

RESEARCH ARTICLE

“I came by the bicycle so we can avoid the police”: factors shaping reproductive health decision-making on the Thailand-Burma border

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Abstract: For over half a century, political conflict combined with an overall lack of economic development has resulted in the displacement of millions of people both within Eastern Burma and to neighbouring Thailand. Given the overarching context, in conflict-affected regions of Burma, women face tremendous challenges in trying to obtain high quality, comprehensive reproductive health services. Drawing from interviews we conducted in Tak province, Thailand with 31 migrant and refugee women from Burma, this article explores women’s lived experiences along the border and focuses on the ways that complex, overlapping barriers impact women’s reproductive health decision-making at different points in their reproductive lives. Our results show that reproductive experiences are highly dependent on the woman’s place of living mixed with her legal status and financial resources. Combined with socio-cultural taboos and externalized and internalized stigma, these dynamics blend to place constraints on women’s autonomy and self-actualization. The way in which women’s experiences are shaped by these barriers offers insights into priorities for education and programming to help improve reproductive health services in this protracted conflict setting.

Keywords: abortion, ethnic minorities, family planning, migrants, Myanmar, refugees

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1. Introduction

Eastern Burma represents one of the longest conflict-affected regions in the world.¹ Infrastructure and services in Eastern Burma have been neglected, impeding movement, and creating enormous disparities in education, healthcare, and income generating opportunities (Sietstra, 2012; Mullany, Lee, Yone *et al.*, 2008; Crawford, 2005). These overall dynamics combined with an overarching lack

¹ In 1989, the military junta officially renamed the country of Burma as Myanmar. However, there continues to be significant debate as to the legitimacy of this name change. Our study team has chosen to use the name “Burma” as this respects the language used by our study participants and the stakeholders that we work with on the Thailand side of the border. We will use Burma to refer to the country throughout this article. This is a decision made solely by the authors and does not reflect the views of the editors, the journal, or the publisher.

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of economic development have resulted in the displacement of millions of people both within Eastern Burma and to neighbouring Thailand (Sietstra, 2012; New Internationalist, 1996). Those who have been internally displaced and those living in conflict-affected areas of Eastern Burma are commonly referred to as “cross-border populations” as they are often provided with services and support from organizations operating in Thailand (Hobstetter, Walsh, Leigh, *et al.*, 2012). Populations from Burma residing in Thailand are comprised of two primary groups — refugees who reside in one of the nine “unofficial” refugee camps in Northern Thailand and migrants, most of whom are undocumented and do not have legal status.²

Consistent with conflict-affected populations around the world, the overall situation has impacted women’s reproductive health. Cross-border populations are at significant risk of dying during pregnancy and childbirth, lack consistent access to contraception, and face high rates of unintended pregnancy (Burma Medical Association, National Health and Education Committee, Back Pack Health Worker Team, 2010; Back Pack Health Worker Team, 2006). Burma’s abortion law is one of the most restrictive in the world and is narrowly interpreted. As a consequence, unsafe abortion is common and is a leading cause of maternal mortality in Eastern states (Ba-Thike, 1997). Women in Burma residing in Thailand — as either refugees or migrants — also face tremendous challenges to obtaining high quality, comprehensive reproductive health services and are at heightened risk of sexual exploitation and violence (Mullany, Lee, Yone *et al.*, 2008; Crawford, 2005; Maung and Belton, 2005; Belton and Maung, 2004). The efforts of a large number of international non-governmental organizations (NGOs) and community based organizations (CBOs) have not been sufficient to meet the overwhelming needs of women on both sides of the border (Hobstetter, Sietstra, Walsh, *et al.*, 2015; Gedeon, Hsue, Walsh, *et al.*, 2015; Sietstra, 2012; Hobstetter, Walsh, Leigh *et al.*, 2012; Lee, Mullany, Richards *et al.*, 2006).

That women in this context face structural, systems, legal, policy, and socio-cultural barriers to accessing desired health services has been well documented (Hobstetter, Sietstra, Walsh *et al.*, 2015; Sietstra, 2012; Hobstetter, Walsh, Leigh *et al.*, 2012; Mullany, Lee, Yone *et al.*, 2008; Maung and Belton, 2005; Belton and Maung, 2004). However, far less research has been dedicated to exploring how women experience those barriers and identifying ways that women navigate these multi-faceted constraints. Drawing from interviews we conducted in Tak province, Thailand with migrant and refugee women from Burma, this article explores women’s lived experiences and the ways that complex, overlapping barriers impact women’s reproductive health decision-making at different points in their reproductive lives.

2. Methods

In the summer of 2013, we conducted a qualitative study dedicated to understanding women’s experiences with the intrauterine device (IUD) on the Thailand-Burma border, a rarely used technology in this setting at the time. This effort was part of a larger project focused on identifying and addressing barriers to expanding access to long-acting reversible contraception and involved a multi-stage, multi-year collaboration between researchers and service providers in the US, Canada, and Thailand. We have reported on the IUD-related findings elsewhere (Gedeon, Hsue, Walsh *et al.*, 2015).

However, our semi-structured interviews with 31 women from Burma explored a range of issues beyond the IUD and our initial study questions. Participants provided extraordinarily detailed accounts of their lives, including reflections on major reproductive health-related decisions and events. In this article, we use the same dataset to delve into women’s experiences along the border and focus on the structural, systems, financial, and socio-cultural factors that influence decision-making and access to services.

² Thailand is not a signatory to the 1951 Refugee Convention nor to the 1967 Protocol Relating to the Status of Refugees, and thus does not officially recognize the camps (Women’s Commission for Refugee Women and Children, 2006).

2.1 Study Sites

Our data collection took place between June and August of 2013 in two cities located along the Thailand-Burma border: Mae Sot, Thailand, and Mae La, Thailand. Located only 5 km from the Burmese border, Mae Sot includes a large population of individuals who fled Burma during the civil strife as well as people who have crossed the border in search of economic opportunities and served as our primary base throughout the project. Mae Sot is home to the Mae Tao Clinic, an independent facility that provides comprehensive care to cross-border, migrant, and refugee populations and serves a catchment area of more than 200,000 people. Our second study site was the Mae La refugee camp, one of the largest unofficial refugee camps located along the border with over 40,000 inhabitants (AMI, 2012), otherwise known as “persons of concern” or as displaced populations (UNHCR, 2005).

2.2 Recruitment and Data Collection

We used a multi-modal, multi-lingual recruitment strategy to identify participants. Because the study was designed to explore women’s experiences with and perceptions of the IUD, women were eligible to participate in the study if they were over 18 years of age, had used an IUD for at least six months, and were living along the Thailand-Burma border as a refugee, migrant, or cross-border individual. Women also needed to be sufficiently fluent in English, Burmese, or Karen in order to participate. Women who were interested in speaking with us first contacted our local Study Coordinator (Saw Nanda Hsue) who provided additional information about the study, confirmed eligibility, and scheduled the interview at a mutually convenient time and location. A local member of our team helped advertise the study in the Mae La refugee camp through her networks which helped recruit the majority of our participants for this study.

We obtained informed consent before commencing and audio-recording each interview. Using an interview guide developed specifically for this study, Jillian Gedeon conducted the interviews with the aid of an interpreter when necessary. We asked women to share with us information about their sexual and reproductive health history, experiences with the IUD, and thoughts on the ways that services along the border could be improved. Due to the sensitivity of the research topics, participants were given the option of having either a male or a female interpreter. Interviews in Mae Sot were conducted in a private room at Mae Tao Clinic and interviews in Mae La refugee camp took place either in a private room courtesy of a local organization or in the woman’s house, per her preference. Women were repeatedly assured that participation and their responses to our questions would have no impact on the health services they received. All participants received the Thai Baht equivalent of USD10 as a thank you for participating, as well as refreshments during the interview itself. The Health Sciences and Sciences Research Ethics Board at the University of Ottawa approved this study (File #H02-13-08), as did the research committee at Mae Tao Clinic, Mae Sot, Thailand.

2.3 Data Management and Analysis

Our analytic plan was iterative, meaning that we reviewed data as they were collected to reflect on categories of content, adapt the interview guide, and identify thematic saturation. Jillian Gedeon also made detailed field notes before and after the interview and formally memoed throughout the project in order to reflect on emerging themes and the ways in which her positionality influenced the process. We transcribed and translated the interviews and used ATLAS.ti to manage our data (Friese, 2014). Using a sequenced approach to coding and interpretation, we conducted content and thematic analyses of the data through employing both *a priori* (pre-determined) codes and categories based on our study questions and the interview guide as well as inductive techniques to identify emergent themes (Gibbs, 2008). Regular study team meetings guided our interpretation.

In the results section we begin with a brief description of our participants. We then turn to the findings related to women’s perceptions of the factors that impact reproductive health decision-making

and access along the border. We use quotations throughout the article to illustrate key findings and have removed or masked all identifying information by using pseudonyms throughout. We also include a series of narrative vignettes that showcase the ways in which participants revealed their experiences, perceptions, and opinions.

3. Findings

3.1 Participant Characteristics

Over the course of the study we conducted in-depth interviews with 31 women. At the time of the interview, participants' ages ranged from 21 to 55, with an average of 32. All of our participants were married and all but one of the women we spoke with had at least one child. Our participants included women who identified as cross-border ($n = 2$), migrants ($n = 8$), and refugees ($n = 21$).³ Consistent with the population of women from Burma residing on the border in general, our participants identified with a range of religious and belief systems including Buddhism ($n = 14$), Christianity ($n = 11$), and Islam ($n = 6$).

3.2 Precarious Legal Status and Restrictions on Freedom of Movement

"If we go to the Mae Tao Clinic, the way to go there, there is no police. But sometimes when we come back...there is a police officer there and we have to pay 100 baht [USD3] to the police"
- Thanda, age 32, migrant

The harsh realities of life in Burma influenced all of the participants in our study. All of the women we spoke with talked at least briefly about the circumstances surrounding their "escape" or departure from their communities of origin. Whether or not our participants had sought formal asylum in Thailand, all of our participants has crossed the border in search of safety, economic security, and/or services for themselves or members of their family. For many, the move was also aspirational, based on hope that life in Thailand would bring additional freedom and opportunities.

However, all of the women in our study also discussed the challenges associated with having a precarious legal status in Thailand, as captured in Lwin's experience (Box 1).

Box 1: Lwin's story

Lwin fled from Burma with her mother and her younger sister in her early teens. As the oldest child, she has been responsible for providing for her family since they arrived in Mae Sot. Since moving to Thailand, she has worked several odd jobs, including construction work, caregiving, and factory labour, in order to help make ends meet. At a young age, Lwin accepted the reality that she would not be able to continue her education due to financial and legal barriers.

Now 22 years old, Lwin is married to a man that she met at the sewing factory where she currently works. They both work 16-hour days, six days a week and only have Sundays off to spend together and with other family members. Lwin and her husband decided to wait to have children until their financial situation was more stable; their long hours at the factory coupled with their duties to provide for family members prevent them from being able to raise a child comfortably.

Lwin gained her contraceptive knowledge from the married women at the factory and learned both

³ There is considerable fluidity in the way in which women living on at the border identify their residence. For example, a woman may typically reside on the Burma side of the border but may engage in seasonal labour as an undocumented worker and reside in Thailand for several months of each year. Whether this woman identifies as "cross-border" or "migrant" is conditioned upon a number of factors, including the time of the year, the duration of current residence, the site of her primary income generating activities, and the location of family members. We acknowledge this fluidity and report women's residence as determined by individual participants.

accurate and inaccurate information about the oral contraceptive pill, the Depo-Provera shot, and the IUD. She explained that trying to seek medical care for her sexual health is challenging both because of the lack of time in her daily schedule and the risk of being stopped by the police on the way to the clinic. She is now an IUD user and hopes to one day be in a position where she can afford to grow her family.

Undocumented migrants like Lwin and cross-border residents “visiting” Thailand are at risk of deportation and are vulnerable to the demands of Thai police who may levy onerous “fines.” Women’s legal status (or lack thereof) becomes an important part of the calculus of where to go and when and how to travel, thus impacting freedom of movement. Women explained that these dynamics shape their decisions about whether and when to seek reproductive health services.

“On the way [to the clinic] we have to worry about the police, so if I take the pill, I will forget to take it regularly and for the depo [injection] I would have to [try to] come to the clinic quarterly. But if I insert the IUD, then I don’t need to worry about anything for 5 years”

- *Khin, age 33, migrant*

Women are aware of these risks and some developed strategies to navigate them. As Lwin explained, “It’s not hard to get to the Mae Tao Clinic. In the past, I used to come by car. But later on I came by the bicycle so we can avoid the police.” Other participants reported, traveling to Mae Tao Clinic at times of the day when encounters with police would be less likely.

The issue of freedom of movement also emerged in our interviews with refugee women. Women living in the Mae La camp are generally able to move freely within the designated borders of the camp itself. However, in the absence of an identification card or travel papers, movement outside of the camp is severely limited and women who leave the confines of the camp without authorization risk confrontation with Thai authorities. Most of the refugee women we spoke with reported that learning about, let alone accessing, reproductive health services outside of the refugee camp was challenging. As Bway Paw, age 47, explained, “It’s difficult to survive in this camp because we cannot go out. And we don’t have any ID, including UN ID, Thai ID, and Burma ID.” Although many women in our study had positive experiences with clinics in the camp, women who require or desire reproductive health services that are not available within the camp borders and those who would prefer to access services outside of the gaze of their immediate community are severely restricted in being able to do so.

3.3 Availability and Accessibility of Services

“...some of the women are far away from the hospital and they believe that they can rely on [child] delivery by their own [peers] in their village at home. However, when they get a serious condition and they go to the hospital, it is [often] too late.”

- *May Ta, age 28, refugee*

The lack of availability of comprehensive services, particularly for those women who live in rural and more remote areas, was consistently raised by our participants as a major factor in their reproductive health decision-making. Beyond the legal risks undocumented women incur in traveling long distances, many women reported that the costs associated with travel shaped their options and influenced decision-making. The Mae Tao Clinic has established accommodations for women and their families who require multiple days of treatment or who have travelled extensively. However, some of our respondents explained that space was limited and often filled to capacity. Women in Mae La camp generally had ready access to primary reproductive health services in the camp itself, but tertiary services (for high risk pregnancies or complicated deliveries, for example) require transfer to

hospital facilities hours away.

The challenges associated with getting to a facility heavily influenced the timing and types of services women sought. Many of the women in our study had worked with a traditional birth attendant or a traditional healer at some point in their reproductive lives. Although some women reported having positive experiences with traditional and lay providers, most described use of these systems as being forged out of necessity. For example, Myia, a 54-year-old who resided in Eastern Burma at the time of interview, delivered her son in her village in Mon State, Burma in the early 2000s. She believes that his death was directly tied to her inability to travel to an affordable clinic:

“I delivered my son [in the village] and after 5 days, he was not healthy...And then we tried to get him some medicine and we also asked some other people to come and check but they could not help us. They gave us traditional medicine but it wasn’t helpful for my son. He continued to feel better for 7 days but then after 12 days, he died.”

- Myia, age 54, cross-border

A number of our participants reported that the availability of health facilities also directly influenced their contraceptive decision-making. Our participants who lived in Mae Sot or in the Mae La camp were overwhelmingly positive about the contraceptive method mix available to them. However, women who resided in communities outside of Mae Sot or the Mae La camp at some point in their reproductive lives described significant challenges in accessing ongoing contraceptive methods and lacked access to long term reversible contraceptive methods. Women explained that even if they had information about more effective methods, their choices were constrained. Indeed, almost all of the participants in our study adopted the IUD after having experienced challenges in accessing or using hormonal contraception consistently and/or having had unintended pregnancies, as showcased in Khin’s story (Box 2).

Box 2: Khin’s story

Khin got married at the age of 16 when she was still living in Pago, Burma. She became pregnant with her first child a few months after being married to her husband; she explains that they were young and did not know about sexual and reproductive health. She later tried to use contraception to plan her family, but could not afford to take contraception consistently. Reflecting on her experience, she reports:

“I got pregnant with my young daughter because I could not really afford to buy the pill. When I had the money, I would use the pill, but when I didn’t have the money, I didn’t use anything. That is when I became pregnant with her.”

Living in Burma presented many financial hardships and after the birth of her second child, Khin tried to use oral contraceptive pills again, but they made her dizzy. She sought contraceptive counseling and experimented with a variety of methods, all of which came at a cost, while trying to help her husband support their family. The financial constraints that her family was experiencing motivated their move to Mae Sot, Thailand. Since then, Khin experienced contraceptive failure with the pill and had a miscarriage. Her migrant status led her to seek medical advice from a doctor at the Mae Tao Clinic. Now in her mid-30s, Khin eventually opted for the IUD and explained that it was particularly useful when living in Thailand because it reduces the need for many clinic visits, which in turn reduces the risk of getting caught by the police and getting fined as an undocumented migrant.

3.4 Direct and Indirect Financial Costs of Obtaining Services

Fines or bribes to ensure safe passage to or from a clinic and the costs associated with traveling long

distances to clinics are but a few of the financial considerations that our respondents described as shaping their reproductive health decision-making. Most of our participants described the costs of obtaining reproductive health services — particularly contraceptive supplies and delivery care — as prohibitively expensive. This was especially true for cross-border women, as family planning services are often not subsidized and facility-based deliveries often require payment in Burma. In comparing services in Thailand to those in Burma, Lwin explained, “Here, [in Thailand] even if you have no money, they just provide a free service for us.”

Many women in our study explained that financial costs not only influenced their decision to consistently use a particular method of contraception but also served as a major factor in the decision to adopt any method of contraception. Women who engaged in small-scale income generating activities, owned small shops and businesses, and worked in factories along the border, all struggle to make ends meet. Women explained that having (in all but one case) additional children would impede their ability to give their existing children as many opportunities as possible. Further, many women in our study described demanding workloads and daily exhaustion that influenced their decisions about the timing of pregnancies and parenting. As one 30-year-old factory worker explained, “[Each week I have one] day off, on Sunday. We usually start at 8 am and [go] until 10 pm or sometimes...they keep us working until 12 midnight.” Sie Sie’s story (Box 3) reflects this dynamic.

Box 3: Sie Sie’s story

Sie Sie is a 27 year old married woman with one child. She currently works in Mae Sot in a cotton factory with her husband. During her late teens, she found out she was pregnant after having unprotected sexual intercourse with her partner. Sie Sie struggled to find abortion services in Mae Sot and she eventually travelled across the friendship bridge to Myawaddy, Burma to consult with a traditional birth attendant. She was initially given a red powder to ingest and later endured a pummel massage, both of which made her feel very sick and uncomfortable.

“I deliberately aborted my pregnancy because I didn’t want it and I [didn’t] want to get married. When I tried to abort my pregnancy [myself] it didn’t work...So I went to a woman in Myawaddy and she treated me with a medicine...After 15 and 20 days the foetus was not totally aborted and it really hurt me. She pressed and squeezed my stomach with her body and treated me with herbal medicine but I was still really hurt and uncomfortable. I was scared and became thinner. I couldn’t eat any more and then I worried that something would happen [to me]”

Sie Sie and her partner were not convinced that the abortion had worked. Thus they decided to get married immediately because of the cultural stigma associated with pre-marital sex. They found out a couple of days after the wedding that the unsafe abortion had been successful.

After a few years of using the oral contraceptive pill provided to her by her employer, Sie Sie and her husband decided to have a child. But after their daughter was born it became clear that the long and exhausting hours at the factory and the costs associated with caring for a child made raising her in Thailand impossible. Sie Sie ultimately sent her daughter to Yangon to be cared for by extended family members. Sie Sie and her husband continue to live and work in Mae Sot; they hope to eventually be able to obtain enough financial security to be reunited with their child.

3.5 Socio-cultural Stigma Associated with Sex Before Marriage

Irrespective of women’s ethnic or religious identification, the majority of participants in our study referenced that sex before marriage was considered a major social taboo. The stigma associated with premarital sexual activity was cited as a major factor influencing women’s reproductive health knowledge and decision-making by cross-border, migrant, and refugee participants. These women

reported that broader social stigma restricted information and service delivery to adolescent populations and added to community pressure towards early marriage. Internalized stigma impacted the ability of unmarried women to ask questions or seek services when needed; a cultural construct often described as “shyness.” Thus, the majority of women in our study reported that they only learned about reproductive health issues — including reproductive anatomy and physiology, contraception, and pregnancy — after getting married, even if they themselves were sexually active before marriage.

Two of our participants shared their abortion experiences during the interviews. In both cases, as illustrated in Sie Sie’s story (Box 3), the women were unmarried at the time of the pregnancy and first attempted to terminate the pregnancy through self-induction practices. Both women then went to a traditional birth attendant and had an unsafe abortion and their stories showcase legal status, service availability, financial and socio-cultural dynamics shaping reproductive health decision-making along the border.

4. Discussion

Women’s reproductive health decision-making along the Thailand-Burma border is shaped and influenced by a multitude of structural, systems, financial, and socio-cultural factors. Our results are consistent with a larger body of literature that explores reproductive health in crisis, conflict, emergency, and refugee settings in general, and on the Thailand-Burma border in particular. Migrant women’s health is affected by pre-departure events (war, trauma, natural disaster, poverty, etc.), the mode and duration of travel to the new destination, the availability of resources in the host community, and discrimination and exploitation associated with relocation (International Organization for Migration, 2013; López-Acuña, 2008). Along the Thailand-Burma border, access to healthcare services such as hospitals or clinics is highly dependent on the person’s place of living combined with her legal status and financial resources. Combined with socio-cultural taboos and externalized and internalized stigma, these dynamics blend together to place constraints on women’s autonomy and self-actualization. The experiences of women in our study make evident the claim that reproductive health and rights are intertwined with the broader issue of human rights and social justice.

However, in addition to the barriers that women experience, our results also showcase the resilience of women in this protracted conflict setting and suggest that there are a number of ways that women navigate existing challenges. In order to reduce the chance of being stopped by Thai authorities, women use their bicycles to travel to and from different health services. If and when a clinic is not nearby, women ask friends and family members for reproductive health advice and support which often leads them to a traditional birth attendant near their village or community. In desperate situations, women will find themselves inducing their own abortions, if legal, structural, and/or socio-cultural barriers stand in the way of much needed abortion care.

That women’s lives are complex and that reproductive health is affected by a range of factors is hardly surprising. However, the ways in which women in this context experience structural barriers offers insights into priorities for programming and service delivery. Many of our participants suggested that one of the most important avenues for improving reproductive health along the border is to increase multi-lingual educational efforts. Our participants’ own lack of knowledge of reproductive health issues — especially in the period before marriage — certainly signals this need. This finding is consistent with a larger body of research with women on the border that has documented the social taboos surrounding sexual and reproductive health among adolescents and unmarried youth (Oh and van der Stouwe, 2008; Women’s Commission for Refugee Women and Children, 2006).

Yet as is evidenced from the experiences of our participants, increasing awareness, at the individual, community, and/or health service provider levels, is not a panacea as education alone will not address the larger structural and systems constraints that women face. Rather, culturally-and con-

text-specific educational programs that explicitly acknowledge the confluence of forces shaping decisions and access are likely to have more resonance. Further, identifying and expanding initiatives, such as the accommodations program at the Mae Tao Clinic, that address the complex challenges women experience in seeking health services appears warranted.

Finally, our findings showcase that the totality of women’s reproductive health experiences shape future decisions. A woman’s decision to use contraception is not only made in the context of structural, economic, and social forces but is also influenced by her earlier reproductive health experiences and those of women in her community. Our findings support an emerging effort to reconceptualise women’s reproductive histories as “reproductive careers,” a sociological construct that recognizes the inter-relatedness of the reproductive health events in an individual woman’s life (Nash, 2014; Bessett, 2010). This can include the utilization of contraception, abortion care, and delivery services as well as engagement with reproductive health issues such as infertility and sexually transmitted infections. The woman who has an abortion, the woman who delivers a healthy infant and parents, the woman who actively prevents pregnancy for a decade, and the woman who experiences perinatal loss, are one and the same. The siloing that has often characterized both rhetoric and policy in the reproductive health field belies women’s lived experiences.

Because of the qualitative nature of this study, this study is not meant to be representative or generalizable. Rather this research provides insight into the reproductive decisions and experiences of migrant, refugee, and cross-border women living in the Mae Sot and Mae La areas of Tak Province. It is worth noting that this particular region stands out along the entire Thailand-Burma border as it is home to the Mae Tao Clinic, a well established not-for-profit clinic that provides services free-of-charge to Burmese migrants and refugees. In conducting a rigorous and credible qualitative study, we believe that our results have import beyond the small number of women who participated in the project. However, our participants are also exceptional within this region as all had used an IUD at some point in their reproductive lives and almost all were current users of the device. Use of the IUD is rare along the border and, until recently, few health care facilities have offered this modality of contraception (Hobstetter, Walsh, Leigh *et al.*, 2012). Thus this sub-set of women had all been able to successfully navigate the myriad barriers to obtain a desired reproductive health service from a trained provider. The experiences of women living along the border who are unable to navigate these barriers or choose not to contracept are not reflected in our study. Additionally, by recruiting women who are (or were) users of the IUD, our study is limited to the experiences of married women. Although women in our study reflected on their previous experiences as unmarried women, rigorous qualitative research with adolescents and unmarried young adults may reveal different perspectives.

5. Conclusions

Women’s experiences with health services along the Thailand-Burma border suggest that legal, structural, financial, and socio-cultural barriers play a role in shaping a women’s reproductive health decision-making and overall health. Educational services and resources that are culturally and context specific can help mitigate these barriers and improving the availability and accessibility of much needed reproductive health services appears warranted. This study sheds light on the complex, intertwining factors that can shape women’s reproductive health and careers along the Thailand-Burma border and may provide health care providers with more insight into women’s health in a protracted conflict and refugee setting. In the last several years, Burma has experienced tremendous political and economic reform and in 2016 elected its first civilian President in more than five decades. This transition to democracy opens the way for improved human rights conditions and may also create an opportunity to improve health services in the eastern part of the country. Understanding and recognizing the importance of women’s lived experiences may help inform these efforts.

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Author Contributions

Jillian Gedeon led the overall project, collected and analyzed the data, and drafted the manuscript. Saw Nanda Hsue coordinated recruitment and data collection, translated and transcribed interviews, and contributed to drafting and revising the article. Dr. Angel M. Foster supervised the overarching project, contributed to data analysis, and contributed to drafting and revising the article.

Ethics Statement

The Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File #H02-13-08) and the research committee at Mae Tao Clinic, Mae Sot, Thailand approved this study.

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