugees were not able to adequately supplement the TBBC ration with other foods to compensate and were much more dependent on the TBBC ration food than was previously assumed.

Beginning in January 2004, TBBC revised the food basket to include 1.4 kg fortified blended food/ refugee/ month (no differentiation for children <5) whilst reducing the rice ration to 15 kgs/ adult/ month. The revised food basket is:

Table: 5. Ration distributed to refugees per month

Rice	15 kg/adult; 7.5 kg/child <5 years
Fortified Flour	1 kg/person
Fish Paste	0.75 kg/person
Iodised Salt	0.33 kg/person
Mung Beans	1 kg/adult; 0.5 kg/child < 5 years
Cooking Oil	1 ltr/adult; 0.5 ltr / child < 5 years
Dried Chillies	0.125 kg/person
Sugar	0.25 kg/person

Source: TBBC

3.3.5.2. Supplementary feeding

TBBC provide budget for the health agencies' supplementary feeding programmes for five vulnerable groups: malnourished children; pregnant and lactating women; tuberculosis and HIV patients; patients with chronic conditions; and hospital in-patients, which included rice, eggs, dried fish, beans, sugar, milk powder (to severely malnourished children only), vegetable oil, fresh fruits and vegetables.

From late 2000, the TBBC nutritionist worked with the health agencies to follow up on the recommendations. The majority of the health agencies phased out wet feeding centres for malnourished children and integrated the programmes into their reproductive health activities. More comprehensive reporting forms and standardized entrance and exit criteria were introduced and standardized feeding protocols were encouraged according to MSF and WHO guidelines.

However, the 2003 ECHO evaluation uncovered inconsistencies in feeding protocols and implementation, and found that most agencies had not fully adopted the TBBC guidelines. The following recommendations were made:

- Feeding protocols (for women and children) needed to be revised and standardized to fully adopt international recommendations for supplementary feeding programmes.
- TBBC and health agencies should phase out current foods and introduce a blended food mix as the supplementary feeding.
- Supplementary Feeding Programmes of health agencies should report nutritional impact using objectively verifiable indicators.
- Reliable growth monitoring of children <3 needed to be set up by all health agencies.

In 2004 the TBBC nutritionist initiated a working group, the Nutrition Task Force (NTF), made up of representatives from TBBC and all health agencies. The NTF first met in July 2004 to strategize on the implementation of the ECHO recommendations. The Centres for Disease Control, Atlanta, (CDC) sent a nutritionist from their International

Health Branch for four months at the beginning of 2005 to work with the TBBC nutritionist in implementing some of the changes and providing training and technical assistance to the health agencies. All agencies had fully implemented new guidelines and protocols by mid-2005. The TBBC nutritionist now conducts refresher training and ongoing technical support annually.

3.3.6. Other non food supply

The other supplied materials are cooking fuel like firewood, cooking stoves, cooking utensils such as a pot or wok, building materials like bamboo, clothing, bed nets and sleeping mats. The average fuel ration for the refugee family is from 7.1 to 7.9 kg/ person/ month. Beginning in 1995, World Concern and Lutheran World Relief (LWR) started sending shipments of used clothing, sweaters and quilts. The Shanti Volunteer Association (SVA) became a major source of good quality jackets/ sweaters from Japan. Unfortunately SVA had to discontinue this project after 2003 but LWR continue to supply used clothing annually and for 2007. The Wakachiai project, a Japanese NGO, sent a consignment of 40,000 clothing items. Used clothing is not available for young children and since 2004 TBBC has purchased one clothing-set for all under-fives.

With malaria and respiratory diseases being major health problems, bed nets and blankets are essential relief items. They have to be supplied and replaced on a regular basis because they wear out rapidly due to heavy use and the rough conditions in crowded bamboo houses. Major distributions are made once each year.

Insecticide-treated nets were introduced in 1997 following recommendations made by the Shoklo Malaria Research Unit (SMRU) and the CCSDPT Health Subcommittee. Malaria transmission rates in the camps then fell dramatically and all camps have since been supplied with non-impregnated nets.

Sleeping mats were formally supplied by TBBC only when requested by the Refugee Committees. The normal distribution rate has been one blanket for every two refugees, one family size bed net and one sleeping mat per three persons. In 2007, TBBC

matched household needs for bed nets and sleeping mats by distributing double and family size items.

3.4. New arrivals and the problems of insufficient supply

Although a large number of people from the camp resettle in the third countries every year, the camp is still full of new arrivals coming from Burma due to several reasons. As a result, food rations become problem in the camp for TBBC which is the main provider for food and nutritional supply. According to some mothers, one third of the camp members are not registered. Although new arrivals have been registered, they are not issued food ration immediately after being registered. The most vulnerable people to that reduced food ration are children under 5 as they need nutrition for their growth and development. Mothers have to struggle more to feed their children with several means some of which force them to work outside the camp leaving their children unattended.

The refugee diet is traditionally rice, salt, and fish paste. Refugees had to supplement it with leaves and roots gathered from the forest, plus any vegetables or livestock that can be cultivated, raised or hunted. On June 2, 2008, 11 ethnic groups based in border areas made an appeal to the international community to immediately grant necessary funding to enable the Thailand Burma Border Consortium to continue providing sufficient food rations to refugees along the border. The lives of over 140,000 refugees are at stake. They appeal in their letter,

> "We urge international donors to respond immediately to this crisis and prevent another unnecessary catastrophe."

Jack Dunford from the Thailand Burma Border Consortium (TBBC) warned,

> "This would have a very destabilising affect on the camps and within a couple of months we could expect to see significant increases in malnutrition. The protective community structures afforded by the camps would be undermined and refugees forced to supplement their food by leaving the camps at considerable risk of abuse and exploitation"

Again on June 11, 2008, KWO and KNWO, together with WEAVE, TOPS and EWOB issued an Emergency Supplementary Feeding Joint Advocacy Letter in which they expressed;

> "Currently, the children at the nursery schools bring their own rice to add to the supplementary feeding program, however due to increased cuts by TBBC on rations, this may soon be impossible. Due to the funding crisis, TBBC rations will have to be reduced to half the international minimum standard of 2,100 kcals/ person/ day from August. Therefore, it will become even more important to secure funding for the supplementary feeding program to meet the basic nutritional requirements of the children."

Photo: 5. Refugees from Mae La camp demonstrating in Mae Sot in July, 2008

TBBC rations were providing a minimum of 2,100 Kcal per person per day based on an average family, with no differentiation for age. If the ration is cut for supplementary feeding, there will be a high risk of malnutrition among children especially under 5 year old.

In 2001/2 TBBC conducted food consumption/ nutrition status surveys in two camps and rapid nutrition surveys in three other camps. The results showed quite consistently that the ration provided was proportionately too high in carbohydrates at the expense of protein and fat, and low in many micronutrients. It was concluded that the refugees were not able to adequately supplement the TBBC ration with other foods to

compensate and were much more dependent on the TBBC ration food than was previously assumed.

According to UNHCR's 2006 Standard and Indicators Report, which is based on data collected by NGO's in the camps, the rate of malnutrition in one of the camps among boys 6-59 months old currently stands at 6% while among the girls it amounts to 4%. The standard should be lower than 5%. The same report indicates very high malnutrition rate – of more than 9% - among children in the new refugee arrivals group. Children in nursery schools should receive daily meals to maintain a basic healthy nutrition.

CHAPTER IV

CURRENT CHILD CARE PRATICES

Major difficulties facing mothers in the camp can be studied through current child care practices. These practices are studied through in-depth interviews with mothers mainly regarding personal hygiene, toilet training and children waste management, health care practices and prenatal care practices. This chapter focuses upon the current child care practices, how mothers have been struggling with these practices and what kind of difficulties they have in taking care of their children.

This chapter also provides information regarding religious and socio-cultural determinants which influence the child's long term cognitive and social development, and how they are related to mothers' daily struggles. By observing religious and socio-cultural determinants such as religions of mothers, languages, generation gap in child care practices and hope of mothers for their children, some difficulties of mothers can be distinguished. And it also describe how mothers encourage or discourage children's social skills and what kind of difficulties mothers are facing concerning socialization skills for the children. Socialization practices are also studied to highlight verbal interaction and communication with children, playing with children, going out with children and disciplining the children.

4.1. Feeding practices

4.1.1. Breastfeeding

Most of mothers in the camp breastfeed their children up to over one year old generally. Some mothers breastfeed up to over two years old. They said it is traditional to breastfeed their children till they are no longer willing to be fed. But some mothers can not breastfeed after they give birth to a younger one. But in most of the cases, mothers still breastfeeding both of their children unless the second last child is not much older. Although they don't know how children should be breastfed systematically, their way of breastfeeding is rather systematic. They breastfeed their children whenever children want

all the time. Even though they are working, they take their children and breastfeed in work place.

"I took my children to my workplace at rice field. I placed my children at a hut near rice field with older sibling then I went there and breastfed while working."

A working mother who works at a rice plantation

They breastfeed their children exclusively up to six or more months old. When asked whether they know how long children should be breastfed, they don't know the technique, but they just breastfeed them till children demand other supplementary food. Only some mothers who is sick when giving birth seek other alternative like gruel or canned condensed milk. Only one mother knows how long she should breastfeed her children, as she used to work in a well off family in Bangkok as a house maid. She has read some information in leaflet at that house.

Daw……., 42 year old mother of three children said;

"I used to work in a rich Thai family in Bangkok as a maid. I had to give care to three babies. I felt very disappointed but I know how to take care of the children. I knew I would have to breastfeed the children exclusively. And I said myself that, I would take care of my children my best in my turn when I had chance of having children."

However, some mothers breastfeed their children up to over one year old exclusively. One of the reasons is that they cannot prepare separate food for their infants. They do not have other special food for their children to feed as supplementary food.

4.1.2. Supplementary Feeding

They start to feed supplementary food in addition to the breast milk when the children is around six or more months old. They feed their children rice crushed by hand. Most of mothers do not add edible oil to their food for children. However some mothers feed their children nutritional packet which they call '*hta min buu*' which literally means lunch box in Burmese, sold at the market or distributed by an NGO.

Supplementary feeding is traditionally prepared and fed. Vegetable, oil and quality protein such as fish or animal meat are rare items in their daily food intakes. For many years the health agencies ran supplementary feeding programmes for five vulnerable groups:

- Malnourished children
- Pregnant and lactating women
- Tuberculosis and HIV patients
- Patients with chronic conditions
- Hospital in-patients.

The budget for ingredients was provided by TBBC which included rice, eggs, dried fish, beans, sugar, milk powder (to severely malnourished children only), vegetable oil, fresh fruits and vegetables.

4.1.3. Feeding and Nutrition

Most of the food they feed the children is what they daily eat. Their daily food items are supported by TBBC which provides all refugees in camps along the border with a monthly food ration. According to TBBC, the current monthly ration provides an average 2,230 kcal / person / day as follows:

Table 6. Food Ration (per month)

Rice	15kg /adult. 7.5kg /child <5 years
Fortified Flour	1 kg / person
Mung Beans	1 kg / adult. 750 gm / child < 5 years
Cooking Oil	1 lt / adult. 500 ml / child < 5 years
Fish Paste	750 gm / person
Iodised Salt	330 gm / person
Dried Chillies	125 gm / person
Sugar	250 gm /

Source: TBBC

Quantity and quality of food basket seem to be sufficient for short term situations. However, refugees living in camps for extended periods assumed to have the ability to

supplement food baskets with non-ration items. However, energy intake made up of 84 percent of carbohydrate, 9 percent protein and 7 percent fat. Average household energy and protein intake was adequate Low intake of vitamins A, B1, B2 and C, and calcium. Intake of iron was reasonable. It is recommended that energy intake consist of 55-65% carbohydrate, 10-55 protein (50 percent from animal sources), and 25-30 % fat[1]. Food insecurity is defined as 'the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways'.[2] Newly arrived refugees may have endured food deprivation, suboptimal nutrition and nutritional deficiencies (vitamins and minerals). And adapting to new environment may lead to difficulties in locating markets or supermarkets to obtain traditional foods or substitutes and reduced capacity to adhere to traditional diet and/or insufficient food in take[3].

According to a dietary assessment of refugees living in Mae La camp, nutritional status measurements of 178 refugee children aged 0 to 4.9 years revealed that 33.7% were underweight, 36.4% were stunted, and 8.7% were wasted. In comparison, the prevalence of malnutrition among Thai children under five years of age, reported in 1996 and based on the NCHS standard was 18.6% underweight, 16.0% stunted, and 5.9% wasted[4].

---

[1] Banjong, O., Menefee, A., Sranacharoenpong, K., Chittchang, U., Eg-kantrong, P., Boonpraderm, A. and Tamachotipong, S. Dietary assessment of refugees living in camps: A case study of Mae La Camp, Thailand. Food and Nutrition Bulletin. Vol. 24 (4): (2005) : 360-367.

[2] Quandt, S. A., Arcury, T. A., McDonald, J., Bell, R.A and Vitolins, M. Z. Meaning and Management of Food Security Among Rural Elders. Journal of Applied Gerontology. Vol. 20 (3) (2001) : 356-376.

[3] The Victorian Foundation for Survivors of Torture. Easing the Transition. Melbourne; 2000. Retreived from the website: http://www.foundationhouse.com.au/publications.php (25 March, 2008)

[4] Kitvorapat V, Chaolilitkul N, Sinawant S, Wanarat L. Sample survey of the nutrition situation among under fives in Thailand. Thailand Journal of Health Promotion and Environmental Health 19 (10) (1996) : 56-66.

Based on WHO-endorsed criteria for identifying the severity of malnutrition among children in refugee populations, children were classified as malnourished if their weight-for-height scores fell below 70% to 80% of the NCHS reference population. The prevalence of severe and moderate wasting were 0.6% and 4.1% respectively. (See table 5)

Although mothers can buy some non-ration foods by foraging, planting trees and vegetables, raising animals, or exchanging ration foods for other items, the quantity and quality are not sufficient to compensate for the nutrients that were low or lacking in the ration. Foods were also purchased from the markets in the camp, but the house-holds had very weak purchasing power, as evidenced by their low monthly food expenditures.

Table 7. Children aged 0 to 5 years within weight-for-height (W/H) cutoffs as compared with WHO/NCHS reference standard % median (percentage of children who fall below 70% and 80% of the median weight of children from the WHO/NCHS reference population of the same length or height)

Age (yr)	No. of children	Children within NCHS W/H cutoffs					
		Severe wasting (<70% of median)		Moderate wasting (70%-80%of median)		Normal (>80% of median)	
		%	*n*	%	*n*	%	*n*
<1	24	0	0	4.2	1	95.8	23
1-1.9	47	0	0	4.2	2	95.7	45
2-4.9	101	1	1	4	4	95	96
Total	172	0.6	1	4.1	7	95.3	164

Table 8. Children aged 0-18 years malnourished according to the criteria weight-for-age (W/A), height-for-age (H/A), and weight-for-height (W/H) as compared with NCHS reference standard -2 SD (1983, mean +SD)[5]

Criterion and age	Children below cutoffs for W/A, H/A, and W/H (< -2 SD)					
	Boys		Girls		Total	
	%	*n/N*	*%*	*n/N*	*%*	*n/N*
W/A						
0-4.9 yr	33.3	30/90	34.1	30/88	33.7	60/178
5-9.9 yr	42.5	31/37	40.2	37/39	41.2	68/165
H/A						
0-4.9 yr	33	29/88	40.0	34/85	36.4	63/173
5-9.9 yr	62.2	46/74	61.1	55/90	61.6	101/164
W/H						
0-4.9 yr	10.3	9/87.	7.1	6/85.	8.7	15/172
5-9.99	2.7	2/73.	1.1	1/90.	1.8	3/163

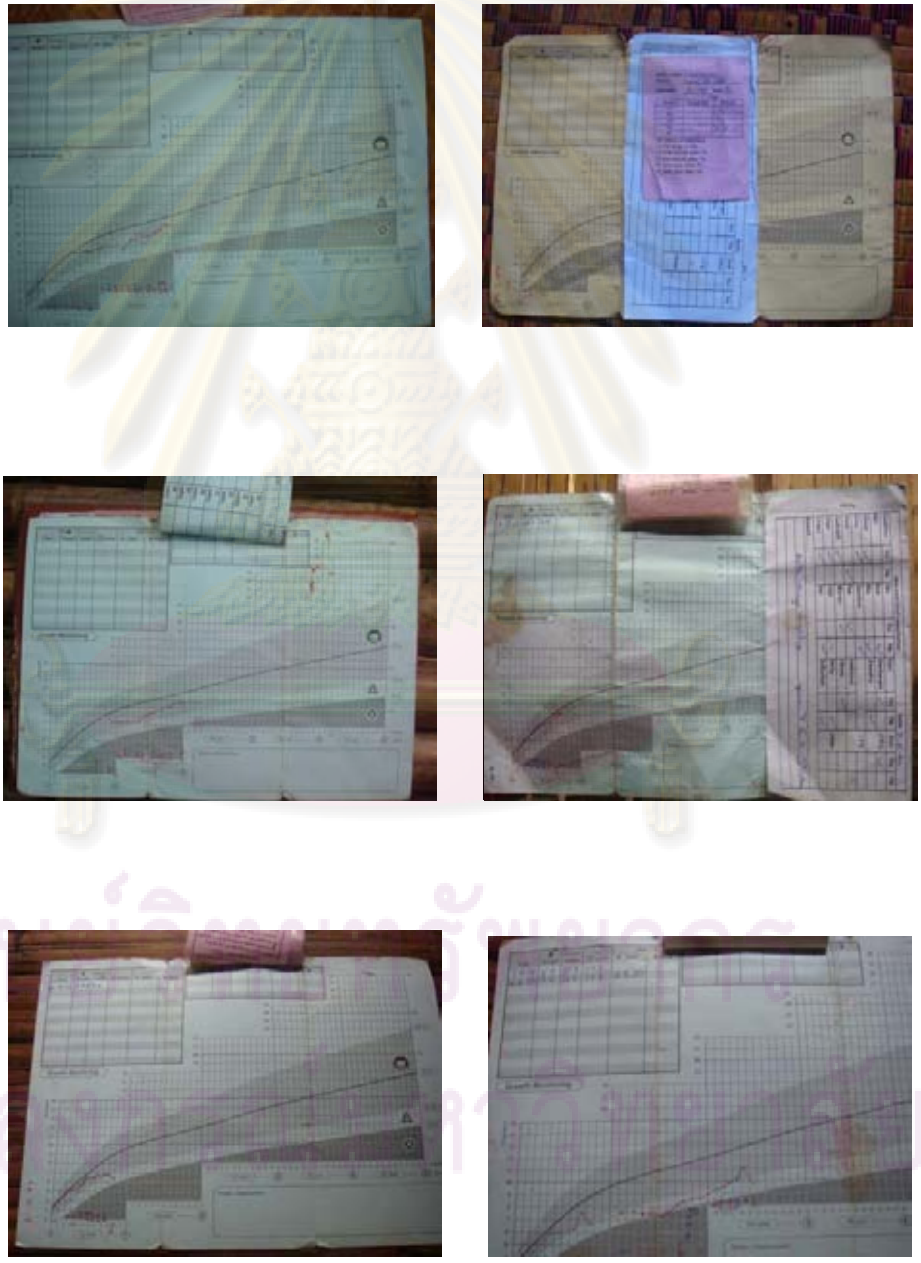
4.1.4. Malnourishment of children

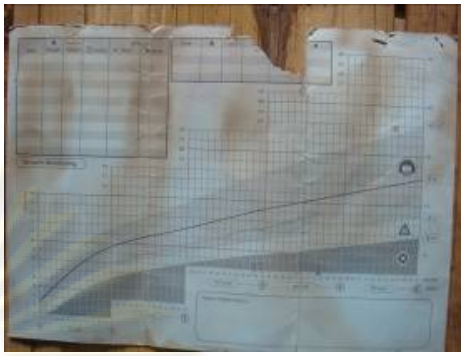
According to the dietary assessment of refugees living in camps mentioned above, only 4.1 percent of the children in the camp are moderate wasting and only 0.4 percent of the children are severely wasting. But by observing children's growth monitoring charts, it is found that most of the children of mothers interviewed are somewhat malnourished. Growth charts are an important tool for monitoring children's development, but they are just one of the tools used to ensure a child is growing and developing normally. The percentile curve on the chart represents what percentages of children are of the same height or weight. Children that are small with a normal growth velocity will have their own growth curve on the charts that runs below, but is still parallel to the percentile curve.

[5] Orapin Banjong, Andrea Menefee, Kitti Sranacharoenpong, Uraiporn Chittchang, Pasamai Eg-kantrong, Atitada Boonpraderm, and Sopa Tamachotipong. Dietary assessment of refugees living in camps: A case study of Mae La Camp. Food and Nutrition Bulletin. vol. 24 (4) (January, 2003) : 26-29.

In the growth charts observed in the camp, it showed children' growth lines are mostly under a normal progress line (percentile curve). According to their daily food intake, it also supports the fact that they can be wasting or stunting. Without any follow up action although growth charts are recorded, these malnutrition cannot be examined or investigated systematically.

Photo: 6. Immunization and growth monitoring charts





4.2. Hygiene and personal hygiene practices

Hygiene and personal hygiene practices in the camp situation can be considered as weak and inappropriate. Mothers are primarily responsible for health seeking practices for children as they are managing water both for drinking and using, feeding, toileting, children waste management, sleeping with mosquito net.

4.2.1. Water for drinking

Most of the mothers in the camp use boiled water for drinking. They use the water from deep water well to boil it. But according to some key informants from SMRU and Soliderites, some mothers drink water from deep water well without boiling especially when they are not free to do so. The water from these well are not recommended for drinking. Mothers who can afford buy purified drinking water and drink it. Most of mothers use only one cup system although the NGO Soliderites educates people to use two cups system for drinking water[6]. They use earthen water pot or plastic water pot with only one cup put on the cover of water pot.

[6] Two cups system is promoted by Soliderites by educating people to use two cups; one cup is for family members and another cup is for guests and other people.

Photo: 7&8. Plastic drinking water pot with only one cup can be seen in above pictures.

4.2.2. Water for using

Mothers use water from deep water well with hand pump. Main water sources are obtained from spring, river tapping, boring and well digging. Most of the mothers use water well for using water. They are equipped with hand pump and regularly chlorinated. They washed their clothes including clothes for children at water well. Some mothers wash their children's cloth at small streams which is not clean and polluted with child and animal's feces.

Photo: 9. Children take bath at water well Photo: 10. A child is urinating at water well

Photo: 11 Rubbish heap at the middle of a stream

.

4.2.3. Personal hygiene

Although water is not difficult to fetch up, mothers who are busy with their works or working mothers can not take care of their children's personal hygiene. Most of the children use their hand to eat food when they are at the age of ability to do so. And mothers do not manage water for children to wash their hands after using latrine.

Young children take bath at least once a day where as some children twice a day. Most of young children are taken bath by their mothers where as older children take their bath by themselves. They use soap for cleaning while taking bath. Most of the young children under 2 years old do not use tooth brushes and tooth paste while washing their faces in the early morning. Even older children under five do not brush their teeth both before going to bed and after getting up from bed. Some mothers said that they are afraid their children will swallow the waster with tooth paste after brushing tooth. Mothers who can afford buy tooth brushes and tooth paste for their children but most of them use salt for tooth brushing even for themselves.

4.2.4. Personal Hygiene for Feeding

Mother feed their children who is younger than 2 year old but let them feed themselves when they are able to do so. Older children (2 to 5 year old) use their hands to feed themselves. Normally, they do not wash their hands with soup before eating food.

Children know how to buy snacks from small snack shops and eat them with their hands also. Ice tubes are among them and the most favorite item for children.

Photo: 12. A girl feeding with her hands

3.2.2.5. Toilet training and children waste management

Most of the children are not properly trained for how to use toilets. For younger children, mothers use small plastic toilet pot for defecating. However, mothers have to take care of cleaning after toileting for younger children who can use toilets. There are still children who defecate on the ground or at a stream. Mothers dispose of their children waste at stream or at latrine.

Photo: 13.

A child is defecating on the ground

Photo: 14.

A child is defecating in the stream

Mothers cannot systematically manage to dispose of their children waste. According to a key informant from Soliderites said "although we educate people how to systematically dispose of their children waste, they cannot do it properly so far. They listened when 'hygiene promoters' [7] explain how to manage it, but they don't really practice it." Most of the toilets are built by themselves with bamboo and thatches roofing. Water system is used for their toilets which are located separately from their houses. Some people still use bamboo stick for cleaning in stead of water after using toilets.

4.3. Health care practices

4.3.1. Accidents prevention practices

During home visits and study their environment, mothers are aware of very unsafe environment their children live in. Sometimes, mothers have to work outside and leave their children in the care of a young inexperienced older sibling, or leave them at home and ask a neighbor to keep an eye on them. At their home, they take some preventive measures by blocking entry of the house with bamboo bars. Most of mothers have experienced at least one of their children fall down from their houses as their houses are tall ones.

Photo: 15&16 Houses with blocked bamboo bars

[7] Hygiene promoters are home visitors from the NGO 'Soliderites" which changed the name of home visitors to differentiate from 'home visitors' from AMI (Aide Medicale Internationale) which is working for mainly medical assistance for Burmese refugees living in the camps.

4.3.2. Minor injuries suffered by younger children and their treatment

Most of the minor injuries suffered are bruises falling from the platform bed, falling through holes in the house or from the houses. Mothers interviewed did not mention any bites from dogs or snakes. Only one mother mentioned cut from floor bamboo slat on hands. Although their houses are small and narrow, they do not mention burns from kitchen or hot water. The reason might be that they always eat as soon as they have cooked their meals. Cuts are treated by pressing the lips of the cut together and applying turmeric powder. For bruises and insect bites mothers usually leave their children uncured and if serious, go to the hospital.

4.3.3. Minor illnesses and their home based treatment

Most common ailments are treated with folk medicine at home if it is not serious. The most common illnesses described by mothers are diarrhea, flu, fever, cough and common colds, skin diseases, measles, jaundice, malaria and dengue hemorrhagic fever. Only one mother mentioned malaria as her child's illnesses. However, there are still 195 malaria positive cases among under-5 population according to SMRU statistics. (See table 6)

The most common one is diarrhea and almost every mother has experienced diarrhea in their children's young ages. They describe polio vaccines as one of the causes of diarrhea affected to all children after immunizing. However, asked about it to key informant (medical assistant) from SMRU, the real cause of the diarrhea at that time was water. He said, "*People thought the cause for diarrhea at that time was polio vaccine as most of the children had to be hospitalized during those days. But, when a water test was made to explore the causes, it was reported that the real cause for it was the water because diarrhea is water borne disease."* Mothers usually neglect diarrhea as they assumed that it will be cured automatically as time passed. Only when their children are not getting better, they seek outside help by going to the hospital.

Table 9. Malaria Cases by Age Group and Sex (2007) (Mae La camp)

Malaria Cases	Age Group						Total
	<5 year		5-15 year		>15 year		
	M	F	M	F	M	F	
Total Positive	112	79	664	295	1673	594	3417

Source: SMRU Mae La Annual Report (Oct-06-Sep-07)

Another common illness is respiratory infection. Mothers mentioned respiratory infection as flu, fever, cough and common colds. Their home based treatment vary from Thai medicine *'Yaa Htan Chai'* according to their pronunciation to some medicines from road side shops such as Paracetemol, Amoxicillin or Burmeton and to traditional Burmese medicine.

When asked how to treat children with these modern medicine, a mother said, "*I let him take paracetemol half tablet if he has fever, sometimes one Amoxicillin capsule. If not get better, I give him another one capsule of Amoxicillin."* A grand mother said she treats her grand children with paracetemol when they have fever, she said, "*I paid one third of paracetemol tablet if the child is young and half tablet if the child is older."*

Another common medicine is mixture of *Chan Aye, Shwe Kyar and Say Pankar*[8] which are traditional Burmese medicines. Theses medicine can be bought easily from road side grocery shops. Some mothers expressed the look of medicines but cannot describe the name of medicines. Asked about the condition of their children after treating with their own medicines, they said their children get better because of their medicine.

[8] They call *Say Pankar* which literally means 'fan medicine' as the trademark 'a fan' is embedded on the cover of the sachet.

Photo: 17 *Yaa Htan Chai* (Thai medicine)

Photo: 18. Three in one indigenous medicine

Table 10. Respiratory infections report: SMRU Mae La camp: July 2007-September 2007

Month	Age	Upper Respiratory	Lower Respiratory	Pneumonia (n)	Hospital ization	Total
Oct-07	< 1 year	82	31	15	3	128
	1-4 years	3	4	4	1	11
Aug-07	< 1 year	102	50	28	9	180
	1-4 years	3	4	2	0	9
Sep-07	< 1 year	144	107	66	7	317
	1-4 years	6	5	5	0	16
Total		340	201	120	20	661

Source: SMRU Mae La Annual Report (Oct-06-Sep-07)

4.3.4. Sleeping with mosquito nets

Younger children sleep both at day time and night time with mosquito nets provided by some NGOs. But for older children (above 2 years old) do not sleep with mosquito nets at day time even at nursery schools. Most of the mothers are not sleeping with mosquito nets at night time. And most of them do not know relation with mosquito bites with malaria or hemorrhagic dengue influenza.

4.3.5. Prenatal care practices

Most of the pregnant women go to ANC (Antenatal Clinic) of the SMRU (Shoklo Malaria Research Unit) which is also taking care of pregnant women, child delivery and

post natal care for both mothers and children. One of the key informants who is also working as voluntary midwife said that some pregnant women do not want to go to ANC as they are afraid of Caesarean section. Therefore some mothers give birth with the help of birth attendant or volunteer midwife. However, there is no maternal death during delivery.

According to key informant from SMRU, the most common problem for those who delivered children with the help of midwife is not during the delivery but septic problem after the delivery. They cut umbilical cord with non sterilized cutter and as a result, naval is septic and infected. It can also cause postnatal jaundice. He said, *"The baby turns yellow all over the body then we know the baby is septic in naval point. It is fatal and two or three children have died of that septic."*

Photo: 19. A certificate of a traditional birth attendant who is now over 80 year old.

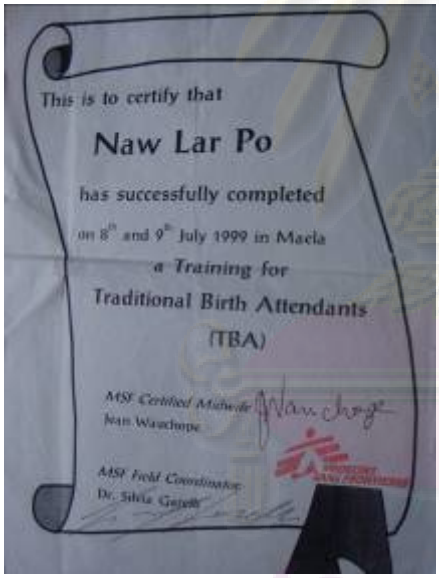


Photo: 20. Naw Lar Po, a traditional birth attendant and the researcher (below)

And he said,

"Our ANC department in Mae La has seen 2083 new pregnant women in antenatal consultations. This represents almost 90% of all pregnant women in the camp. 90% of the pregnant women were fully immunized against tetanus. Less than 5% of the women tested had a Middle Upper Arm Circumference (MUAC)[9] under 21 cm. Our delivery room has been fully functional and the midwives delivered 1753 women."

[9] (the cut-off of entering the supplementary ration program)

Table 11. Outcome of pregnancy and weight in Mae La camp 2007 (ANC - SMRU)

		Outcome of pregnancy				Weight					
		alive	stillbirth	abortions	Caesarean section	< 1.5kg	>=1.5 to <2.5kg	Low Birth Weight %	>= 2.5 kg	un-known	Total
Mae La	Singleton Delivery	1465	17	265	59	18	210	15%	1241	13	1482
	Multiple Delivery	6	0	0	0	0	5	83%	1	0	6
Mae La Resident	Singleton Delivery	1416	17	244	45	18	206	16%	1197	12	1433
	Multiple Delivery	4	0	0	0	0	3	75%	1	1	4

Source: SMRU Mae La Annual Report (Oct-06-Sep-07)

Table 12. ANC's data on consultation (SMRU)

camp	Register	present	absent	new	Anemia (%)	Consultation
Mae La	11154	9092	2062	2083	12.0	36532
Mae La Resident	10745	8281	2464	1973	12.0	35974

Source: SMRU Mae La Annual Report (Oct-06-Sep-07)

Table 13. Mental death and Tetanus

camp	Maternal death	Defaulters	Tetanus (%)
Mae La	0	256	90
Mae La Resident	0	201	91

Source: SMRU Mae La Annual Report (Oct-06-Sep-07)

Table 14. Middle Upper Arm Circumference

	MUAC	Registered	New	Outcome	Defaulter
Mae La	< 21	537	92	88	10
	≥ 21	10546	1984	1657	245
Mae La Resident	< 21	525	87	84	8
	≥ 21	10152	1881	1590	192

Source: SMRU Mae La Annual Report (Oct-06-Sep-07)

Keys

- ANC: Antenatal Clinic
- Registered: Total registered last week of month (lab list)
- Present: At least one attendance in the month
- Absent: No attendance in the month
- New: First ANC attendance for this pregnancy
- Anemia: % of women with hct <30% at least once in the month
- Consultation: Total consultations in the month
- Tetanus: No. of delivered women who have >=T3 completed.
- Defaulters: Lost/move/go to work/Not pregnant.
- MUAC: Middle Upper Arm Circumference

4.3.6. Seeking outside help

Most mothers seek help for their children's health by going to the hospital. There are two hospitals for Zone B dwellers to visit for their children's health problem. SMRU is for prenatal and postnatal care for both mothers and children till the children is 9 months old. As SMRU is special unit for malaria, either mothers or children who have been positive have to remain consulting with SMRU. Mothers have to go to AMI (Aide Medicale Internationale) hospital which is located in Zone C for immunizations, weighing and other consultations for diseases happened in children. Home visitors from AMI hospital visit mothers and educate them concerning child care and health seeking practices. They also warn in advance of the date for young babies to be immunized on time.

One of key informants from AMI said, *"Mothers are not aware of the importance of immunizations. They are afraid of visiting to the hospital so we have to encourage them to come to the hospital. But some mothers who are working outside the camp in plantation are not able to visit even for immunization."*

4.4. Religious and socio-cultural determinants

4.4.1. Religions of mothers

Most of the mothers in Zone B are Christians. Buddhists are second majority but no Karen mothers who worship Islam. In Christianity, majority is Baptists and the rest are Seventh Day Adventist. They have their own churches and usually attached with schools. There are those who worship animism too. They are not devout their religion. And they do not go to religious institutions such as church or monastery. When asked about religious rituals, most of mothers do not practice them regularly. They do not teach their children about religious rituals. They do not go to church or monastery with their children regularly. The main reason they expressed is that it is the rainy season and most of the church or monastery are situated on the hill so the way to these place are too muddy and slippery for children to walk up.

4.4.2. Languages

There are two main languages among them; Sgaw and Poe Karen. They call *'shaung*' for Sgaw and *'pha long'* for Poe Karen. In easy way of distinguishing, *"shaung'* is hill tribe Karen (living in hilly frontier areas of Burma) and '*pha long'* as ground Karen (living in main land of Burma). Two languages are different in usages and vocabulary but according to a Poe Karen mother, they can understand and speak Sgaw Karen in short time. Mothers speak their own language to their children. Most of mothers can understand Burmese a little but can not speak it. Children cannot speak or understand Burmese at all. Only when they attend school, Burmese is taught and introduced.

Mothers do not know Thai language well, too. Thai language is very rarely used in the camp except in schools including nursery schools. Another dominant language among Karen community is English language. However, English also is nothing related to mothers in the camp. Only Karen language, Sgaw or Poe is the principal tool for communicating with Karen mothers and children.

One mother interviewed is totally ignorant of Burmese language as their origin is in the Thai soil on hilly region, but they understand *'shaung'* language. Her husband who is *'shaung'* Karen interpreted for her to speak with the interpreter. Most of husbands of mothers interviewed can speak Burmese well in contrast to their wives who can just understand a little bit but not be able to speak Burmese. The reason they describe is husbands are working outside or able to attend school in their place of origin than wives in their younger ages.

Due to limited access to many places, children are not exposed to out side world. As a result, children do not know things like train, ship or airplane. A mother said, *"One day my son told me that he saw a very big goad near market. The next day, when we went to the market, he pointed me to a cow. Even then, I understand that he meant a cow. Then I explained him that it is a cow not a big goat."*

4.4.3. Generation gap in child care practices

Grandmothers are worried about grand children for their future. According to a grand mother, the children of today are much different from their age especially in the camp. They said they can admonish their children about 30 years ago but the children of

today are totally different from them. A grandmother said, *"They are difficult to talk with (nar kauk tal)*[10]*. When we take care of our children, they can be easily admonished. But now they can do whatever they want. They ask pocket money from every body, even from the foreigners. And they know how to buy snacks even though they are 4 or 5 years old. They go to video parlor and watch movies."*

Due to the discrepancies between the two generations, grandmothers are helpless in taking care of their grandchildren with their old models. As grandmothers have not encountered modern utilities and services, they protest their children not to follow the models of present age which makes mothers difficult to adjust old and new model of child care practices.

A grandmother said, "I do not force them or admonish them to do or not to do. They know by their experience. If I tell them not to touch fire, they never listen to me till they know the fire is hot by their own experience. So I just let them do it and watch it."

Mothers cannot convince their mothers or fathers who believe in traditional practices, especially in health seeking practices. For example, they don't believe in modern or western medicine so they never agree to send their children to be hospitalized.

4.4.4. Hope of mothers for their children

Most of mothers do not have special expectation for their children. They said they want their children to be *thra* or *thra mu* [teacher (male) or teacher (female)]. They want their children to be educated. Some mothers said they do not know what they want their children to be; they will be on their own. Family who are under process of resettlement program to go and live in third country, describe their main reason of education or good future for their children. In some cases, husbands want to resettle in third country but wives do not want to go.

A mother said, *"I don't want to go abroad. But my children have no future in this camp. And we cannot work properly in this camp. So I we go abroad, at least our children will have a good education. We can rely on them in the future."*

[10]*'nar kauk tal'* literally means that the ear is not straight but crooked so that what ever told to them cannot be reached inside their ears.

A grand mother said, *"I don't want my grand children go abroad. My daughter wants to go abroad, but I ask her not to go as long as I live. And she also told me that her children will die in other country for they will long for me very much."*

Some mothers describe their expectation by naming their children with meaningful and beautiful names. A mother called her first child as "E` Kaw Mu (May be peaceful), E` Khee Lar Phaw (May wishes be fulfilled), and E` Htoo Lay Phaw (May love the country). A mother named her last child as 'Ak Ka Luu Soe' which means 'patriot'.

4.5. Socialization practices

4.5.1. Verbal interaction and communication with children

Most of mothers do not talk much to their children. They sometimes answer children's questions. Most mothers sing songs or rhymes to their children. They love singing songs and sometimes even dance with their children. However, most of mothers do not tell story before sleeping or at day time. Only two mothers out of 25 mother interviewed answered yes to question story telling. They said children even sing them songs or tell them story when they come back from nursery school.

4.5.2. Playing with children

Most of the mothers do not play with their children. Some mothers play with their children when they children are very young, but they no longer play with them when children get older. A mother said, *"She plays alone herself or with her cousin. I cannot play with her as I am working. But sometimes we play together on bed with our pillows and blankets as we have no materials to play with."*

Most parents interviewed during home visits do not teach much about traditional games they used to play when they are young. There is no play ground for the children except one play ground in Zone C which is very far away from Zone B. Even the play ground in Zone C, just a small number of children use them. However, most houses have spaces under their houses as they are tall bamboo huts. Children usually play under the house. Most young children are kept inside and to play at home due to lack of safe places outside especially in the rainy season.

Photo: 21. Children playing at home

Photo: 22. A toy made by father, a carpenter

Children have no special toys or play materials to play with. Parents who can afford buy some toys or play things but most of them cannot afford to buy them. Parents especially fathers cannot make toys for their children. Only two fathers who are carpenters make some toys for their children. Children usually play with household utensils like cups, pillows or blankets or natural things such as pebble, leaves or sticks.

Photo: 23&24. Children playing at a play ground, the only one ground in Mae La camp

4.5.3. Going out with children

Mothers usually go out in the early evening after having their dinner to neighborhood with their young children. Mothers do not go far away places unless they have to do so. However working mothers do not have time to visit neighbors in the evening. They have no other place to go with their children for pleasure or entertainment except video parlor or café shop. Sometimes they take their children to line up to accept for ration food or at clinic for medical reason.

Photo: 25. A mother with two children going for shopping

4.5.4. Disciplining

Mothers are primary people who discipline their children. They use coaxing and cajoling to do something for them. However, sometimes they have to use threat such as ghosts, ogres, or animals such as coach roach, rats, or spiders. Mothers living with husband said that children are afraid of their father but not them. So if they want something to do, they have to threaten with their father.

A mother said, *"My husband does not beat them, but shout at them sometimes. I usually beat them when they disobey. But they are not afraid of me but their father."*

Beating is a common practice among mothers to discipline their children. Mothers usually beat their children if they are not listening to them. Only two mothers respond they do not beat their children. Most mothers declared resorting to beating the child when necessary.

"At first, I coaxed them or threatened in turn. If this does not work, they are beaten. But I have no intention of hurting the child. I only want my child to be good." responded a mother.

Mothers also explain their children to obey by pointing out other good or bad children as examples. However, they never use story telling as a means of disciplining their children. A grandmother complains that mothers of these days do not beat their children much as they did in the past.

She said, *"In my age, every children are afraid of me, and I beat them when they disobey. I entrusted my children to school teachers also to beat them as he likes unless*

my child are not broken or blind. Theses days, mothers do not beat them at home and complain their teacher if their children are beaten."

As mothers are primary care givers, they tend to use carrot as a means of discipline but not stick. Although beating is a culturally and traditionally acceptable ways to discipline children, they do not want to beat their children as they are more attached to their children than anybody else in their family.

A mother said, *"I have to live with my two children and they are my world. I only live because of them. So I don't want to beat them so much. Sometimes I beat them and I regret it all night."*

As disciplining is an art of child care practices, most of mothers have different approaches to discipline. They traditionally believe forcing and using stick rather than carrots works more. However, attachment between mothers and children are so firm that loving kindness compass the bitterness between mothers and children. Eventually, children listen to their mothers' words which become a new kind of disciplining.

Conclusion

Mothers have faced difficulties in child care practices which are different and changing from their former native places. Some mothers find it difficult to breastfeed their children while working where as some mothers are difficult in finding supplementary food for their children. Some mothers have difficulties to have a good habit of personal hygiene whereas some mothers have some difficulties in health seeking practices. Religious and socio-cultural determinants become obstacles for mothers to take care of their children. Socialization is also a major factor for mothers who have some limitation due to the camp environment.

Mothers are primary care givers in taking care of their children in the camp as there are no other people in the family who can help them out in daily routines and monotonous house keeping works. Grandmother or father, neighbors or older siblings, or even fathers are not very helpful in taking care of the children. As a result, heavy load of child care practices fall upon the shoulder of mothers who, in some cases, have to even work for their living.

CHAPTER V

CONCLUSION AND RECOMMENDATION

5.1. Conclusion

5.1.1 Major Difficulties in current socio economic situation

Major difficulties faced by mothers in the Mea La refugee camp in taking care of their children are related with their socio-economic situation, current child care practices, psycho social background and lack of sufficient assistance to them. They could not care their children properly due to lack of conducive environment in which they have to adapt to and struggle to survive. As the refugee camp is not their own native community, but mixed with different cultures, different religion and different nationalities, they cannot fully sustain their own value of child care practices.

Most of the mothers interviewed do not want to resettle in third countries. And, given the political situation in their native country, they cannot go back to their native places too. As the refugee camp is no longer just a temporary shelter for them to take refuge, they find some opportunities to work inside or outside the camp. Working either inside or outside the camp affects not only their living style but also their child care practices in daily routines. Father or mother or both have to work for their living as the supply for their food and other non food items could not fulfill their daily needs for them and their children. As a result, social problems follow. They have to leave their children with their grand mother or aunts or on their own.

Although non working mother can be assumed as they have no other work than to take care of their children, they are the only one in their family to do all the things in their house including taking care of their children. Non working mothers also have their own social problems or difficulties as their husbands are away working in plantation. Even though their husband are working inside the camp, some of them are not helpful to their wives in taking care of their children as they are busy all the time or drunk all the time or not in good health. For husbands who are working outside the camp, mothers are worried

all the time as they can be easily arrested by immigration or police or forest guards. Or they cannot know whether their husbands are married with another woman until they come back home safe.

In most of the cases of mothers who are widows or divorcee, their husbands are killed or died of some diseases or married with other women. Some of them are still working for the Karen National Liberation Army (military arm of the KNU) so that subject to die in battle field. When they become widows or separated, they don't know how to struggle for their living. In the camps, although food and other non food items for construction, cooking and health care are supplied, mothers have to fulfill other needs by working or foraging for food. Mothers need extra things more than any other people in the camp as they have to fulfill the material needs of their children. Sometimes, they are foraging foods such as collecting bamboo shoots or finding small fish in the stream. They have to focus on their works leaving their children unattended without anybody else to take care of them.

Working mothers' main difficulties are that they do not have enough time for their children as they are working at day time so that they cannot take care of their children. Most of their works are outside the camp so have to take risk of being arrested. Some mothers work as staffs in NGOs; nurses in hospitals or teachers in schools or nurseries. However, these kinds of works need special skill and also skill in English language so that most of mothers cannot approach them. Most of them are working outside the camp in plantation such as rice or corn fields. Mothers in good living condition open a shop at home or at the road side market. Some mothers do not have regular job so they have to forage bamboo shoots or mushrooms in the nearest forest and sell them back at the market. Some mothers forage fish at small streams in the camp for selling back or eating. Some mothers have their own small vegetable fields. Some raise animal like pig and sell them back when they grow old enough. Some mothers who work outside plantation legally have some difficulties as they have to sell vegetables once they are back in camp from the plantation. So they have less time to take care of their children.

For working mothers, nursery schools become a reliable place entrust their children when they are working. But these schools are too small for 100 children in a limited space. Feeding programme for children is also low in quality as they have to feed children with limited food ration collected from parents. A large portion of parents, mostly new arrivals cannot share their food supply. And due to limited resources, they cannot provide quality child care for children with systematic time table and play materials. Language is another difficulty that nursery schools are facing. Although most of the children speak Sgaw Karen, some new arrivals like Burman, Kachin and Chin. Nevertheless, nursery schools are necessary service for children especially whose mothers are working. 'Special Education' programme implemented by KWO is also helpful service for disable children under 5 years old.

5.1.2. Major difficulties with supply materials

Mothers also seek help from institutions for health as resources to deal with health care problems. Mothers go to the hospital when they cannot take care of their child's health problems with their home treatment or no treatment at all. The primary health care services providers are the Aide Medicale Internationale and the Shoklo Malaria Research Unit (SMRU). Solidarites take responsibility for sanitation programme including hygiene promotion education. Catholic Office for Emergency Relief and Refugees (COERR) is running waste management and environmental protection. All of health care services have done their best to meet basic needs of mothers in the camp given their limited sources. However, major difficulties of children concerning health problems such as diarrhea or respiratory infection remain unsolved due to very limited financial, material and human resources.

The diet mothers provided is traditionally rice, salt, and fish paste. So they have to supplement it with leaves and roots gathered from the forest, plus any vegetables or livestock that can be cultivated, raised or hunted. As there are a large number of new arrivals coming in the camp, food rations become problem in the camp. The children at the nursery schools bring their own rice to add to the supplementary feeding program, however due to increased cuts on rations by TBBC which is the main provider of food,

this may soon be impossible. Due to the funding crisis, TBBC rations will have to be reduced to half. It will adversely affect mothers especially who are not working. TBBC rations were providing a minimum of 2,100 Kcal per person per day based on an average family, with no differentiation for age. If the ration is cut for supplementary feeding, there will be a high risk of malnutrition among children especially under 5 year old. Moreover, mothers who have to fulfill the children's daily nutritional needs will be more burdensome than ever before.

Although non food supply like cooking fuel like firewood, cooking stoves, cooking utensils such as a pot or wok, building materials like bamboo, clothing, bed nets and sleeping mats are supplied to registered refugee in the camp, every thing is available at the small market. For those who are affordable, electricity is a service which is easily available. Electronic wares including mobile phone are available if you have money to buy them. Using mobile phone is not allowed in the camp but you can buy even top up card, which make children feel more envious about modern stuff. And mothers who cannot afford to use them tend to suffer from moral discouragement which affects their psycho-social state.

5.1.3. Major difficulties regarding child care practices

Child care practices of mothers such as breastfeeding, supplementary feeding practices, health seeking practices, socialization practices are average in general in terms of child development. However, prenatal and ante natal care of child needs not only regular medical check up but also sufficient nutritional value both for mothers and children. Although pregnant and lactating mothers are supported two cans of canned fish per month, one bottle of edible oil per two weeks and two cans of lentil per month, mothers have difficulties to feed nutritious supplementary food items. Although mothers can buy some non-ration foods by foraging, planting trees and vegetables, raising animals, or exchanging ration foods for other items, the quantity and quality are not sufficient to compensate for the nutrients that were low or lacking in the ration.

Foods can be purchased from the markets in the camp, but the households have very weak purchasing power, as evidenced by their low income. The diet mothers and

children are taking everyday is too high in carbohydrates and lacks sufficient quality protein. The overwhelming majority of dietary nutrients are provided by ration foods, and although the ration diet and the overall diet may be adequate for short-term subsistence, they do not suffice for long-term survival and optimal growth, especially for younger children. Newly arrived refugees may have endured food deprivation and nutritional deficiencies, especially for pregnant mothers and children under 5.

A hygiene practice is generally weak due to lack of knowledge and financial difficulty of mothers to purchase items necessary for personal hygiene. They cannot take much time to take care of their children's hygiene, feeding, toileting, children waste management. Drinking water in the camp is available only by boiling the water from deep water well or from the rivulet. However, there are still some mothers who do not boil water for drinking due to lack of sufficient time, cost or proper knowledge. Water for using is sufficient for mothers if they can fetch it regularly. However, they usually use it for cooking, washing and bathing. They do not usually use it for personal hygiene purpose such as washing hands after using toilets or brushing teeth. They also use water from nearby stream for washing clothes or raising animals which is totally not appropriate for health and hygiene. Children are susceptible to water borne diseases due to lack of proper personal hygiene practices and clean water. Although some NGOs and health assistants educate mothers for their hygiene and personal hygiene practices, mothers who have been loaded with daily routines or earning cannot accept their instructions into daily practices.

Mothers have difficulties in health care practices also due to unsafe and healthy environment, lack of proper medical knowledge and insufficient medical service and facilities. Home and their environment are obviously not suitable for children to play and run around. Due to unsafe environment, mothers are loaded with some unnecessary works in taking care of their children. Although mothers have taken preventive measures against unnecessary accidents and injuries, falling down from the house or raised platform bed is common among children. Once children have some accidents, mothers do not treat them properly or leave them if not serious. Diarrhea, flu, fever, cough and common colds, skin diseases, measles, jaundice, malaria and dengue hemorrhagic fever

are common among children but not treated or prevented in proper ways. Although malaria is under control according to some statistics and response of some key informants, mothers' practices to prevent malaria from being infected such as sleeping without bed nets, are still inappropriate. Their home treatments are still not enough but dangerous in some cases.

Most of the mothers have no expectation for the future of not only themselves but also of their children. Socialization with children, thus, is weak and social development skills of the children are also affected. Besides the provision of necessary facilities for physical growth and survival, children can be assisted to attain their highest potentials by organizing physical and social home environment. Although their eventual implementation has to be adjusted according to their original socio-cultural setting, some part of physical or social environment can be established through coordinated efforts among camp authorities, NGOs working inside the camp, Royal Thai Government and the community in which mothers themselves are staying. Most of mothers do not talk much to their children. They sometimes answer children's questions. Most mothers sing songs or rhymes to their children. They love singing songs and sometimes even dance with their children. However, most of mothers do not tell story before sleeping or at day time. However, attachment between mothers and children are still high due to very nucleus family type in which only mothers and children are key protagonists.

Playing is the most important for child development especially for their physical and cognitive as well as social development. By creating opportunity for children to play well at home or outside ground, mothers can help their children's variety of skills and learning process. However, most of the mothers do not play with their children according to in-depth interviews. Some mothers play with their children when they children are very young, but they no longer play with them once children get older. There is no play ground for the children except one play ground in Zone C which is very far away from other zones. Children usually play under the house. Most young children are kept inside and to play at home due to lack of safe places outside especially in the rainy season. Children have no special toys or play materials to play with. Parents who can afford buy

some toys or play things but most of them cannot afford to buy them. Parents especially fathers cannot make toys for their children. Children usually play with household utensils like cups, pillows or blankets or natural things such as pebble, leaves or sticks. Mothers usually go out in the early evening after having their dinner to neighborhood with their young children. Mothers do not go far away places unless they have some business to do so. However working mothers do not have time to visit neighbors in the evening.

Mothers are primary care givers who discipline their children with authority. They use coaxing and cajoling to do something for them. However, sometimes they have to use threat. Beating is a common practice among mothers to discipline their children. Mothers usually beat their children if they are not listening to them. Mothers also explain their children to obey by pointing out other good or bad children as examples. However, they never use story telling as a means of disciplining their children. As mothers are primary care givers, they tend to use carrot as a means of discipline but less stick. Although beating is a culturally and traditionally acceptable ways to discipline children, they do not want to beat their children as they are more attached to their children than anybody else in their family. Difficulties of mothers concerning disciplining lies in traditional values and practices which differs just a little bit in the present days in the refugee camp setting.

Mothers are not pious about religion although they follow some of their respective religious rituals. They do not teach their children much about religious rituals nor let them practice on regular basis. Most of mothers do not have extra money to conduct religious practices in the camp. Although major language in the camp is Sgaw Karen, there are a large number of people who cannot speak it. Burmese cannot be used as a common language among them as all of them cannot speak well nor understand it. In nursery schools, medium of instruction is Sgaw Karen but some children do not understand it. Mothers, especially new arrivals have difficulties to complain or say something about their children due to language discrepancy. They do not use Thai language which is a favored one in order to have a good work inside or outside the camp. Family who are under process of resettlement program to go and live in third country, describe their main reason of education or good future for their children. But only two

families out of 25 interviewed are under the process of third country resettlement programme. Mothers' unfamiliarity of original cultural practices and rituals make children feel sourceless. Changing life style and easy access to modern utility make a gap between old and new generation of Karen nationals in the camp.

5.2. Recommendations

5.2. 1. Recommendation to NGOs

- International NGOs are key players to fulfill the basic needs of mothers as well as children under 5 years old. Integrated services should be provided with coordination and consultation with one another.
- A community project that will facilitate child development in full, socially, mentally and physically through play and toys, with inclusion of disabled children, should be established in the refugee camps.
- NGOs should examine how the changes and diversities in socio-cultural issues and poverty affect child care practices in refugee community and set up programmes to deal with psycho social stress of mothers especially who are loaded with child caring.
- Health care programmes should be more integrated with preventive measures such as hygiene, water and sanitation in order for mothers to be able to follow the practices that health and hygiene promoters are advocating.
- What is happening in the refugee camps should be more accessible through NGOs' networks so that international community will be more aware of the situation especially for potential funding agencies.

5.2. 2. Recommendation to Thai Authority

- Thai authorities should be aware of the socio-economic situation of mothers in the camp and manage some work opportunities outside the work without high risk of being exploited by local manufacturers.

- Religious activities should be allowed with the support and cooperation of local religious organization in order to raise their moral ground.
- Children especially who are born in the Thai soil should have some legal rights and considered as categorized citizens which can guarantee Child's rights according to the Convention of the Rights of the Children (CRC).
- The MOI should consider promoting outsourced and in-camp jobs for refugees. Outsourcing projects must be carefully planned to protect refugee workers' rights and to guard against the use of underage labor. UNHCR could initiate a discussion on protecting refugee laborers, involving the government departments concerned

5.2.3. Recommendation to Camp Authority

- Mothers especially with under 5 year old children should be prioritized in providing food ration or any other services or supply distribution.
- Water both for drinking and using, drainage system and other camp development system should be improved with participation of the camp population
- More job opportunity should be explored in cooperation with the local manufacturer, provincial authorities, International NGOs and Royal Thai Government.

5.2. 4. Recommendation to Burmese Authority

- Refugees especially mothers and children who want to return to their native places should be welcome and accepted without harassment or legal indictment.
- Peaceful reconciliation and genuine political solution should be settled as soon as possible so that opportunities for mothers and children who want to decide their own future will occur.

REFERENCES

Almerigo Grilz and Gian Micalessin. Letter From Wankha. Far Eastern Economic Review (November, 1984) : 90.

Amnesty International Report. Myanmar: Crimes against humanity in eastern Myanmar. ASA 16/011/20085. June, 2008.

Basran, G.S. Indo-Canadian Families: Historical constraints and contemporary contradictions. Journal of Comparative Family Studies 24 (3) (1993) : 339-352.

Banjong, O., Menefee, A., Sranacharoenpong, K., Chittchang, U., Eg-kantrong, P., Boonpraderm, A. and Tamachotipong, S. Dietary assessment of refugees living in camps: A case study of Mae La Camp, Thailand. Food and Nutrition Bulletin. Vol. 24 (4): (2005) : 360-367.

Bornstein, M. H. Approaches to parenting in culture. Indo-Canadian Families: Historical constraints and contemporary contradictions. Journal of Comparative Family Studies, Cross-Cultural Study. New Haven: Yale University Press, 1993.

Burmese Border Consortium. Refugee Relief Programme. Programme Report for the Period January to June 2000. Bangkok: Burmese Border Consortium, August, 2000.

Burma Ethnic Research Group and Friedrich Naumann Foundation. Forgotten Victims of a Hidden War: Internally Displaced Karen in Burma. Chiangmai: Nopburee Press, April, 1998.

UNESCO. Strong Foundations: Early Childhood Care and Education. Place de Fontenoy: the United Nations Educational, Scientific and Cultural Organization, 2006. 11-17.

Department of Health, Ministry of Public Health, Government of Thailand. Recommended dietary allowances for Thai people. Bangkok: War Veterans Publishers, 1989.

Orapin Banjong, Andrea Menefee, Kitti Sranacharoenpong, Uraiporn Chittchang, Pasamai Eg-kantrong, Atitada Boonpraderm, and Sopa Tamachotipong. Dietary assessment of refugees living in camps: A case study of Mae La Camp. Food and Nutrition Bulletin. vol. 24 (4) (January, 2003) : 26-29.

UNICEF. Fertility and Reproductive Health Survey. Yangon: Department of Health Planning, Ministry of Health, Myanmar. 2003.

Foss, G. F. A conceptual model for studying parenting behaviors in immigrant populations. Advances in Nursing Science 19(2) (1996) : 74-87.

Garcia Coll, C., Lamberty, G., Jenkins, R., McAdoo, H. P., Crnic, K., Wasik, B. H., & Garcia, H. V. (1996). An integrative model for the study of developmental competencies in minority children. Child Development, 1891-1914.

Holt, K.S. Child development: Diagnosis and assessment. London: Butterworth-Heinemann Ltd, 1993.

Innes-Brown Mark, and Mark J Valencia. Thailand's Resource Diplomacy in Indochina and Myanmar. Contemporary Southeast Asia. 14(4) (1993)

Karen Human Rights Group. Inside the DKBA. KHRG report. 96(14) (March, 1996)

Karen Human Rights Group. Attacks on Karen Refugee Camps. KHRG report. 97(05) (March, 1997).

Kitvorapat V, Chaolilitkul N, Sinawant S, Wanarat L. Sample survey of the nutrition situation among under fives in Thailand. Thailand Journal of Health Promotion and Environmental Health 19 (10) (1996) : 56-66.

Lang, Hazel J. Fear and Sanctuary. Cornell University Press, 2002.

Lay T., Where You're Not Welcome. Burma Issues. Vol. 13(1) (January, 2003) : 33

Burmese Border Consortium. Burmese Relief Programme Report for Period January to June 1997. Bangkok: Burmese Border Consortium, 1997.

UNICEF. Multiple Indicator Cluster Survey; National Nutrition Planning Consultant Report. UNICEF Myanmar, 2002.

Opoku-Dapaah, Edward. Somali Refugees in Toronto: A Profile. Toronto: York Lanes Press, 1995.

Parke, R. D., Ornstein, P. A., Rieser, J. J., & Zahn-Waxler, C. The past as prologue: An overview of a century of developmental psychology. In R. D Parke, P. A. Ornstein, J. J. Rieser, & C. Zahn-Waxler (Eds.), A century of developmental psychology. Washinton, DC: American Psychological Association, 1994.

Quandt, S. A., Arcury, T. A., McDonald, J., Bell, R.A and Vitolins, M. Z. Meaning and Management of Food Security Among Rural Elders. Journal of Applied Gerontology. Vol. 20 (3) (2001) : 356-376.

Suvannathat, C., Bhanthumnavin, D, Bhuapirom, L., Keats, D. M (Eds). Handbook of Asian Child Development and Child Rearing Practices. Bangkok: Behavioral Research Institute, 1985.

Swick, K. J. Cultural influences on parenting: Implications for parent educators. Journal of Instructional Psychology. 12(2) (1985) : 80-85.

Thailand Burma Border Consortium (TBBC). Internal Displacement in Eastern Burma, 2007 Survey, October 2007. Retrieved from the TBBC Web site: http://www.tbbc.org/camps/mst.htm (21 March, 2008)

UNHCR. Policy on Refugee Children Document EC/SCP/82 Retrieved from the UNHCR website; http://www.unhcr.org/statistics.html (3 October, 2007)

The Victorian Foundation for Survivors of Torture. Easing the Transition. Melbourne; 2000. Retreived from the website: http://www.foundationhouse.com.au/publications.php (25 March, 2008)

Whiting, J. W. M. and Child, I. L. Child Training and Personality: A H. (Ed.) Cultural Approaches to Parenting. Hilldale, New Jersey: Lawrence Erlbaum Associates, 1953.

Whiting, J. W. M. and Whiting, B.B. Contributions of Anthropology to the methods of studying child rearing. In Mussen, P.H. (Ed.) Handbook of Research Methods in Child Development. New York: Wiley, 1960.

Young, M. Early childhood development. Netherlands: Elsevier science B.V., 1997.

APPENDICES

APPENDIX A

Questionnaire for In-depth Interviews with mothers

(Learn about the family history)

I. General questions for anybody at home

- How many people live in the house? (Eat together)
- How many children are there? How old are they? (Children under 5)
- Do the children go to school? (If no) Why?
- Do you have any works for your extra income? Father? Other family members?
- How much does the family earn per month?
- How much do they work? (Morning or afternoon or evening)

II. Questions for Mothers at home

Current Child Care Practices

A. Feeding & Hygiene, health seeking practices

1) Are you still breastfeeding this child? (If yes; how often? At night?)
2) What food do you give your child in addition to feeding?
3) How many times a day do you feed your child? How much?
4) What do you do when your child does not want to eat?
5) Do other people in your neighborhood feed your child?
6) In your opinion, what food are not good for young children and why?
7) When you are away, who looks after your child?
8) What advice do you give this person?
9) How often do you bathe your child? How do you toilet train your child?
10) When you got out, what do you do with your child?
11) When your child has an earache, fever, cold, cough, etc. what do you do? (home treatment) Why?
12) When do you seek help for your child? (signs of sickness)

B. Illnesses and health care practices

1) What kind of illnesses young children have most often? (Ear ache, colds, fevers, worms, toothache, and eye problems)
2) What are the seasonal health problems?
3) How do you deal with them?
4) What do you do when a young child has a cold? Fever? Diarrhea? Cough? etc?
5) For what kind of sickness do you seek help?
6) How do you know the child might be sick? (danger signs)
7) Whom do you consult first? Then whom?
8) Who decides what to do when there is a severe health problem at home?
9) What are the health problems for young children you are most concerned about?

C. Minor injuries or accidents

1) What kind of accidents or dangerous events for young children happens at home? On the road?
2) Why? How often? (Participants recall accidents or incidents which happened in the last tow years)
3) How is rescued organized? Where do you go for help?
4) How such accidents can be prevented? What should be done?
5) What kind of minor injury young children suffer from most frequently? (cuts, burns, bites, bruises, broken toes or fingers, etc.)
6) How do you treat them at home?

D. Socialization (Disciplining),

1) Besides you, who are the people your children interact with? What do they do?
2) Do you encourage your child to play with other children? Why?
3) When do you play with your child? And what do you do with him/her?
4) According to you, what is the most important thing a child needs?

5) According to you, how does your child learn to speak? To crawl? To walk? To sing & dance?
6) What game do the children play? With what? With whom?
7) What do you do when your children is naughty (dirty, breaks something, etc.)
8) What do you do when your children refuses to obey? Why?
9) How much time is spent in child care? What does the caregiver actually do with the child?

E. Religious and socio-cultural determinants

1) What are the child care practices people like most? Least?
2) What are the characteristics you most want to see in your children? (Obedient, healthy, etc.)
3) What is good behavior? What is bad behavior? (Lack of respect to elders, stealing, disobeying, lying and answering back...)
4) How do you courage good behavior? How do you make your child be a model child? (Demonstrate, explain, praise, encourage, stimulate.)
5) How do you discourage bad behavior? (Refer to the "nats"? Say "no", gentle slap, beating, talks softly, shout or yell, punish)
6) What do you do when your children disobey? Does bad work? Does it help? How? What are the problems?
7) Do you think it is bad or good for children to ask questions? Why?
8) Do you think it is important to talk to your children or not? Why?

Home and community

1) Do people in the family have different roles in disciplining the child?
2) Do you have other people at home to help you care children?
3) Do neighbors help you care your children?
4) What is the problem you faced in your daily routine to take care of your children?
5) What is your daily routine? (Time line)

6) How often do you send your children to play ground, outside entertainment (if any)?
7) What are the problems or difficulties the caregivers have in caring for young children? Why? (What are the causes?)
8) What are the most serious problems and how common are they?
9) Whom do you talk to when you have concerns and problems in childcare?

Available Services and Materials

1) Where do you go for your children's health problem? (Hospital, clinic, etc.)
2) Do you send your children to nursery school or other child care center?
3) Is your child immunized regularly?
4) Have you been supplied nutritional food for your children? How many and what?
5) Have you been provided any non food supply for your children?
6) From whom or from where do you get information about childcare (ways to bring up children)?
7) How many organizations do you know working for children? And what do you think of these organizations?

APPENDIX B

Questions to ask key informants

Name of Key Informant:

Designation:

1) What do you think about the way mothers in the camp bring up their children?
2) What do you think the most difficult problems or difficulties for caregivers to take care of their children?
3) What do you think about available Services and Materials?
4) How do you think these problems or difficulties can be solved?
5) Explain your organization's function for children.
6) Do mothers come to you and consult the problems when they have concerns and problems in childcare?
7) From whom or from where do mothers get information about childcare (ways to bring up children)?
8) Whom do mothers trust to help them bring- up their children?
9) What suggestions do you want to give for mothers to have better child care practices
10) Any thing to mention or add?

APPENDIX C

Check List for Home Visits

Name of mother:

Age:

Nationality:

Religion:

No. of children and their age:

1) Home Setting
   - Place to play for children
   - Toys and games
   - Living space, kitchen, and toilet
   - Hygiene system
   - Drinking water and its source
   - Water sufficiency for other use like bathing
   - Play ground surrounding the house
   - Bedding and mosquito net
   - How to keep food items
   - Ventilation
2) Feeding Practice
3) Interaction with children
4) Disciplining
5) Religious and socio-cultural rituals
6) Playing
7) Toileting
8) Neighboring environment
9) Family size
10) Family relationship

BIOGRAPHY

Moe Zaw Oo was born in Rangoon, Burma in 1969. He was graduated with Bachelor's degree majoring in English from the Yangon University Distant Education in 2002. He worked with a local NGO in a development project namely 'Early Childhood Care and Development Network Project' assisted by the UNICEF from 2000 to 2006, after graduation. In 2007, he won a scholarship from Open Society Institute and Prospect Burma to study in the Master Program in Southeast Asian Studies at Chulalongkorn University.