



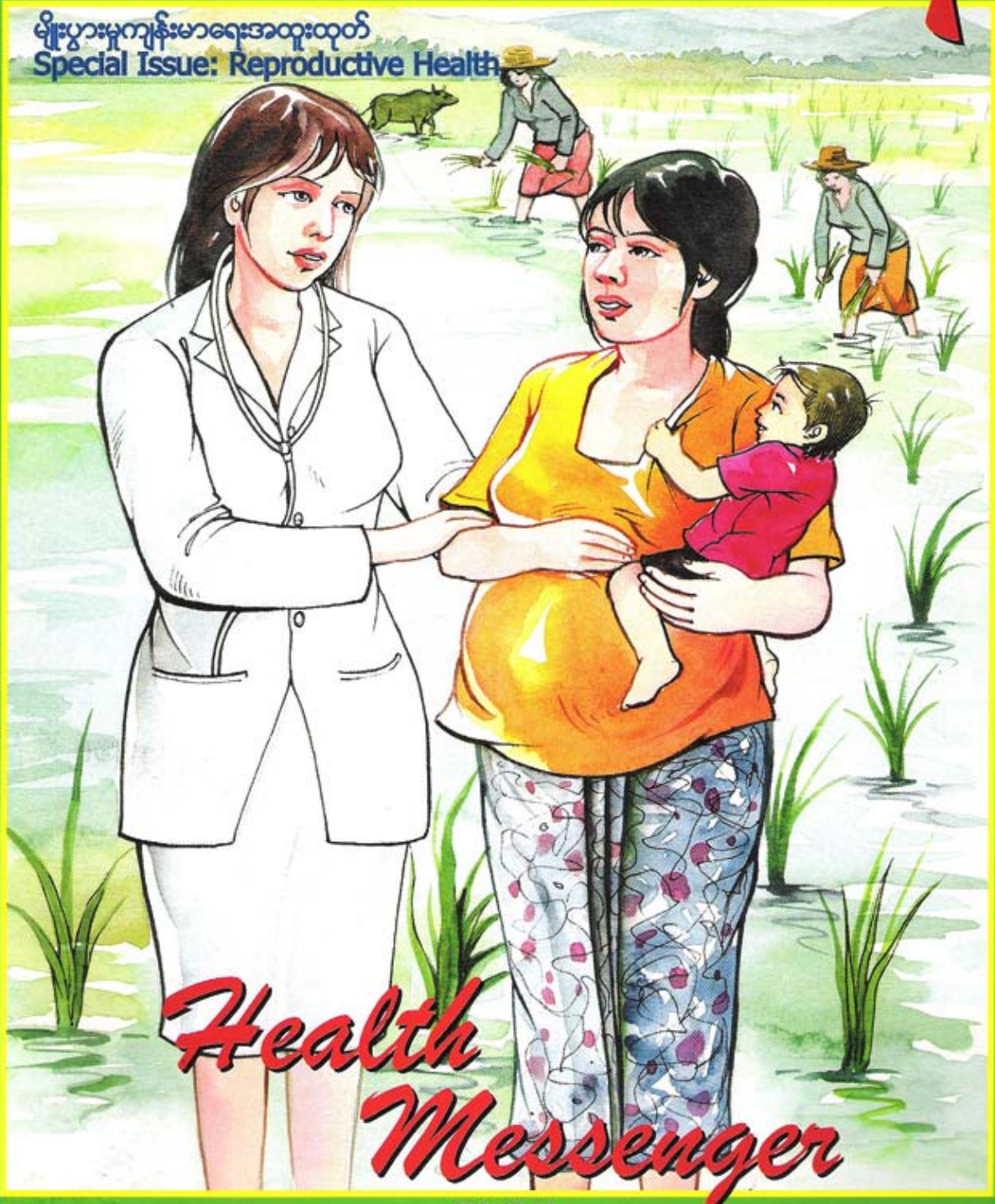
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Special Issue: Reproductive Health



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Messenger*

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MARCH 2003

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(Health Messenger Team in collaboration with Ruth Margerison, Consultant with UNHCR)



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The views expressed herein, in no way reflect the official opinion of IRC/USAID.

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Editorial

Dear Readers,
This issue on Reproductive Health, the first issue of year 2003, is very important to us for several reasons.

It is the first issue produced by our new Medical Editor, Dr. Than. Dr. Seerat Nasir, after working with us for three years joined another project last December. She has been replaced by Dr. Than, who has extensive experience working both in Burma, and here in Thailand with migrant population as well as with refugees.

With this issue we are responding to one of the main requests that you, our readers, expressed during the impact assessment we implemented last year, that is to also address health related social issues and not only pure medical problems.

Violence against women and unsafe abortions; problems health and social workers often have difficulty coping with, are issues affecting communities on both sides of the border. We hope that the following articles will help you to face such cases, and also will help your communities to openly discuss the said problems. In addition, we have articles explaining what the nutrition of pregnant women should be, as well as the issue of mother to child transmission of HIV/AIDS.

Enjoy your reading!

Best Regards
Rene' Queffelec
Project Coordinator.

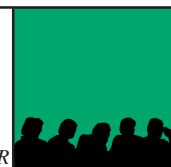
Health Messenger Magazine Programme

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Sexual and Gender-based Violence (SGBV)

Health Messenger Team in collaboration with Ruth Margerison, Consultant with UNHCR



This article will impress upon the community to better understand what gender-based violence is, and the possible solutions.

In recent months, we have heard a great deal about issues of Sexual and Gender-based Violence. Refugee women have recently reported cases of rape. This year the publication of a report on the systematic rape of women and girls inside Burma's war affected areas stirred international concern about the plight of women who experience violence in situations of conflict. Earlier, a scandal in Africa hit the headlines, in which humanitarian aid workers have been accused of supplying food aid in return for sexual favours.

None of this is startlingly new. In the 1990s, the terrible crimes of violence committed against the women of Rwanda and the former Yugoslavia have been recognised as crimes against humanity. The International Criminal Court includes the following in its list of crimes against humanity: rape as a weapon of war, sexual slavery, enforced prostitution, forced pregnancy and enforced sterilisation.

Once we start to become involved in this subject, we realise how pervasive violence is in the lives of many women and the enormous task of raising awareness about this very sensitive issue.

There are three main areas we need to understand when dealing with violence against women, which we know is happening in every corner of the globe.

First, we need to be clear about what we mean when we discuss violence against women. What kinds of actions do we include under this heading, and who are the men who commit acts of violence against women.

Second, we must uncover the reasons why violence happens to women and children.

Third, we must think of ways in which we can work towards putting an end to the use of violence against women.

What is gender-based violence?

"Gender-based violence" is a broad term referring to any form of slavery through the use of physical, verbal, emotional or economic force by one gender (usually male) over another (usually female). Thus it includes rape, sex trafficking, sexual exploitation, intimate partner violence and domestic violence.

The United Nations definition (1993) identifies the different types of violence and places gender as a central focus:

"Violence against women means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."

(United Nations Declaration on the Elimination of Violence Against Women, General Assembly, December 1993).

A woman often finds it difficult to talk about the violence she suffers from because she is too afraid or ashamed to tell anyone about it. A woman may not know who to trust and may



bear the harassment for many years, suffering both physical and psychological damage. She may even think that if her husband is treating her like that, she must have “deserved” such violence and it must be her fault.

If a woman has suffered rape perhaps within her marriage, from a relative or friend, or from soldiers, again she may choose to keep silent and blame herself. She may think it is her fault for not wanting to have a sexual relationship

with her husband every time he insists on his “rights”, or her fault for doing something which provoked an attack, such as wearing the wrong clothes or being too friendly, or her fault for being in the wrong place. One of the first things to understand and accept is that it is the perpetrator of the violent act who must take the responsibility and blame for such behaviour, not the one who bears the indignity, whatever the circumstances.

The Effects of violence:

on Women:

- lack of motivation or sense of self-worth
- mental health problems like anxiety and problems eating and sleeping
- serious pain and injuries: broken bones, burns, black eyes, cuts and bruises, as well as headaches, belly pain, and muscle pains that may continue for many years after the abuse happens.
- sexual health problems. Many women suffer miscarriages from being beaten during pregnancy. They may also suffer from unwanted pregnancies and STDs as a result of sexual abuse. Sexual abuse often also leads to a fear of having sex, pain during sex, and lack of desire.
- death.

On children:

- angry or aggressive behaviour – copying the violence. Or they may become very quiet and withdraw to escape notice.
- nightmares and other fears. Children in abusive families often do not eat well, grow and learn more slowly than other children, and have many illnesses, like stomach aches, headaches and asthma.
- injury if the violence is turned on them.

On the community:

- the cycle of violence continues into new generations.
- everyone’s quality of life suffers because women take part less in their communities when they are silenced by the violence.

Sometimes a question such as this one is asked - “*If my wife throws a bucket at me and screams that I am a lazy, good – for - nothing husband because I have no paid work and sit at home all day or go and drink with my friends, is that gender-based violence?*”

Yes, it is gender-based violence. Such a situation may occur when a man is not living up to the social expectation of the husband who is the hardworking breadwinner for his family. But the vast majority of such violence is carried out by men against women, in an effort to control women.



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The violence affects the entire family.

Source: Where Women Have No Doctor.

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But women, when talking together in confidence and trust, are more able to tell the truth with less fear of being ridiculed or doubted as when talking to men.

In confidential discussions with women inside and outside the refugee camps, we often hear about ordinary everyday events which all come under the heading of violence against women:

i) physical violence such as slapping and beating with a hand or stick, pushing and shoving to frighten a woman.

ii) sexual violence such as unwanted and forced sexual activity of any kind, rape both within a marriage and in other relationships, sexual harassment

iii) psychological and emotional violence to undermine a women's self-esteem by verbal abuse such as:

- Telling her she is no good, worthless, useless, no longer attractive.
- Threatening a wife that if she doesn't agree to have sex, then he will find another woman who is willing.
- Keeping a woman separated from friends or isolated from communal activity, so she cannot confide in anyone.

Why does gender-based violence happen?

Recently UNHCR staff worked with women and men in the refugee camps to identify and understand what according to them are the reasons why violence occurs.

Here are the main reasons women in the refugee camps have given:

Men tend to protect their dominance over women in society

- Men believe that they are the most important and they should have more power than women to decide what should happen: they want to be the leaders.

- Men want to keep things the way they are, so that their needs are met – food, sex, a comfortable family life; they make sure women keep providing these and threaten to leave if the women refuse.

- Men believe they should have more freedom than women, and should not have to do housework

- Men see women as weak, uneducated and unable to do many things; they think their physical strength means they can use it to control women and children.

- Women who try to improve their knowledge are seen as a problem by the men, a threat to men's control and this sometimes leads to more violence.

There is a lack of understanding between men and women

- Men do not understand women; they have no real idea of what it is like to be a woman and do woman's work and they are selfish and not interested.

- Women find it very difficult to explain to the men how they feel about the way they are treated; everything in the culture keeps women in second place and we accept violent behaviour as part of the culture.

- Women and men think about sex in different ways; men want it all the time and expect women to be available, even when we have just given birth.

Women lack knowledge and confidence to defend their rights

- Women do not know what rights they have and they lack education in all areas including human rights.

- Women do not have enough confidence to be in the camp committees, and if we are elected, we sometimes feel our ideas are not wanted or taken seriously by the men.

GENDER ROLES IN BURMA

In Myanmar Society, the husband is the single head of the family, and this is generally not disputed by the wife. However, he does not interfere with the day-to-day running of the household and gives her a free hand to attend such matters. She, on her part, not only refrains from questioning his authority in front of the children, but takes pains to compel obedience and deference to it.

Sein Tu, Myanmar Perspectives



a, mub;awmifawmharmi/rwphxmiif

A real he-man has a thousand lesser wives! (Source : Save the Children -UK - Myanmar.)

A person's gender role refers to the way a community or culture defines what it is to be a woman or a man. Each community expects women and men to think, feel and act in certain ways, simply because they are women and men. In most communities, for example, women are expected to prepare food and do household work, whereas men are expected to work outside the home to provide for their families. Therefore, in most communities, men's work is traditionally more valued than women's work.

Gender roles are passed down from parents to children. From the time children are very young, parents treat girls and boys differently – sometimes without realising they do so. Children watch their parents closely, noticing how they behave, how they treat each other, and what their roles are in the community. As children grow up, they accept these roles because they want to please their parents. These roles also help the children know who they are and what is expected of them.

Many commentaries have favourably compared women's status in Burma to that of women in neighbouring countries; and many women within Burma vaunt their high status and the recognition they enjoy within society.

In reality, gender roles arising out of cultural and religious stereotypes continue to underpin laws and practices that prevent women from enjoying their full right to personal safety, health, education, employment, freedom of movement, and participation in leadership, recreation and community activities.



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Examples:

Most peoples prefer boys...because you know if you have a baby boy, he can go through shinpyu (Buddhist ordination) and they can feel proud, but if you don't have boys, you cannot do this.

Interview CINT94

In our Kachin society, men have to look after the family. Women we give to another family... Women's responsibilities are less than men, in preserving the family line. For example if the man is from the Maran Clan and the woman is from the Inko Clan, their child will be Maran not Inko.

That's why we give more priority to boys

Interview CINT109

In Chin society, girls are for others. Interview CINT169:

In Karen culture, if a woman told a man she loved him, everyone would look down on her.
Interview CINT75:

Source: Interviews From Gathering Strength



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The boy - a champion.

Source: (WEAVE)

Refugee conditions worsen the situation

- Women and men do not have enough income in the refugee camps; they worry and are frustrated, so they fight more and sometimes the men become violent.
- Men who have no job and no money are angry and will drink to make themselves forget their problems and they often become more violent.

Many of these reasons are about the same basic injustice between the sexes - namely that men see women as subordinate (also women still tend to think in the same way about female abilities). They dislike change or challenge to the status quo, where they may lose position and power. It has been shown over and over again that violence and the threat or fear of violence has a strong controlling effect on women.

How can we prevent violence?

This is a difficult topic. When women do get to say these things to the men of their

community, it is often seen as an attack by women against men. Men often express their fear that women are going to take over, as women become stronger, better educated and more confident. Discussion with men about male violence can quickly turn to a joke about women wanting to boss men around.

More and more men will feel defensive about women expressing themselves and want to distance themselves from violence. Men tend to skip the problem and any responsibility. They often see violence as a problem that does not

TALK ABOUT IT

TALKING ABOUT THE VIOLENCE IS THE FIRST STEP TO CHANGING IT. TRY TO FIND OTHER WOMEN WHO HAVE THE SAME PROBLEMS. FIND MEN WHO BELIEVE THAT VIOLENCE IS WRONG.

MAKE VIOLENCE SOMETHING PEOPLE TALK ABOUT, SOMETHING THAT PEOPLE THINK IS WRONG.



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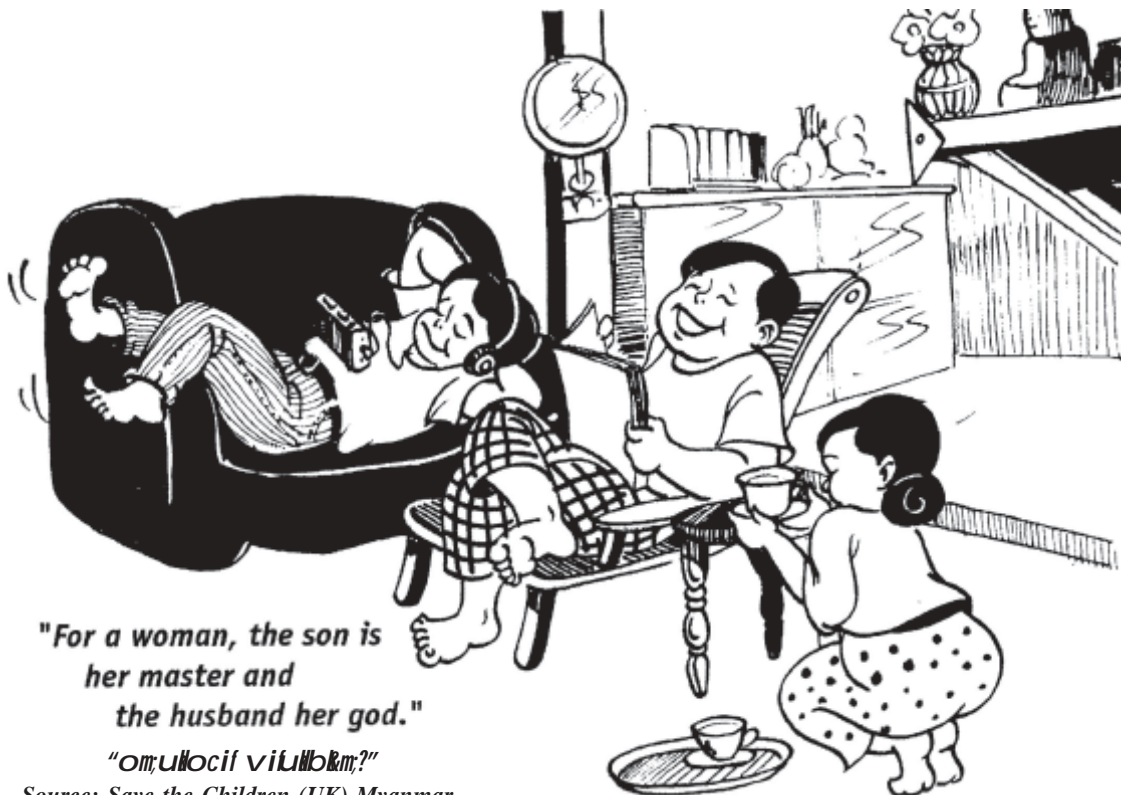
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"For a woman, the son is
her master and
the husband her god."

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Source: Save the Children (UK)-Myanmar.



concern them but *other* bad men who don't know how to behave. Sometimes we hear men say, "Don't talk to us, we don't beat our wives or rape women, go and deal with men who commit those acts".

We need women and men to take responsibility for seriously addressing the issue in their own communities. When women start talking to men, and men listen and see the issue as a community responsibility, then progress can begin. Listening and understanding the reality of the problem are important stages for starting the process. Men may feel that this topic is too threatening when discussed in a group and want to maintain their position amongst their friends. They may respond more genuinely in a one to one situation.

In one of the refugee camp workshops during November last year, the women wasted no time in involving men. They asked them to wear white ribbons to support the International Day of Stopping Violence Against Women. Men were at first a little reluctant to be drawn into this activity, but women were able to express how important it was to stand up and be counted in this struggle and the men responded positively. In another camp, the men remained indifferent.

A major focus of work on violence must be education of both women and men concerning the real meaning of human rights. Without understanding of rights and their relationship to responsibilities, they become meaningless statements. For example, men often continue to champion democracy and human rights but if they fail to recognise and understand that WOMEN have equal rights with men, there can be little progress. We often hear that the key to lessening men's anger and violence to women is for women to be nicer to men. If only women were more co-operative, less assertive and demanding of rights, if they smiled more and did not provoke men to anger

in any way, if they wore clothes that did not invite sexual thoughts from men - THEN, all could be peaceful and violence would be unnecessary! Why do we think that men's violence against women is women's fault?

We all need to realise that violence occurs because men are stuck in a mind set. This mind set makes them think that certain forms of violence against women, at certain times and in certain situations, are justified. Progress is possible, when men understand that violence against women is wrong and recognise that they have to respond rather than leave it to someone else.

Many deeply rooted traditional beliefs involve the idea that women need to be controlled and for that reason, resorting to violence is acceptable. Such beliefs are in conflict with human rights and especially women's human rights.

We all need to acknowledge the fact that a long and committed attempt by both women and men to change such traditional beliefs, which accept violence against women, as necessary.

Women often start the discussions on this matter because violence is a common feature of so many women's lives. But men also need to start thinking more critically about the use of violence.

Men and women need to think together about how to build a future, where women will be free from violence.

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The author during a workshop.

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Frequently Asked Questions About Domestic Violence

Peggy Bacon, Ph.D. and Jack McCarthy, Ph.D. Burma Border Projects



The article answers to questions asked by the participants in workshops on domestic violence along the Thai - Burmese border. The authors are psychologists from the U.S. who specialize in psychological trauma.

They are members of the Burma Border Projects Mental Health Team. They along with their colleagues, Elizabeth Call, Psy.D. and Kathleen Alden, M.D. have made numerous trips to the Thai-Burma border to provide training, supervision and consultation in mental health knowledge and skills. They have recently taught the subject of domestic violence to safe house workers from 3 refugee camps and to medics at the Mae Tao Clinic.

What exactly is domestic violence?

Domestic violence is most commonly thought of as a wife being physically abused by her husband. However, women often speak of the emotional wounds being more painful and long-lasting than the physical wounds. Physical abuse often occurs along with verbal abuse such as insults, criticisms, name-calling and threats. Abusive husbands often isolate their wives from family and friends. They may withhold money or use household money for

drugs and alcohol. They may damage their wife's belongings, restrain her, and force her to have sex and threaten or abuse the children.

Aren't women violent too?

Yes. Women have verbal and psychological weapons that can be hurtful. Sometimes women resort to physical violence. However, in the struggle for power and control, women are generally at a physical disadvantage. They may threaten, but a man can back his threats up with superior size and strength.

Why do husbands abuse their wives?

Essentially, men use violence as a means of getting what they want. That might be relief from tension, control over their wife's behaviour, a sense of personal power and control, or a way to hurt someone else so they don't have to feel their own pain. Men who are stripped of the dignity of their role as protectors





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and providers by economic and political circumstances often feel powerless and depressed. They may use drugs or alcohol to reduce painful feelings. These substances also lower their self-control and contribute to their use of violence.

Why do women stay in abusive relationships?

There are many reasons women stay. These range from love for their husband to fear of greater retaliation if they leave. There are social, economic, cultural and religious reasons for staying. Because of all these reasons, women continue to hope that their husbands will change their behaviour. This contributes to what has been called the **cycle of violence**. As tension develops in a relationship, women get anxious and men become upset. He may use drugs or alcohol to relieve his tension. An explosive episode follows in which the husband is violent towards the woman. The husband's tension is relieved. The woman feels battered and hopeless and begins to consider leaving or threatening to leave if the battering continues. The husband, threatened with loss and relieved of his anger, apologizes and promises never to let it happen again. The woman believes him, sees his better side and decides to forgive. Then the cycle repeats. This pattern is very difficult to break once it has started.

What is the effect of domestic violence on children?

Children from violent homes suffer a number of consequences. Their normal development is interrupted because they are filled with fear and focus their energies on coping with an out-of-control situation. Their loyalties are divided between two people they love and trust. They are confused about relationships and learn to expect that violence



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The author during a workshop.

and fear are part of a loving relationship. They are at risk for repeating these behaviours as adults.

How can domestic violence be prevented?

Domestic violence increases isolation. People are hesitant to intervene in what appears to be a private matter. Domestic violence needs to be acknowledged as a community problem. Public education and awareness are key. Violence is a crime and a violation of human rights. At the leadership level, laws need to be in place to deter domestic violence. Consequences need to be consistent and consistently enforced. People in charge of enforcing the laws need to be trained in how to intervene in domestic violence. Safe houses need to be established and protected to ensure that women fleeing abuse are safe. Abused women and their batterers need education, support and treatment. Women need to be strong enough to make good choices for their family. Men may need drug and alcohol treatment. They also need to learn to take responsibility for their violence and learn new ways to cope with their feelings. They need guidance on healthy ways to seek power and justice. This can happen in group counselling programs that are created to help men change their violent behaviour.



THAN MYINT, 24

My husband was not good. He drank, played cards and beat me. Sometimes he worked as a day labourer to get some money, or he stole the family rice and sold it. With that money he drank and played cards. But even without that, we did not have enough to eat. When we had a little money, he could buy drinks and he would beat me. When we had no money at all, he could not afford to drink and he would not beat me.

He usually punched me or beat me with a stick. I was bruised, in my face and all over my body. But I was married to him, so I had to accept it. When he was drunk, he always complained about everything. He said that I was a bad woman.

I tried to beat him back, but I am weak. Women always have to suffer. I wanted to run away from him. But I never ran out of the house. I was afraid that my husband would make problems for my parents. My parents would say, "Don't beat her!". But my husband never stopped. Sometimes they would leave the house. My parents were afraid of him. He used to tell them that he would send someone to kill them. My brother never defended me. They wanted peace in the house and didn't want to interfere between husband and wife. The neighbours never helped because they do not want to interfere between a couple.

I never complained to the authorities. Now I think it is better that I am separated from him. We discussed coming to Thailand together and arrived in March 1998. Then he left me when I was one month pregnant. Now he has another wife. I am eight months pregnant and work as a housekeeper for a Thai family. I get food but no money. I hope that after my baby is born, I can go back to Burma.

Interview CINT130

Source

Story from: *Gathering Strength: Women from Burma on Their Rights*. Brenda Belak. Images Asia. Jan 2002.



Source: WEAVE



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A Story of Sexual and Gender-based Violence

Baik Lay, Karen Women Organization-Health Messenger



This article tells a real story about sexual and gender-based violence; and gives counselling guidelines for social workers to better handle such cases.

Presently, the author lives in a refugee camp and works for a women's group and almost every day, she has to solve many social problems. This is a true story that happened in August 2002.

Naw Sain Wah was about a 14-year-old girl. She was mentally retarded and her limbs were not able to move well due to some childhood illness. She attended school for the disabled.

One day, an old man of about 70 years of age, living near her house, raped her. The people living around her house saw the event and took action against him. Health workers from the camp provided care although no physical injury was detected on her body.

On September 15th, a 35-years-old man raped her again, and then gave her 5 baht. The case was reported to the women's group and referred to the camp administration. The rapist



was taken into custody. The women's group was responsible for taking care of her again.

Her mother talked with the health workers about performing sterilization on her to prevent her from getting pregnant in case of another rape. The health workers suggested that she was too young to be sterilized and that it would not protect her against sexually transmitted diseases.

Counselling:

- Counselling is a method used to help treat people with emotional trauma. It is sometimes referred to as “talking cure”.
- The method used to help people is by listening to their story and discussing their problems with them.
- The counsellor can help them to find solutions to their problems and find better ways of dealing with their emotional trauma.
- Counselling generally takes a long time and experience to be fully effective.

To begin with: explain that you want to help the patient and introduce yourself and your position (medic, social worker). Explain that you would like to get to know her better so that you can effectively deal with her problems/circumstances. Ask her if she has any questions and answer them. Be honest. Find a quiet, comfortable and private environment to talk .



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r & i f -- b b d s (j r e f m e, p y l v r f n ē f - 2003)





- Establish a climate that allows the patient to feel accepted so that she can drop her defences and speak openly.
- Help the patient to analyse her own situation and resources that are available to her so that she can find her own solutions to remedy the physical, psychological and social consequences of the violence.
- Support the patient in putting these solutions into practice.

DO NOT TRY TO DO TOO MUCH DURING THE FIRST SESSION. The first session is mainly to begin the process. Successful counselling can take months.

Some of the rules:

- **CONFIDENTIALITY:** This means that whatever you learn in the counselling session is not told to anyone else without the person's consent. The only exception to this rule is if the person has told you that she plans to either harm herself or others. It is through confidentiality that a trusting relationship can develop.
- **TRUST:** Needs to be developed between the counsellor and the patient. Without trust, effective counselling cannot occur.
- **EMPATHY:** The counsellor must try to understand the person's situation as well as possible. To empathise means to see the world through another's eyes, to imagine being that person and imagining how it would have to felt to have suffered her problems.
- **NON JUDGEMENTAL:** When listening to the person's problems and life story, you are being placed in a very powerful position. The person has placed her trust in you and is relying upon you for acceptance. The people who need counselling are in a very fragile emotional state and need acceptance and support. Not judging the person's behaviour, even though you may disagree with it, is an essential element of counselling.
- **LISTENING:** The counsellor needs to be a good listener. Allow pauses in the conversation, do not try to push the person to speak and let her tell you what she feels comfortable in telling you at that time.
- **BODY LANGUAGE:** The way a person sits and his/her movements often display what she/he is feeling. During counselling, it is important to make the person aware that you are interested and listening to her. One way of doing this is to follow these rules:
 - Square: sit facing the person, do not sit sideways to her, be able to look directly at her.
 - Open: sit with an open posture, don't cross your arms or lower your head.
 - Leaning forward: by leaning slightly forward towards the person, you are showing her that you are interested.
 - Attentive: be attentive to what she is saying, listen to her and nod your head to show you understand.
 - Relaxed: be relaxed during the counselling session, try not to feel tense or excited, hopefully the person will sense this and will become more relaxed herself.

Sources: Burmese Border Guidelines, 2003



In a SGBV case, what can the social worker do?

Action taken by social groups in the camps in case of SGBV:

1. **Counselling sessions:** see below.
2. **Provision of safe houses:** see below.
3. **Treatment of physical injuries:** see article on rape.
4. **Legal and administrative action:** In the camp the women's group refer cases to the camp committee.

THE SAFE HOUSE: A SAFE PLACE FOR WOMEN

The safe house is a safe place where women can go with their children:

- to escape violence and any kind of abuse
- to be protected against the perpetrator
- to recover from the violence
- to prepare the future

Remember: look for what resources are available in your community for abused women

- legal help
- safe house
- money-earning projects for women
- mental health services
- education services for adults



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Medical Treatment of Rape

Health Messenger Team, Based on the BBG 2003 by Dr. Ann Burton, IRC



Rape is not only a social problem and a crime, it also has serious effect on the health of the victim. This article will help health workers to overcome victims of rape.

Rape is a traumatic experience both emotionally and physically. Women may react in a number of ways to this trauma. By presenting to the clinic the woman shows that she has a health concern. The clinic staff can address these health concerns and help her to recover by providing compassionate and quality medical care. Women will recover more quickly if they have emotional support and understanding from people they trust.

DO NOT BLAME WOMEN WHO HAVE BEEN RAPED. IT IS NOT THEIR FAULT.

REMEMBER: RAPE IS A SERIOUS CRIME AND NOBODY DESERVES TO BE RAPED.

Be very careful of maintaining **confidentiality**. Do not discuss the case with anyone who does not need to know.

Note:

- The patient may want to **report** this incident to the police, or to the **Women's group** or to the **Camp Committee** if she is in a **refugee camp**. Ask her if she would like you to accompany her.

- If she is in Thailand and wants to **report the incident to the police**, she will need to have the **medical examination in a Thai hospital**. Advise her not to change her clothes or bathe before the medical examination as evidence will be collected at this time. It is best if a trusted female staff member from the camp

goes with her.

MANAGEMENT:

Treat the patient with kindness and understanding

1. Wound care:

- Examine the patient to check for wounds if she gives permission /consent.
- Clean any tears, cuts and abrasions and remove any dirt or dead and damaged tissue.
- Suture if necessary and give appropriate wound care.

2. Prevention of sexually transmitted infections:

- Treat for Gonorrhoea and Chlamydia even if there are no symptoms: give Ciprofloxacin po 500 mg stat, or Ceftriaxone im 250 mg stat or Azithromycine po 2g stat



Wound care.



PLUS

Doxycycline po 100 mg BID/200 mg OD x 14 days or Azithromcyne po 1 g stat.

- See follow-up schedule for Syphilis testing.

3. Prevention of Tetanus:

- If the woman has external wounds and is not vaccinated against Tetanus, give Tetanus vaccine. Advise her to finish the course.

4. Prevention of Hepatitis B:

- If the woman has not already been vaccinated, give immunisation with hepatitis B vaccine **as soon as possible**, if available. Advise her to finish the course.

5. Prevention of unwanted pregnancy – Emergency contraception :

- Women are going to be very concerned about the possibility of pregnancy as a result of the rape.
- They should be counselled about the availability of emergency contraception.
- **The decision to take emergency contraception should be left to the woman.**

- If the survivor wants to take emergency contraception but the **health worker does not want to prescribe it, the survivor should be referred to someone who is willing to prescribe it.**

- The management varies depending on how soon the woman presents to the clinic after the incident.

A. IF THE WOMAN COMES TO THE CLINIC WITHIN 72 HOURS OF THE INCIDENT:

You can offer 2 types of emergency contraception:

• **Hormonal: Emergency Contraception Pills, (ECP)**

- a) Combined oral contraceptive pill, for example, Anna: each pill contains 30 micrograms of Ethinyl Oestradiol and 150 micrograms of Levonorgestrel.

Dose: Give four tablets stat and another four tablets 12 hours later OR

- b) Levonorgestrel 0.75 mg.

Dose: Give one tablet stat and then another tablet 12 hours later.



Rape is a traumatic experience both emotionally and physically.



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Accompany the patient if she wants to report to authority.



- Give Metoclopramide 10mg IM or PO one hour before the pills (both doses) to prevent vomiting.
- Taking emergency contraception pills (ECP) within 72 hours of unprotected intercourse will reduce the chance of an unwanted pregnancy by about 80%.
- Ask the woman to come back for a follow-up in 2 weeks time (see below).

Before giving ECP **do a Pregnancy Test (PT)**. Give ECP only if PT is negative.

• **Non-hormonal: Intrauterine Device (IUD)**

- An IUD should be inserted by an experienced person.
- If an IUD is inserted at this time, it can be removed after one month.
- Ask the woman to come back for a follow-up in 2 weeks time (see below).

Before inserting an IUD **do a Pregnancy Test**. Insert IUD only if PT is negative.

B. IF THE WOMAN COMES TO THE CLINIC AFTER 72 HOURS BUT WITHIN 7 DAYS OF THE INCIDENT:

- It is too late to offer the Emergency Contraceptive Pill.
- You can only offer IUD (see above).

C. IF THE WOMAN COMES TO THE CLINIC AFTER 7 DAYS OF THE INCIDENT:

- It is too late to prevent pregnancy.
- Do a Pregnancy Test and ask her to come for a follow-up (see below).

6. Prevention of AIDS

- Women may be very concerned about the possibility of HIV infection.
- Explain to her that she has valid reasons to be concerned, but that the actual risk of contracting HIV is very small.
- Offer her voluntary testing and counselling.
- **Post exposure prophylaxis** for HIV may help to prevent HIV after rape (but the evidence for this is still not clear).

The treatment (for the moment not available in Burma, but possible in the refugee camps in Thailand) is a combination therapy with AZT, 3TC and Indinovir. It should be taken daily for a period of 4 weeks.

AZT (Zidovudine) 300 mg BID for 4 weeks
3TC (Lamivudine) 150 mg BID for 4 weeks
(for high risk exposure it is recommended to add Indinovir to this regime if available)
Indinovir 400 mg TID for 4 weeks

- Where available, prophylaxis should be prescribed **after** counselling **if** the woman has come **within 72 hours** of the incident.

HIV prophylaxis should be started as soon as possible after the incident, preferably within 1-2 hours, but no more than 72 hours after.

- If the woman comes to the clinic more than 72 hours after the incident, it is too late for HIV prophylaxis.
- Refer the woman for voluntary testing and counselling three months after the incident (see follow-up).

After the appropriate medical management:

- Ask the woman if she has a safe place to go and if someone she trusts will accompany her when she leaves the clinic. If she has no



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safe place to go, care should be taken to find a safe place.

- Refer the woman to the relevant person in your community for psychological support.

FOLLOW-UP

Follow up on these patients regularly. They will need continuing emotional support.

Inform them that she can return anytime to the clinic if she has questions or other health problems.

Give clear advice on the need for follow-up on wound care or vaccinations.

The **minimum** follow-up should be:

1. TWO WEEKS:

- Do a Pregnancy Test.
- Ask about STI symptoms and treat if necessary. Take blood for Syphilis testing.
- Offer emotional support, make sure she is getting continuing mental support from the appropriate person in the community.

2. ONE MONTH

- Repeat the Pregnancy Test.
- Ask about STI symptoms and treat if

necessary. Take blood for Syphilis testing.

- Offer emotional support.

3. THREE MONTHS:

- Ask about STI symptoms and treat if necessary. Take blood for Syphilis testing.
- Offer voluntary testing and counselling for HIV.
- Offer emotional support.

To the health worker

- **Treat her mental health needs.**

Ask her whether she has someone to talk to. Help her to respect herself again and to gain control of her life.

- **Help her to make her own decisions.** If she wants to go to the law, help her find legal services. Help her find other services in the community for women who have been raped.

- **Help her to tell her partner or her family.** If they do not know already, offer to help her tell them. You can help them find ways to support her until she recovers. Remember that family members usually also need help to overcome their feelings about the rape.



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Medical Treatment of Unsafe Abortion

Julie Price, Cynthia Maung, Naw Sophia, Tara Sullivan, and Naw Dah, Mae Tao Clinic



This article will help the workers to provide care for patients with post abortion complications. Its content draws heavily on material presented at a post-abortion care workshop conducted by Engender Health at the Mae Tao Clinic from August 28th - September 7th 2002.

Abortion is defined as the termination of a pregnancy from whatever cause before the foetus is capable of extra-uterine life. Along the Thailand-Burma border, due to the limited access and utilization of health facilities and the special circumstances of the patient population, a foetus can only survive outside the mother's body after 28 weeks gestation. This article outlines the diagnosis and treatment of unsafe abortion at the Mae Tao Clinic's Reproductive Health (RH) In-patient Department (IPD). The Mae Tao Clinic does not perform medical abortion because it is illegal in Thailand. However, the clinic does treat patients who present after having undergone unsafe abortion in the community. The Mae Tao Clinic RH- IPD provides care for an average of 22 such patients per month. Treatment of post-abortion complications include emergency treatment of incomplete

abortion and potentially life-threatening complications along with post abortion family planning counselling and services.

In Thailand and Burma, induced abortion is considered illegal. A woman desperate to terminate a pregnancy may resort to unsafe means by either self-inducing or visiting a traditional birth attendant or midwife. She may utilize a variety of methods to expel a foetus including ingesting herbs, undergoing abdominal massage, or having twigs or herbs inserted into the uterus. Many of these women experience complications as a result of incomplete abortions (the uterus not completely emptying of products of conception), questionable cleanliness of instruments to induce abortion, or trauma to the sexual organs from instruments used to induce abortion.

Women who have unsafe abortions are at higher risk for complications such as death, infection, perforated uterus, tetanus, abscess, haemorrhage, and shock compared to women who undergo abortion at a medical facility. Complications not only decrease a woman's future fertility but cause pain, stress and grief for families and community. In some cases women delay seeking medical treatment for between 10-20 days after an unsafe abortion. Complications, such as sepsis or haemorrhage, could be avoided if women sought care earlier.



Source: Where Women Have No Doctor.



Emergency treatment of incomplete abortion and potentially life-threatening complications start with an initial screening (history, physical examination, pelvic examination and appropriate laboratory examination) for emergency conditions like incomplete abortion, haemorrhage, shock, or infection. First, it is critical to determine the severity of the case and to swiftly stabilize and refer the patient if necessary. Second, it is important to determine the stage of the abortion: Is the abortion complete or incomplete? A third important factor in treatment and care is to determine if abortion is septic or not.

History Taking and Clinical Examination

A thorough **history** includes the following:

- age of the patient
- number of previous pregnancies, children living, past abortion history
- **LMP (Last Menstrual Period)** or bleeding/menses overdue during the last few months
- duration, amount, and colour of bleeding
- expulsion of tissue (products of conception such as foetal parts, placenta, and membranes)

Evaluate patient for signs of shock.

If a woman is suspected of unsafe abortion, health workers should immediately evaluate her for signs of shock (see Table 2).

Stabilize the patient.

If any of the signs of shock are present, the patient is immediately stabilized. To stabilize the patient have her lie down, turn the head and body to the side (in case of vomiting to prevent aspiration), raise her legs or the foot end of the bed (if patient has trouble breathing this way, the head end is raised too), and keep her warm. Then start an IV infusion (the first liter given in 20 minutes, if possible). Do not administer fluids through the mouth to prevent aspiration from vomiting.

Identify if the woman presenting is a post-abortion care case.

A woman of reproductive age (14-45 years old) experiencing any one of the following symptoms may be a post-abortion case:

- possible history of delayed menses or period.
- vaginal bleeding, and/or
- cramping and/or lower abdominal pain

- presence and duration of foul smelling discharge
- presence and amount of cramping, presence of abdominal or shoulder pain
- presence and duration of fever or malaise
- history of induced abortion (where, when, by whom, how, and why)

Physical examination includes:

- vital signs with temperature, pulse, blood pressure, respiratory rate

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- general level of consciousness
- pallor
- rousability, hydration
- lung auscultation for signs of fluid overload
- abdominal palpation and fundal height measurement to assess the gestation
- abdominal examination for tenderness or signs of abdominal injury
- haemoglobin/malaria parasite blood test

Pelvic examination: is conducted in a private room with a speculum and a strong light. Colour, quantity of bleeding, and visible blood clots are noted as well as source. Also note presence of tissue protruding from the cervix, presence of foreign bodies (twigs, etc.), and presence of foul discharge. The cervix and vaginal walls are examined for tears or swelling and the cervical os visualized for dilation.

Treat the patient.

If there is evidence of infection (history of prolonged bleeding, objects inserted into the uterus, fever, abdominal and/or uterine tenderness, purulent cervical discharge, generalized malaise-antibiotics are given: Ampicillin 1 gr stat followed by Ampicillin 500 mg IM every 6 hours AND Gentamicin 80 mg stat followed by 80 mg every 8 hours and oral Metronidazole 400 or 500mg every 8 hourly.) The uterus must be evacuated after 1 hour. There is no benefit in waiting longer than 1 hour. **IV antibiotics are preferred, IM acceptable. Oral antibiotics should only be given if IV or IM is not available.**

If there is continued bleeding because pregnancy tissue remains in the uterus (bleeding is heavy, cramping severe, cervix dilated, tissue in the cervix or vagina)-tissue

that is seen at the os is gently removed using gloved fingers, or ring (or sponge) forceps. Manual Vacuum Aspiration (MVA) is used to completely remove the tissue.

Treatment Options:

Manage pain of the patient.

Women who have undergone unsafe abortion may have pain related to infection, trauma, anxiety, exhaustion, dehydration and fear. Do not give any analgesics until diagnosis and examination are complete. Paracetamol can mask fever symptoms and Ibuprofen can interfere with clotting ability.

It is important to provide calm assurance to woman presenting in any state and is essential during a procedure.

Choice of pain management will depend on the swiftness of action of a drug. Oral and IM routes take longer to take effect but provide longer lasting pain relief, while IV and inhalation drugs are quick to take effect and to wear off. Restriction of oral fluids will affect choice as well.

Monitor Post Abortion Care patients.

A successful evacuation of uterine contents will decrease suprapubic/abdominal pain. The patient will feel cramping in the uterus for 2-4 hours afterwards. Signs of infection should decrease over the next 24-48 hours and vaginal bleeding will decrease to spotting. Check haemoglobin to assess whether the patient requires fluid or blood replacement.

Complications include placental adhesions, anaemia, trauma to the uterus or cervix, sepsis. Carefully observe for any suprapubic/abdominal pain or cramping that lasts for more than 4 hours. Also check for fever, bleeding, or low haemoglobin that lasts for more than 2 days.



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Table 1. Guidelines to determine the stage of abortion

DIAGNOSIS	BLEEDING	CERVIX	UTERINE SIZE	OTHER SIGNS	MANAGEMENT
Threatened abortion	Slight to moderate	Not dilated	Equal to dates	Cramping Uterus soft	Bed rest Observation for progression to inevitable abortion
Inevitable abortion	Moderate to heavy	Dilated	Less than or equal to dates	Moderate to severe cramping	Uterine evacuation to avoid complications of incomplete abortion
Incomplete abortion	Slight to heavy	Dilated	Less than or equal to dates	Partial expulsion of products of conception Uterus tender and firm	Immediate evacuation of uterus
Complete abortion	Slight to moderate	Dilated or closed	Less than dates	Complete expulsion of products of conception	No uterine evacuation needed Reassurance and counselling
Missed Abortion	Little or none	Closed	Less than or equal to dates	Foetus dead with delayed expulsion Decrease in signs and symptoms of pregnancy	Make sure pregnancy is non-viable Evacuation of uterus in referral level facility

During the treatment process, instruments may have inflicted trauma to the uterus, products of conception may have not been fully removed, the patient may not be given sufficient fluid replacement for the amount of blood loss, and/or aseptic technique may not have been followed completely. It is important to keep the patient until all signs and symptoms have abated. Upon discharge give the patient

instructions on symptoms to look for, and where to go if these symptoms are discovered.

Because of the circumstances of the migrant population, every woman should be discharged with a family planning method in her hand or a plan to get one, if she does not want to get pregnant again soon. (articles on family planning will be included in a further issue).



Table 2. Signs and symptoms and management of unsafe abortion complications

Complication	Sign and symptom	Management
Incomplete abortion	<ul style="list-style-type: none"> • Heavy vaginal bleeding • Severe cramping • Dilated cervix • Tissue in the cervix or vagina • Lower abdominal pain 	<ul style="list-style-type: none"> • <12 wk MVA* • >12 wk D&C* • Give antibiotic • Give tetanus toxoid injection
Haemorrhage	<ul style="list-style-type: none"> • Heavy, bright red vaginal bleeding with or without clot • Blood-soaked pads, towels, or clothing • Pallor 	<ul style="list-style-type: none"> • Assess magnitude of shock (amount of blood and fluid lost) • Stabilize the patient by replacing fluid • Correct the underlying problem (eg. repair laceration, evacuate uterus, perform laparotomy) • Monitor condition carefully (e.g. BP, pulse, RR, urine output, continued bleeding)
Shock	<ul style="list-style-type: none"> • Pulse > 110 • Diastolic < 60 • Respiratory rate > 30 • Pallor • Clammy extremities • Anxiety, mental status 	
Infection	<ul style="list-style-type: none"> • Fever • Uterine tenderness • Purulent cervical discharge 	<ul style="list-style-type: none"> • Assess for abdominal injury • Assess for shock • Begin broad spectrum antibiotics given, (bleeding, and patient's general condition permitting) • Tetanus antiserum and toxoid if indicated • Monitor condition carefully for signs of improvement or shock
Sepsis	<ul style="list-style-type: none"> • Fever, chill, sweats, malaise • Foul smelling vaginal discharge • Abdominal pain with tenderness, distension, guarding • Low blood pressure, rapid pulse • Possible alterations in consciousness • History: recent induced abortion 	
Intra-abdominal injury	<ul style="list-style-type: none"> • Nausea, vomiting • Shoulder pain • Abdominal tenderness • Guarding • Rebound tenderness • Distension • Signs of intra-abdominal bleeding (pallor, shock, etc.) 	<ul style="list-style-type: none"> • Stabilize and send to referral hospital

*Note: If the foetus has not yet been expelled, MVA and D&C are not appropriate procedures to use. Women with greater gestation are at higher risk for a uterine perforation.



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Refer patients with septicemia or intra-abdominal injury.

If there is evidence of interference with the pregnancy, there is the possibility of serious infection (including tetanus) or injury to the abdomen or uterus. These cases are stabilized and referred to the hospital.

If there is evidence of intra-abdominal injury (history of nausea and vomiting, shoulder pain, abdominal tenderness, guarding and rebound tenderness, distention or diminished bowel sounds on exam), the patient is stabilized and referred immediately to the hospital. Signs of intra-abdominal injury are similar to those of an ectopic pregnancy. It is important to consider this factor when making a differential diagnosis.

Counseling Post -Abortion Care Patient.

For many women this emergency situation may be the only contact they have with the health care system. They have already experienced the trauma of an unwanted pregnancy, from either not using contraception or method failure. They are in need of gentle and supportive family planning counseling and services. These services must be made available to the woman during treatment for her acute problems. One-week follow-up appointments may be too late! Migrant women may not return for their follow-up and need to know that they can get pregnant within 11 days.

Women need to know that they can get pregnant as soon as 11 days after their abortion. They also need to know that there are safe and effective means to delay pregnancy and that all modern methods can be started immediately after abortion care in most cases. Before they leave the health facility, they should know where and how to obtain these methods if they are interested.

Guidelines for providing post-abortion care counseling.

Treat the woman with respect

- if she does not feel well, counsel her when she feels better
- show concern for her feelings and her experience
- keep counselling private
- include her husband

Find out about the woman's needs and situation

- ask her if she wants to become pregnant again soon
- ask if she has used family planning and if there were any problems in using it
- ask if she has a preferred method

Provide the information that is appropriate for her

- help her get the preferred method
- do not pressure her if she wants to get pregnant again soon
- make follow-up appointments or referrals for any other reproductive health needs



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Unsafe Abortion and its Prevention: Who cares?

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*This article gives the social and economic reasons for
the high number of unsafe abortion on the border.*

During 2001 I spent most of the year studying women's experience of unwanted pregnancy by looking at hundreds of health records as well as talking with some women and their husbands. Before I tell you more about that, let's start by telling a story. It is not about one woman but a compilation of many women's stories. It is intended to show that abortion is not only sometimes a life threatening event for a woman, but it also reflects the social conditions, legal and religious norms of the communities we live in and how we value human rights and the status of women.

A story of unsafe abortion

Ma Win Kyaw is 32 years old, Buddhist and comes from Karen State. She has lived in Thailand for six months and is married. She has three children in Burma that are being looked after by her mother and she sends money home when she can. She and her husband work in low paying jobs in a factory making clothes. She works long hours and doesn't get enough sleep.

She uses Kathy Pan¹ every month to make sure her period comes, but she hasn't seen any blood for two months now. She told her husband and a couple of friends that she thinks she is pregnant and her husband said she should stop the pregnancy because they need to save money. She asked her friend what to do and they decide to go to the market and find some



Women working at a textile factory.

Women working at a textile factory.

medicine. At the market they bought Nequezee for 12 Baht and the woman behind the stall said that if that didn't work she could help her fix it. One week later after trying Nequezee and drinking ginger and sugar cane juice, she felt sick with worry, as her period had not come. The Thai boss came and quietly threatened her. He had found out that she was pregnant and he told her that she and her husband would lose their jobs if she didn't get rid of it. He said he didn't want any pregnant women in his factory.

What should she do? She could travel home and have the baby in Burma, but one more mouth to feed would push them into deeper poverty. The situation in Burma is bad and the price of food and essentials rises every week. No one taught her or her husband about family planning and she only went to school for three years, but she can read. She knows that it is possible to stop the pregnancy, but she doesn't know where to go to get help.

¹ Kathy Pan is a herbal medicine sold in shops and markets for about 30B that is widely used to 'regulate periods'; Many Burmese women use it as a defacto contraceptive/ abortifacient.



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2000	414	213
1999	291	277

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Table 1. The increasing numbers of deliveries and post - abortion care cases at Mae Tao Clinic

Year	Number of deliveries	Number of post - abortion cases
2001	563	457
2000	414	213
1999	291	277

Her friend took her to the market again and the woman told them where to find the ‘old woman’ (*aporgee*) who knows these things. Ma Win Kyaw felt frightened but determined not to spoil her family’s chance to earn some money in Thailand. Her family relies on her income. It is a sin in her religion, but she hopes Buddha will understand her desperation and she will do something very good afterwards to improve her karma. Also she thought it was just a little piece of blood at this stage and not essentially human yet. She found the house near the market, the old woman was friendly and told her that she would use a ‘medicine stick’ and it wouldn’t hurt. She hardly felt anything as the woman put two 10cm bent sticks from a tree inside her cervix, just a little cramping like a period. She payed the woman 500 Baht and went home feeling relieved.

A little over a week later she was spotting and cramping and felt happy that it would soon be over. She continued to work in the factory until the pain and blood loss increased so much she could not stand any more without fainting. She has chills and fever and felt like vomiting. She had a terrible headache and pain worse than when she gave birth. Her husband took her to the clinic on the back of his bike. It was late in the evening when the health worker examined Ma Win Kyaw and diagnosed an induced inevitable septic abortion. The health worker asked her why she risked so much, her

fertility and her life? She felt so guilty she didn’t say anything.

So who cares about post - abortion care?

Such a story is far from being uncommon. Many Burmese women who live outside of the refugee camps report living in unstable conditions with very few human rights or access to health services. Their decision to end their pregnancy is often economically motivated and they risk their fertility, future health and sometimes their life in procuring the end of the pregnancy. Studies have found that basic knowledge of sexual health issues such as fertility and reproduction are extremely low (Caouette, Kritaya Archavanitkul et al. 2000; Kritaya Archavanitkul 2000).

In 2001 at the Mae Tao Clinic, 457 women attended for for post-abortion care due to complications. About three-quarters of these 457 women had natural abortions or miscarriages and ***one quarter had tried to end their pregnancy themselves***. The majority of the women who attended the clinic required in-patient treatment because they were so unwell (Out Patient Department, 197 women; In-Patient Department, 260 women). In 2001, thirty-one women were referred to the local Thai hospital and one woman died².



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Health services and prevention of complications of abortion

How can health service providers prevent the complications of abortion that cause sickness, loss of income, infertility, feelings of guilt, or death among female migrant workers? A community education promotion campaign about contraception and sexual health for men and women would be one way, but there are many barriers and difficulties. Migrant workers are mobile populations that have little free time and employers often fail to understand their health needs. The illegal status of some of the people conducting abortions make contacting them difficult. Attitudes can prevent discussion of this sensitive topic and communities do not have the financial means of providing education and services.

Providing safe, legal abortion services is one way that some countries use to prevent the women from serious illness and loss of life. In this region of the world access to contraception and safe, clean abortion services is uncertain. Thailand has experienced several decades of public awareness campaigns regarding family size and contraception, which has led to the idea that two children per family is enough and also the acceptability of many forms of modern contraception. Thai people also have accessible village and town-level health services at a reasonable cost. Thai maternal and infant mortality rates are low and sanitation and the general well-being of people are quite good.

Access to safe abortion is not easy and a Thai woman needs to prove that her life is in danger or that she has been raped in order to legally end her pregnancy. Many Thai women do opt to have an illegal abortion and about 19

women die each year (Whittaker 2000). Although Thai people have generally accepted the idea of using many modern methods of contraception, it was found that Burmese women who had been referred to the local Thai hospital for post-abortion care were not given contraceptive options at the time of discharge. A few Burmese women were offered tubal ligation, but no other modern method was discussed with them and neither was reading material provided. Tubal ligation is not a method of choice for women who have not yet completed their family. As most women require some form of short-term or long-term contraception after either a spontaneous or induced abortion, it is surprising that women are not offered easier access to a reliable method of fertility control. Mae Tao Clinic do offer women a variety of modern methods at the time of discharge.

In Burma legal abortion is restricted to the criteria to save the mother's life only. Regarding family planning, Burma's situation is quite different to Thailand. The country has been strongly pro-natalist and only began a limited child spacing programme after a visit and some financial support by United Nations Family Planning in 1995 (United Nations Family Planning Association 1999). The United Nations assessment noted "Reports from previous studies indicate that approximately 50 percent of maternal deaths are due to abortion related complications (Tun Yee 1990, Than Than Yin 1992, Central Women's Hospital 1997)." [UNFPA 1999: 22] An article by Dr Ba Thike (Ba-Thike 1997) inside Burma showed that the morbidity and mortality due to unsafe abortions were very high and complications from abortions have appeared in the top ten list of public health problems by the military

² I have also unconfirmed reports of other Burmese women dying of post abortion complications that I will follow-up.



government for several years now. This is a strong indicator of the unmet need for contraceptive services.

In addition Burmese women use traditional or herbal methods with unknown efficacy to regulate their periods and provide some contraception. A quick walk in the local market will find on display an array of quack potions and out-of-date medicines that are offered to women by market vendors. I asked a group of traditional birth attendant trainers how many methods of contraception they were aware of. They reported 20 different non-modern methods and five modern methods. Non-modern methods practiced by mainly Karen people included eating special types of roots, leaves or vegetables, twisting or lifting the womb, coughing out semen after sex, putting a thread around the woman's waist, washing after sex, massages and breast-feeding. Interestingly they included abortion as a non-modern method of fertility control. Another significant difference is the ideal family size. Some Karen health workers were asked what was their idea of the right number of children in a family and most reported that three to four children per couple would be perfect.

Singapore provides abortion on request. Bangladesh provides early abortions for women and Malaysia's abortion laws are also quite liberal. In Australia abortion is provided up to 12 weeks by the government health sector at a reasonable cost if the woman and two doctors agree that the pregnancy would be negative to her mental or social well-being.

A high level of knowledge does not always equal healthy behaviour. But some culturally appropriate reproductive health education programme in the Karen and Burman languages and provision of modern contraceptive methods would be beneficial for preventing the risks of unsafe abortion and associated suffering for women. The author will write a report to give more information about fertility and unwanted pregnancy issues in Burmese and English languages that will be distributed during 2003. Please contact the author by email for a copy.

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Mother to Child Transmission of HIV/ AIDS (MTCT)

Health Messenger



This article explains what mother to child transmission of HIV/ AIDS is, and how it can be limited.

Mother to Child transmission means transmission of Human Immunodeficiency Virus (HIV) to a child from an HIV-positive women during pregnancy, delivery or breast-feeding.

Women of childbearing age constitute nearly half of the 30 million adults living with HIV/ AIDS worldwide. This mode of transmission accounts for an estimated 1,600 of the 16,000 new infections that occur each day in the world.

HIV/AIDS are different for women because:

- Women get infected with HIV more easily than men do. A man puts his semen in the woman's vagina, where it stays for a long time. If there is HIV in the semen, it can pass easily into a woman's body through her vagina or cervix, especially if there are cuts or sores.
- Women become sick with AIDS more quickly after becoming infected with HIV than men do. Poor nutrition and childbearing may make women less able to fight the disease.
- Women are blamed unfairly for the spread of AIDS. But men are just as responsible as women. For example, they are the ones who buy sex, which is a common way that AIDS is spread.

How does the transmission happen?

During the pregnancy:

Evidence suggests that HIV can infect the placenta at all stages of pregnancy. Transmission may occur through the placenta or transfusion of infected blood into the foetal circulation.

Studies suggest the risk of a mother transmitting HIV to the foetus during pregnancy as between 15 and 40 percent.

Risk factor: When a woman becomes infected with HIV during her pregnancy, close to the time of birth or when she is breast-feeding, the risk of transmission is higher because the amount of the virus in the blood is particularly high just after a person becomes infected.

During the delivery:

Transmission during labour and delivery could occur during passage through the birth canal by direct contact of the baby with infectious maternal blood and genital secretions. It can also happen if the child swallows the mother's vaginal mucus and/or blood.

The skin and mucous membranes of newborns are ineffective barriers to HIV. A prolonged or traumatic delivery, the presence of maternal Sexually Transmitted Diseases (STDs) or premature ruptured membranes



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Source : (WEAVE)

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- v l b u b q l v f i u e f b b l j c i f ?
- v l b u b q l u f t c s i f c s i f o p m & j i f ?
(E p o p v h t d v t s t l l A g h & b p &)
- x l o f a o m v l b u b q l t r j y l c i f ?
- v l b u f _ v l o r j y l c i f ?

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a o m f y i b i x m ; & r n j z p a - u m i f 3 0 & m E e f y l u l p u c i f
j z p E l l a o ; a - u m i f a q a E f a y m u m ; & r n f

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u l p u E e f o b b m o m u s q i f o r a - u m i f a w b o n f
o l o m f t q l y q ; r s r u l l z o r q E l l i f s r ; Y w e l u s , p h
r o l E l l a o ; a - u m i f a w b . ?

r , h a w m a q ; c e f E s f l u Q o n p c e f w e f a w e f p w i b h
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p l l r n j z p a - u m i f a w b o n f

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1992 - a r v w e f ' A , l t d v t s t E s h , b l q u i w h
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u a v ; a o q l b j c i f . t ' d u t c u r s r ; j z p l u t q l y g
a ' o r s r ; w e f a e x l l u a o m t d v t s t l l A g h & r o r d



increases risk of HIV transmission.

Transmission during delivery is the most common factor, accounting for 60-85% of cases.

During breast-feeding:

Transmission through breast-feeding accounts for 15% of the infection rate, depending on the duration of breast-feeding. It is supposed to happen through the tissue of the mouth or gastrointestinal tract of the baby.

A story:

Naw Bel Sae lived in a refugee camp. She got married at the age of 19 and was pregnant soon after the marriage. She was not aware that her husband was used to visiting commercial sex workers. During the delivery of her first child, the writer noticed that she had many vaginal warts. When her first child was five years old, she got pregnant again. During an antenatal care visit, the health worker discovered that several large itchy warts were blocking her vagina. The health worker cleaned the warts with soap and water. After delivery, she was tested HIV positive. Her baby died at the age of 4 months because of diarrhoea, and herself two months later.

Courtesy: Naw Dah, KWO

How to prevent or limit the transmission?

During conception:

When a woman of child bearing age discovers that she is infected with HIV, she should receive counselling as soon as possible on issues related to her fertility. She should know about the risks of transmission to the child if she becomes pregnant. She also should be sensible about the information to be given to her sexual partner(s). If she is sexually active, she needs to be informed of the contraceptive methods available and particularly about the condom, which is the only method that can prevent the transmission of HIV to her partner(s).

How to prevent the transmission of HIV between sexual partners?

There are four ways:

- Intercourse with a condom
- Mutual fidelity (if both partners are not infected)
- Non-penetrative sex
- Abstinence

If a woman is HIV positive, she should be prepared for the possibility that her child may be born with HIV. But she should also be told that there is at least a 70 percent chance the child will not be infected.



Source: WEAVE



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During delivery:

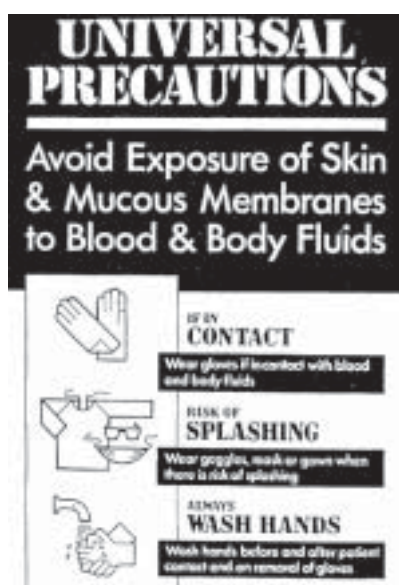
Caesarian section can help to reduce the transmission.

Prevention for Health Workers

Universal Precautions

A set of simple guidelines applicable in all health care settings including at home can prevent the transmission of blood-borne infections:

Taking care to prevent injuries when using, handling, cleaning or disposing of sharp instruments; avoiding the recapping, breaking or bending of used needles; disposing of sharp items in puncture-proof containers; using protective barriers (gloves, eyeglasses, waterproof aprons and footwear) to prevent exposure to blood and other potentially infective body fluids; washing immediately skin surfaces which are contaminated with blood or other potentially infective body fluids.



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Source: A Guide For Health Workers On The Thai-Burmesse Border

Since the middle of the 1990's, more and more efficient anti-retroviral treatments for HIV infected pregnant women have been developed and can reduce drastically the mother to child transmission rate. Unfortunately, those treatments are not available in most of the developing countries. However, they have started to be used at the Mae Tao Clinic and in some refugee camps in Thailand. In the future, they might be more available.

During breast-feeding:

WHO and UNICEF issued this statement in May 1992:

“Breastfeeding should be recommended to HIV infected women in areas where infectious

This is the currently recommended regime in Thailand:

HIV infected pregnant women can be offered AZT (Zidovudine)

- 300 mg PO BID from 34 weeks gestation until labour
- 300 mg PO every 3 hours from onset of labour until delivery

Babies born to HIV infected mothers can be offered AZT treatment 2mg/kg QID as follows:

- If mother receives AZT for more than 4 weeks, infant receives AZT for 1 week
- If mother receives AZT for less than 4 weeks, infant receives AZT for 6 weeks plus avoid breast-feeding ONLY IF POSSIBLE



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diseases and malnutrition are the main causes of infant deaths and infant mortality is high. However, in areas where infant mortality is low and the main cause of infant deaths is not infectious disease, a safe substitute for breast milk should be used”.

In many countries in Asia, where infant mortality rates are high for most of the cases, it is important for mothers to continue to breast-feed their babies despite the risk of transmission because:

- Breast milk is very important to the health and well-being of infants. Without breast milk babies are more vulnerable to diarrhoea, respiratory and other infectious diseases, all of which can be life threatening.
- When an infant has already been infected with HIV (during pregnancy), breast milk from an infected mother may protect the infant from infections.
- In many countries in Asia, it is not always possible for women to gain access to safe alternatives to breast milk. There may be problems concerning lack of clean water, difficulties in sterilising feeding equipment and a lack of money to buy adequate amounts of the substitute food.

Alternatives to breast-feeding:

- Infant formula: is an **expensive solution** and it is not available everywhere. It might also be dangerous if the mother lacks knowledge on the correct use of the formula. If it is prepared without proper and very strict hygiene, it can be a cause of severe infection, which can lead to malnutrition and even death.
- Expressed breast-feeding: The mother has to express the milk, to boil it for 30 minutes to kill the virus and then to cool it down immediately in cold water or refrigerator. It is a **solution difficult to manage** for most women.

- Wet nursing: Women who are not infected with HIV can breastfeed the infants of HIV infected mothers. This is a difficult solution as it is difficult to know the health status of the breast-feeding woman.



ရည်စူးမှု? Breast-feeding.

**FOR MOST WOMEN IN
BURMA, BREAST-FEEDING
REMAINS THE BEST SOLUTION.**

Health workers and social workers should introduce all the possible choices to the mother and provide her with all information to allow her to choose the best solution in regard to her situation.

Health workers and social workers can help the mother to assess her situation: If she can afford formula milk (if it is available), does she have access to safe water, or can she prepare replacement food in strict hygienic conditions?

**BUT THE FINAL DECISION SHOULD
BE TAKEN BY THE MOTHER.**

**Remember that knowledge on
HIV/AIDS is increasing every day, so
protocols are subject to frequent
revision and possible change!**



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Healthy Pregnancy, Healthy Baby

Andrea Menefee, Nutritionist, Burmese Border Consortium



This article explains how important nutrition is for pregnant women and for the health of their unborn babies.



The Story of Mah Koh

Mah Koh is 27 years old. She is in her 5th pregnancy – her first child, a boy, is now 7 years old. Her second child was born very small, only 20 months after the first child, and died soon after birth. The third child, a girl, was also born with low birth weight (<2500 gms), but she lived. Then she had a boy, who is now 21 months old. He is underweight and often sick.

Mah Koh is afraid of having a large baby, thinking that the delivery will be more difficult. Because of this, she limits what she eats during her pregnancy, and never gains more than about 5-6 kg.

EXCEPT FOR HER FIRST CHILD, ALL HER CHILDREN WERE BORN UNDERWEIGHT AND ONE DIED. MAH KOH IS WORRIED ABOUT HER CURRENT PREGNANCY, AND VISITS THE MCH CLINIC TO GET SOME HELP. HERE'S WHAT SHE FINDS OUT...

Weight gain in pregnancy.

Pregnant women need extra energy and nutrients. Women who do not get the extra food that they need may become undernourished during pregnancy, OR may not gain enough weight to have a healthy baby.

Weight gain in pregnancy is made up of (approximately):

3.0 kg = the baby

4.0 kg = increase in size of uterus and breasts, increased blood and fluids, and placenta

3.0 kg = fat stores, to be used after baby is born to make breast milk

10 kg = total average weight gain during pregnancy

During the first 6 months of pregnancy, most of the extra food is needed to build up the mother's tissue and fat stores. Only a small amount is needed for the growing baby.

During the last 3 months of pregnancy, more of that extra food is needed for the growing baby, and to build up the baby's stores of fat, iron, and vitamin A.

Undernourished women often have undernourished children.

Undernourished children are more at risk of death and disease, and are more likely to have underweight babies later on, which continues the cycle.

Eating well during pregnancy should not make the baby too large to deliver, *if the mother*



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How Maternal and Child Nutrition Are Linked

Birth weight is closely associated with child survival, well-being, and growth, which influences nutrition in adolescence and determines how well nourished the mother is when she enters pregnancy.



Prevention of stunting in girl children during the first two years can help break the cycle of malnutrition.



Nutrient stores built up in adolescence help the nutrition of women during and between pregnancies.



Mother's nutrition before and during pregnancy influences growth and development of the fetus and its birth weight; it affects her chances of surviving the delivery.



Adequate nutrition for the mother should be maintained during breastfeeding.



Mother's nutrition is important for practicing child-rearing, care, and household/economic tasks, and for recovery...



...for future pregnancies.



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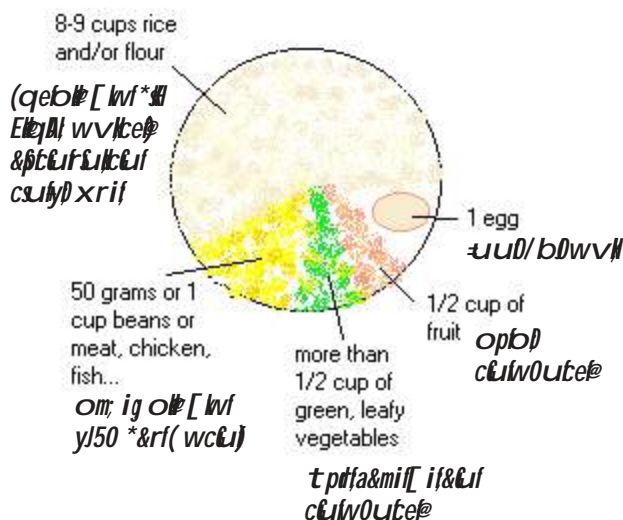
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A simple guide for pregnant women nutrition.



herself is not too small.

In order to be sure that a woman is getting enough good nutrition, the health care worker can monitor her weight gain – a woman should gain around 10 kg during pregnancy to ensure that her baby is born healthy and strong.

In addition to eating extra food, pregnant women should also try to eat plenty of different kinds of supplementary foods, such as beans, eggs, fruits and vegetables. These foods provide extra protein and important vitamins and minerals needed to help the baby grow and develop properly.

If the woman has access to meats, eggs, and other supplementary foods, she can eat a little less of the beans and rice or flour.

Here's a simple guide to how much a pregnant woman should eat every day....

- almost 1 milk tin of raw rice (8-9 cups of cooked rice/flour)
- 1 or more cups of beans (about 50 grams raw)
- 1 egg + meats, chicken, fish, if available
- a little more than ½ cup of leafy green vegetables
- ½ cup of fruit, or other vegetables
- plenty of oil to cook foods

All pregnant women should be sure to take their prenatal vitamins and minerals – the extra iron, folic acid and B vitamins are important in ensuring a healthy delivery and healthy baby!

Sources:

Nutrition for Developing Countries: F. Savage King and A. Burgess, Oxford Medical Publications, 2000

Nutrition Essentials: A Guide for Health Managers: WHO, UNICEF, 1999

MAIN POINTS

- an underweight mother is more likely to have a underweight (low birth weight) baby
- an underweight baby is more likely to die or suffer from frequent illness
- a healthy mother is less likely to have a difficult delivery
- good nutrition = healthy pregnancy = a healthy baby = healthy and strong child!





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Source : WEAVE

Let's Raise our Children for a Better Future

Health Messenger



From the moment our children are born how we raise them will determine much of what they believe and how they act as adults.

As parents, we teach our children every day of their lives:

- When we teach our sons that it is manly to be violent, we raise violent men.
- When we do not speak out against violence in our neighbour's house, we teach our sons that it is acceptable for a man to beat his wife and children.
- When we feed the men and boys first, we teach our children that girl's and women's hunger is less important.

As parents, we have the power to change who our children will become.

- We can teach our sons to be kind and compassionate, so they will grow up to be kind and compassionate husbands, fathers and brothers.
- We can teach our sons to respect all women and to be responsible sexual partners.

Source: Where Women Have No Doctor, Macmillan, 1997



Source : WEAVE

MAP FOUNDATION FOR THE HEALTH AND KNOWLEDGE OF ETHNIC LABOUR

MAP Foundation is a member of the “Network of Thai NGOs working with migrant workers and their families,” which is committed to ensuring that migrants can exercise their reproductive health and rights. The issue is also high on the agenda of states in Asia. In December 2002 Parliamentarians from Asia pledged to:

Give high priority to achieving universal access to sexual and reproductive health services in national health and poverty reduction frameworks, both in terms of budget allocations and in terms of programme activities¹

The right to health, including reproductive and sexual health and family planning is a basic human right. MAP arranges workshops with young male and female migrants to talk about issues of sexuality, sexual health and relationships, and to offer counselling services. MAP can assist migrants in being able to access state family planning services and services offering AZT to HIV positive pregnant women to reduce the risk of mother to child transmission.

MAP also produces brochures on health issues in Shan and Karen on:

- Contraceptives/birth control
- Pregnancy
- STDs
- HIV/AIDS
- Safe sex

MAP broadcasts daily radio programmes on health issues, including a soap opera on HIV/AIDS, on the National Radio Broadcasting Station of Thailand, AM 1476Khz. You can tune in on your radio and listen to Karen language from 6.00pm to 7.00pm and Shan language between 10.00pm and 11.00pm.

Although reproductive health is the responsibility of both men and women, we also run women only activities. Migrant women have identified discrimination, violence and cultural and religious beliefs as barriers to accessing information, making informed choices and participating in decision-making processes. Many women have very little time and no space to discuss issues affecting their health, so MAP organises monthly meetings where women can exchange information and experiences, gain confidence and develop self-esteem. Only when an environment free from violence, coercion and discrimination exists can women take control over their reproductive health.

If you would like any of our brochures or need more information, please contact:

MAP Foundation, PO Box 7, Chiang Mai University, Chiang Mai 50100

Tel/fax: 053 811202

email; mapnet@cm.ksc.co.th

We also welcome any comments or suggestions about our radio programmes.

1 The Asian Parliamentarians Meeting on ICPD Implementation, 12-13 December 2002, Bangkok

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Glossary

Trauma:	A wound or injury, whether physical or psychic.
Intra Uterine Device:	A small object that is put into the womb to prevent pregnancy.
Prophylaxis:	prevention of disease, preventive treatment.
BID:	Latin- bis in di'e, twice a day.
TID:	Latin- ter in di'e, three times a day.
PO:	Latin- per os, by mouth, orally
Abdominal:	Portion of the body which lies between Chest and pelvis.
Pelvis:	The lower portion of body.
Protruding:	To push foreword.
Cervix:	The passage of the womb at the back of vagina.
Foul discharge:	Bad smell fluid comes of out of the vagina.
Cervical OS:	Open of cervix.
Tubal Ligation:	An operation in which the fallopian tubes are cut or tied, so the egg cannot travel to womb to be fertilized.
Induced abortion:	Abortion brought on intentionally.
Birth canal:	A tube made of muscle that goes from the opening of the women's genitals to the cervix.
Secrection:	Specific product as a result of the activity of a gland (example- saliva from salivary gland in the mounth.)
Mucus:	A thick wettness that the body makes to protect the inside of the vagina, nose, throat, stomach and intestines.
Foetal circulation:	Blood circulation of the baby in side the mother's womb.
Gastro intestinal tract:	Tube-like part of the food cannal from the mouth to anus.

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