

**Assessing the experiences of IUD users living on the
Thailand-Burma Border**

Thesis

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Résumé

Le déplacement forcé de plus de 100 minorités ethniques en Birmanie au cours des dernières décennies a eu un impact négatif sur la santé globale de cette population. Le taux de mortalité maternelle le long de la frontière entre la Thaïlande et la Birmanie est l'un des plus élevés au monde et l'accès aux services et technologies de la santé reproductive est minime. Le but de cette étude est de comprendre les expériences des utilisateurs du dispositif intra-utérin (DIU) vivant le long de la frontière, tout en explorant les diverses influences qui ont modelé leurs expériences de santé reproductive. En utilisant des méthodes qualitatives, j'ai trouvé que les différences entre le statut légal/minoritaire, la culture, la disponibilité des services, l'état de santé, la situation financière, et de l'éducation/sensibilisation à la planification familiale peut déterminer la santé globale des femmes dans la région. L'utilisation du DIU a permis de réduire l'influence de ces facteurs et a donné l'autonomie reproductive aux femmes ; cette méthode de contraception a été très appréciée par les utilisateurs pour son efficacité et absence de danger. Les résultats de cette étude suggèrent que le DIU peut être la solution d'importants problèmes concernant la santé reproductive dans la région et devrait être plus disponible de façon universelle le long de la frontière entre la Thaïlande et la Birmanie.

Abstract

The forced displacement of over 100 ethnic minorities in Burma over the last few decades has negatively impacted the overall health of this population. The maternal mortality ratio along the Thailand-Burma border is one of the highest in the world and access to life saving reproductive health services and technologies is minimal. The purpose of this study is to understand the experiences of intra-uterine device (IUD) users living along the border while exploring the various influences that have shaped women's reproductive experiences. Using qualitative methods, I found that differences in legal/minority status, culture, availability of services, health status, financial status, and education/awareness of family planning can determine women's overall health in the region. The use of the IUD helped reduce the influence of these factors and provided women with reproductive autonomy; the contraceptive technology was greatly appreciated by users for its efficiency, its effectiveness, and its safety. The findings from this study suggest that the IUD can address significant reproductive health problems in the region and should be made more widely available along the Thailand-Burma border.

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List of Acronyms and Abbreviations

CPR	Contraceptive prevalence rate
IDP	Internally displaced person
IUD	Intra-uterine device
LARC	Long acting reversible contraception
MMR	Maternal mortality ratio
MTC	Mae Tao Clinic
OCP	Oral contraceptive pill
REB	Research ethics board
SRH	Sexual and reproductive health
SMRU	Shoklo Malaria Research Unit
PAC	Post-abortion care
PI	Principal Investigator
TBA	Traditional birth attendant
WSP	Women's Studies Project

Chapter 1: Introduction

Background

A resource-rich country with an abundance of teak and rice, Burma, also known as Myanmar, is the second largest country in South East Asia (CIA, 2010).¹ From British colonialism to Japanese invasions, this country has seen several occupations in its long history, and finally gained independence in 1948 (Topich & Leitich, 2013). A decade following this national milestone, internal strife and the ascension of military rule led to the demise of the country's economy, culture, and environment (Charney, 2009; New Internationalist, 1996; Topich & Leitich, 2013). The military junta, which has long been overwhelmingly comprised of Burma's ethnic majority, ruled over 130 ethnic minority groups, often violently and unjustly (Back Pack Health Worker Team, 2006; Topich & Leitich, 2013).

For over five decades, Burma has been characterized by severe human rights violations, civil conflict, and persecution of ethnic and linguistic minorities. The military regime surrounded villages with landmines, enforced slave labour among villagers, sexually assaulted women, and burned existing crops (Mullany et al., 2008; Sietstra, 2012). In addition, inequity in food distribution, health care services, and education has resulted in the displacement of millions of people, many of whom now reside in Burma as cross-

¹ I will refer to the country as "Burma" throughout this thesis. The name "Myanmar" was determined by the military junta in 1989. Use of this name is perceived by many ethnic minority group and organizations operating along the border as legitimizing the ruling military and its authority to rename the country.

border populations or in Thailand either as refugees or undocumented migrants (Sietstra, 2012).² **Appendix A** offers a map of the Thailand-Burma border region.

Survival is a daily challenge among populations living in conflict-affected areas in Eastern Burma. Lack of adequate nutrition for both women and children as well as lack of access to medically accurate pre- and post-partum reproductive health services contributes to the child (under 5) mortality rate which is approximately 221 deaths per 1,000 live births (Back Pack Health Worker Team, 2006), over three times the national rate (World Health Organization, 2013). Public health care in Burma is so inadequate that the World Health Organization's Health Systems Report (2000) puts it in the "least fair financing of health systems" category, as only 1.8% of total government expenditures are spent on health (Burma Medical Association, National Health and Education Committee, & Back Pack Health Worker Team, 2010; World Health Organization, 2000).

A major health indicator is the maternal mortality ratio (MMR), which is currently 200 deaths per 100,000 live births in Burma (CIA, 2010; Greene, Joshi, & Robles, 2012; UNFPA, 2013). However, in Eastern Burma, the primary site of longstanding civil conflict and population displacement, the MMR is estimated to be much higher (Mullany et al., 2008). Although the reported MMR in Eastern Burma varies from 700 to 1,200, it is widely recognized that the MMR is at least three times higher than the national average (Back Pack Health Worker Team, 2006; Burma Medical Association et al., 2010).

Access to high quality health care services is a significant challenge for women living along the border, leading to poor family planning, unsafe abortion, nutritional deficiencies (especially iron) in pregnant women, and poor pre-natal and post-partum care

² Cross-border populations refer to individuals who are internally displaced and/or living in villages in conflict affected settings within Eastern Burma. (Hobstetter et al., 2012)

(Back Pack Health Worker Team, 2006; Burma Medical Association et al., 2010; Hobstetter et al., 2012; Sietstra, 2012). In Burma, 43% of all births are not attended by a skilled health worker (Lee et al., 2006; UNFPA, 2001) and approximately 70-90% of deliveries in rural areas take place at the home or with an untrained traditional birth attendant (TBA) (Macaya, 2008). Lack of access to comprehensive, medically accurate, and financially accessible reproductive health services contributes significantly to increased maternal mortality (Lee et al., 2006; Mullany et al., 2008). However, studies show that access to and use of modern contraceptives is one of the most cost-effective and safest ways to prevent maternal mortality and in turn can address significant health needs along the border (Burma Medical Association et al., 2010; Greene et al., 2012; World Health Organization, 1995).

Despite the benefits of modern contraceptives on the overall health of a nation, the national contraceptive prevalence rate (CPR)³ in Burma is only 41%, largely due to its explicit pro-natalist policy (Back Pack Health Worker Team, 2006; "Myanmar: Adopts pro-natalist policy," 1998; Rotberg & Foundation, 1998; World Health Organization, 2010). Unlike the national CPR, the percentage of married women of reproductive age using any form of contraception in Eastern Burma is reported at only 21% (Burma Medical Association et al., 2010). The most commonly used methods are oral contraceptive pills (OCPs) and Depo-Provera⁴ (Burma Medical Association et al., 2010), but these methods are still inaccessible for many women. Unsafe abortions are very common among this vulnerable population (IRIN News, 2012), and the strict Burmese law prohibiting abortion

³ Contraceptive Prevalence Rate refers to “the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used”. It is usually measured for married women aged 15-49 only. (World Health Organization, 2013)

⁴ Depo-Provera is a progestin-only injectable contraceptive that is administered by a health care professional every 12 weeks (3 months) (Hatcher, Trussell, & Nelson, 2007)

for all reasons except to save a woman's life further exacerbates reproductive health related morbidity and mortality (United Nations, 2011). In fact, about 50% of maternal mortality along the border can be directly attributed to unsafe abortion (Ba-Thike, 1997).

In addition to the cross-border populations who live in conflict affected eastern Burma, approximately 1.5 million people have crossed the border to live in Thailand either as migrants or in one of the nine "unofficial" refugee camps (Sietstra, 2012).⁵ Even though Thailand allows abortion for a broader array of reasons (to preserve physical and mental health, in the event of rape or incest, and for women and girls under the age of 15) (United Nations, 2011), women from these persecuted and displaced groups often do not have access to safe abortion care due to their legal status (Belton & Whittaker, 2007; Hobstetter et al., 2012). Being "undocumented" puts them at risk for deportation to Burma and thus many women choose to stay in close proximity to their homes or places of work. As such, women are often unable to seek legal and safe reproductive health services, including abortion care (Caouette, Archavanitkul, & Pyne, 2000). There are various techniques that women, lay midwives, or TBAs outside of a health clinic will use to induce an abortion, such as "abdominal massage, consumption of malaria medications, insertion of a packet of plants into the vagina, use of 'traditional' medicines, and insertion of a stick, fishing hook, or other instrument into the vagina" (Hobstetter et al., 2012, p. 28). Complications from such unsafe and unsanitary procedures include vaginal bleeding, weakness, incomplete abortion, infections, and death (Hobstetter et al., 2012; IRIN News, 2012).

⁵ 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).

Women from Burma on both sides of the Thailand-Burma border are continuously at high risk of unwanted pregnancy and unsafe abortion, making the few clinics that serve the reproductive health needs of this population critical. The Mae Tao Clinic (MTC), located in Mae Sot, Thailand (see Appendix A), has been the backbone of health service delivery along the border for decades. Importantly, this multi-service health clinic serves about 200,000 people in the region and operates a high-volume post-abortion care (PAC) clinic, which provides both treatment for unsafe abortion and abortion complications and post-abortion contraceptive counseling (Krause, Otieno, & Lee, 2002). MTC's PAC clinic emphasizes the importance of contraceptive counselling to help aid women with family planning; the overwhelming majority of patients in the PAC service adopt hormonal contraceptive methods such as OCPs and Depo-Provera. However, although 99% of PAC clients adopt a modern method of contraception at discharge, in 2009, less than 1% of clients adopted the intra-uterine device (IUD), a method of long-acting reversible contraception (LARC) which is extremely safe and requires low maintenance (Mae Tao Clinic, 2012).

LARCs, such as IUDs, may be ideal in conflict-affected settings where women experience physical, structural, logistical, and service barriers to accessing contraceptives that require either ongoing maintenance or regular visits with a clinician. The IUD is a device inserted in the woman's uterus and can act as a reliable contraceptive for 5-12 years, depending on the type (Planned Parenthood, 2012). IUDs are non-user dependent, meaning that "user's behaviour has little or no effect on the likelihood of pregnancy" (Hatcher, 1997, p. 18) and require little to no adherence on a daily basis (Hatcher et al., 2007). IUDs prevent fertilization by altering the uterine environment and are one of the most effective

contraceptives available today, with a failure rate of less than 1% (Arrowsmith, Aicken, Majeed, & Saxena, 2012; Hatcher et al., 2007; McNicholas, Peipert, & Stoddard, 2011; Planned Parenthood, 2012; Winner et al., 2012). IUDs are unique in the sense that they can also be used as emergency contraception if inserted up to five days following an unprotected sexual encounter to prevent an unintended pregnancy (Hatcher et al., 2007; Trussell, 2012). In addition, the documented safety of the IUD makes it an appropriate contraceptive for a variety of women regardless of age, parity, marital status, or lifestyle (McNicholas et al., 2011; Planned Parenthood, 2012). The few contra-indications associated with this IUD (e.g. known or suspected pregnancy, allergies to copper, uterine cancer, abnormal uterine bleeding) (McNicholas et al., 2011) make it ideal for a variety of women – including refugees, migrant workers, and cross-border populations.

Rationale

In 2011-2013 a team from the University of Ottawa, MTC, Ibis Reproductive Health, and the University of Massachusetts conducted an interventional study which aimed to:

1. Identify counseling, training, and service delivery barriers to IUD utilization among refugee, migrant, and cross border populations utilizing PAC services at MTC;
2. Develop, implement, and evaluate actionable strategies for improving IUD service delivery at MTC; and
3. Seed a larger project dedicated to expanding LARC access in this long term refugee and conflict setting.

In 2011-2012, the original study team (PIs Dr. Angel M. Foster and Ms. Meredith Walsh) completed baseline research with health service providers and PAC clients. Based on those findings, the team then conducted a comprehensive IUD training with clinic staff in May 2012. In the year after the completion of the training, the clinic witnessed a significant increase in the adoption of IUDs by both PAC clients and women utilizing the general family planning clinic.

My thesis project represents the next phase of this larger project. Because use of the IUD is fairly new in the area and implants have not been available, there is no documented research on the experiences of women who have opted for LARCs. To address this gap, my thesis project explores women's experiences with the Copper-T IUD, since this is the type of IUD that was provided through the intervention and is the most widely used type of IUD along the border. This qualitative study includes women who have received IUDs at the family planning service at MTC as well as family planning services elsewhere along the border.

Specific Objectives

Use of a non-user dependent and highly reliable LARC method has the potential to make a significant impact on reproductive health, specifically unintended pregnancy and unsafe abortion, in this longstanding conflict setting. However, understanding women's perceptions of and experiences with the IUD and reproductive health services more generally is critical to developing responsive programs.⁶ Through in-depth interviews with

⁶ Experience with the IUD includes desire to adopt the IUD, awareness, advocacy, and process of obtaining the IUD, positive/negative feelings toward this contraceptive technology, interaction with clinicians, and how contextual factors play a role in women's opinions, perceptions, and experiences.

women who are current or past users of the IUD and who had used the method for at least six months prior to the interview, this project seeks to address the following:

1. What are the perceptions of and experiences with the IUD among women who received the method at MTC and other Thailand-Burma border clinics?
2. What do these women know about the IUD and how do they talk about the method with friends, family, clinicians, and others?
3. What do these women feel could be done to improve contraceptive service delivery along the Thailand-Burma border?
4. What strategies for improving the quality of IUD service delivery on the border and expanding access to IUDs in this region can be identified?

Outline of thesis

This is a “thesis by articles” and is divided into five chapters. This first chapter provides an introduction of the situation on the Thailand-Burma border, the rationale for the study, a list of specific objectives (including the research questions), and the outline of the thesis. Chapter two describes the methodology of the study including the recruitment strategy, the interview process, details about the analytic approach, and an explanation of the conceptual framework.

Chapters three and four are comprised of the two research articles and constitute the bulk of the thesis. The first article (Chapter 3) describes the experiences and perceptions with the IUD users living along the Thailand-Burma border. This article highlights the major themes that emerged during the interviews and discusses how contraceptive service delivery on the border might be further improved. The article has been formatted for submission to *Conflict and Health* and conforms to the standards of that peer-reviewed journal. The second article (Chapter 4) examines the complex dynamics on the Thailand-Burma border that shape women’s reproductive health and decision-making throughout their lives. Using narratives from the interviews, this article provides local stakeholders and

contraceptive service providers insight into the realities that their patients face in order to improve and expand sexual and reproductive health (SRH) resources. This article has been formatted for submission to *Reproductive Health Matters* and conforms to the standards of that peer reviewed journal.

The last chapter begins with an overview of the two articles and how they relate to each other and the broader reproductive health field. By analyzing and combining the results from both of the articles, I provide an in-depth look into the intersectional issues that affect women's reproductive health along the Thailand-Burma border. This chapter then moves to a reflection on reproductive justice and what implications this overarching concept has for the thesis project. In addition, I have reflections on the significance and implications of the study as well as future directions for research in this area. The chapter concludes with a section on reflexivity in the context of this thesis, the limitations associated with the study, a statement of contribution for the overall study and for each individual article, and the final conclusion. The bibliography and appendices can be found at the end of the document.

Chapter 2: Methods

Following an extensive review of the existing, but limited, literature as well as looking at the intervention study in depth, we determined that a qualitative approach was the most appropriate method to investigate our research questions. Qualitative research allows for a detailed description of “procedures, beliefs and knowledge related to health issues” (Ebrahim & Sullivan, 1995, p. 196), which in this case involves the target population’s reproductive health.

In order to investigate the perceptions and experiences of IUD users who received the method at clinics along the border, as well as explore users’ knowledge and opinions of the IUD, other contraceptives, and health care services in the region, my thesis project involved primary data collection and intensive fieldwork along the Thailand-Burma border. During the summer of 2013, I based myself in Mae Sot, Thailand to recruit women for semi-structured, in-depth interviews. I aimed to interview between 20 and 30 women in order to get a comprehensive understanding of women’s experiences and perspectives.

Mae Sot was an ideal location to conduct this research because of its large population from Burma and its proximity to the Burmese border (approximately 5km from the Friendship Bridge that crosses over into Myawaddy, Burma). Moreover, MTC’s close location to the border allows for relatively easy access to health care services among patients making it one of the main “go-to” clinics in the region. This busy facility was an ideal location for me to establish key connections with local medics and to begin the recruitment process.

I conducted in-depth interviews because this technique allowed me to investigate the situation as whole, shedding light on how various factors can influence behaviours, reactions, and experiences (Miles & Huberman, 1984). Qualitative methods allowed me, the researcher, to explore and understand the context while in the participant's setting (Creswell, 2013) and through the voices of participants. I was able to understand women's IUD experiences with an "in-depth, comprehensive understanding" (Miles & Huberman, 1984) of their circumstances and how their experience along the border played a role in their perceptions and experiences with this device. In addition, the use of in-depth interviews allowed me to examine the medical accuracy of participants' knowledge of IUDs as well as their opinions of reproductive service delivery along the border.

Selection of participants

I was able to start recruiting eligible participants when I was on the ground in Mae Sot, Thailand. Upon my arrival to the Thailand-Burma border, I met with local study partners to review recruitment protocols and eligibility criteria. Using purposive, convenient, and snowball sampling, our study team used the following eligibility criteria to recruit participants:

- A woman living along the border (either as a refugee, migrant, or cross-border)
- A woman who had used the IUD for at least 6 months prior to the study
- A woman who received the IUD from MTC post-abortion care clinic or from any family planning service located along the border

We informed the staff at MTC about the study and asked them to identify participants and provide information about the study at discharge (PAC clients) or the end

of the clinical/counseling interaction (family planning service). Per the standard research protocol at MTC, staff members knew to explain the study and assured women that participation was voluntary and that the decision to participate was not tied in any way to the care they received. To help further raise awareness of the study, I became oriented with the clinic and was introduced to key community members and medics to help with the help of our partners at MTC.

I also collaborated with the Shoklo Malaria Research Unit (SMRU), a field station of the Faculty of Tropical Medicine, part of Mahidol University, Bangkok and the Mahidol-Oxford Research Unit, which is in charge of three medical clinics located along the Thailand-Burma border. I recruited participants from one of their clinics located an hour and a half north from the city in the Mae La refugee camp, the largest camp on the border and home to over 40,000 refugees (AMI, 2012). This clinic was comprised of a hospital, a laboratory, an obstetrics unit and an ante- and post-natal clinic (SMRU, 2013), making it an ideal location to interview IUD users for this study. Finally, one of the local interpreters helping with the study used word of mouth both in the city and in the Mae La refugee camp to help recruit women to participate. Those who were interested in participating were invited to contact one of the local study coordinators to arrange an interview time (if recruited from the clinic, it was typically within one hour of discharge/conclusion of interaction). Our study team members, the clinicians, and the counselors were informed when the study was closed.

In addition to relying on local stakeholders, we created posters in both English and Burmese and distributed these recruitment materials throughout the Burmese market located in Mae Sot, Thailand. We also displayed these posters in every department at MTC

and gave them to local organizations that see a high volume of Burmese clients, customers, and/or employees.

Interview process

I developed an interview guide before the commencement of my fieldwork, and upon refinement of these questions by myself and my supervisor, I was able to start the interviews as soon as I arrived to Mae Sot. Prior to the interview, detailed information about the context and the goals of the study were given to the women, and upon agreement to participate, they arranged a meet-up time and place with the local study coordinator.

The interview began with an informed consent process, which was either read to the participant or given to her to read, depending on the participant's preference. We offered women the consent forms in English, Karen and Burmese to further accommodate the participant's language of choice. We assured women that their responses would remain confidential, their responses would not impact their clinical care either at MTC, SMRU, or any other health clinic that they attend, and their names and identifying information would not be associated with the findings. Once I obtained their consent, the interview commenced.

I conducted the interviews in a quiet and private location both at MTC and at the SMRU clinic. Among the participants that were recruited through word of mouth, interviews often took place in an area that was most accessible for them, such as their home. The interviews varied in length, averaging approximately one hour and ranging between 30 minutes and 90 minutes in length. While conducting the interviews, I asked the questions in English and had one of the two local study team members interpret into and

out of the participant's language of choice, as needed. One of the local study team members, who was based in Mae Sot, served as the main interpreter for participants recruited from MTC and SMRU, and the other study team member was in charge of the interviews that took place outside of the clinics, either in the outskirts of Mae Sot or in the refugee camp. I recorded all interviews with an Olympus digital recorder and took detailed field notes throughout the interview. As a thank you for participating in the study and to cover the costs associated with women's travel, I reimbursed each participant with the Thai Baht equivalent of CAD 10. I also offered women drinks and small snacks during the interview itself.

The interview was divided into five sections: general information, general sexual, contraceptive, reproduction and pregnancy history, experience with the IUD, knowledge of contraceptives/the IUD, and opportunities for change. I used probes and prompts to accompany the questions within each section in order to further explore the participant's responses to a question. Although I created an interview guide with questions in a specific order, I used a flexible approach to asking questions to ensure that the interview flowed organically.

At the end of every interview, I engaged in formal memoing, which helped me understand the impact of my own subjective influences and gave me "heightened sensitivity to the meanings contained therein" (Birks, Chapman, & Francis, 2008). Memoing also allowed me to capture reflections and insights after each interview as well as observations of daily life in Mae Sot, dynamics at MTC and SMRU, and other contextual events. This allowed me to be iterative in the analysis process, giving me a refined understanding of the data being collected from the interviews that had just taken place (Srivastava & Hopwood,

2009). By actively memoing, I was also able to see if I had reached thematic saturation, a term used in qualitative research when new ideas and themes stop emerging from the data (Marshall, 1996). I stopped recruiting participants after completing 31 interviews because I determined that I had reached thematic saturation on the key research questions. At the conclusion of the fieldwork and data collection, I hired a local translator to transcribe and further translate (to English) the interviews for analysis.

Analytic approach

The data collection and analysis process was designed to be iterative, which is why I began reviewing data as it was collected. I had my supervisor listen to the initial interviews, review the memos, and read transcripts to provide me with feedback and thoughts about the participants' answers. I attended regular meetings with my supervisor as well as with a co-investigator and we collectively addressed issues and questions that emerged.

Upon my return to Canada after my summer fieldwork, I conducted a content and thematic analysis of interview content using both *a priori* (pre-determined) categories and codes and inductive techniques. The initial categories and codes were informed by the research study aims and my research questions. Insights derived from the memos acted as supportive documentation (Birks et al., 2008) and when combined with the content of the interviews and discussions with my supervisor, I had the resources to create an initial code book. I carefully described and defined each code and added new codes as the analysis phase progressed, using the Atlas.ti qualitative software to manage the data. Once I coded the transcripts, I worked within each code to identify principal sub-themes that reflected

finer distinctions in the data. I then turned to the interpretation phase of the analytic plan where I focussed on identifying relationships among themes and concepts while paying particular attention to differences expressed by women who obtained IUDs at different clinics and at different stages of their lives.

Ethics

This study received approval from the Research Committee at MTC as well as the Health Sciences and Sciences Research Ethics Board (REB) located at the University of Ottawa. The letter of approval from the University of Ottawa's REB can be found in **Appendix C**.

Conceptual Framework

This study drew upon the Women's Studies Projects (WSP) conceptual framework to help assess and analyze women's experiences with the IUD while acknowledging that external factors can influence women's family planning experiences (Hardee, Ulin, Pfannenschmidt, & Visness, 1996) . As shown in **Appendix B**, the framework takes into consideration "the larger context of social, cultural, economic and other factors associated with the quality of women's lives as defined by women themselves" (Hardee et al., 1996, p. 3). I adapted the framework prior to the data collection phase of the study to include factors such as reproductive health experience (pregnancy/childbearing experience, use of family planning programs and reproductive health services, the role of clinicians and providers, contraceptive use/non-use); domains of the woman's life (psychological and physical factors, household/family roles, societal/economic roles); gender norms; and life cycle

stage and other personal factors that might influence women's experiences with the IUD. The framework acknowledges that all identified factors can be related to one another and that these relationships can be reciprocal. For this particular study, I focused on how women's experiences with abortion, PAC, family planning/contraceptive, and reproductive health services in general have made an impact on women's experiences with and their perceptions of the IUD. Throughout the analysis, I also paid special attention to the influence that the factors in this framework, such as societal/economic roles and gender norms, had on women's overall reproductive careers.⁷

⁷ Reproductive career in this thesis refers to a sociological construct that recognizes the inter-relatedness of the reproductive health events in an individual woman's life. This can include the utilization of family planning services, abortion services, and childbearing services as well as dealing with reproductive health issues such as infertility and sexually transmitted infections.

Chapter 3: Article #1

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Title

Assessing the experiences of intra-uterine device users in a long-term conflict setting: A qualitative study on the Thailand-Burma border

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Abstract

Background: In Burma, severe human rights violations, civil conflict, and the persecution of ethnic and linguistic minority populations has resulted in the displacement of millions of people, many of whom now reside as internally displaced populations (IDPs) in Eastern Burma or in Thailand either as refugees or undocumented migrants. Use of the intra-uterine device (IUD), a non-user dependent and highly reliable method of long acting reversible contraception, has the potential to make a significant impact on reproductive health in this protracted conflict setting. *Objectives:* This qualitative study aimed to understand Burmese refugees and migrants' experiences and perceptions of the IUD with the hope of informing service delivery along the Thailand-Burma border. *Methods:* In the summer of 2013, we

conducted in-person in-depth open-ended interviews with 31 women who obtained IUDs from a clinic along the border. We conducted a content and thematic analysis of these data using both *a priori* (pre-determined) codes and inductive techniques. *Results:* Women's experiences with the IUD are overwhelmingly positive with the experiences of friends and family having a large impact on their adoption and use of the device. Furthermore, financial considerations and access to reproductive health facilities can shape the use of the IUD in this region. The IUD is rare along the Thailand-Burma border and more education is needed in order to raise awareness about family planning among both married and unmarried women. *Conclusion:* The overall positive experience with the IUD suggest that this modality is culturally acceptable and may be able to address structural barriers to access reproductive health services along the Thailand-Burma border. Ensuring evidence-based and accessible health information along with affordable and available IUDs could help improve the reproductive health services in this protracted conflict setting.

Keywords

Myanmar; contraception; family planning; abortion; maternal health; refugees

Background

For more than half a century, Burma¹ has been characterized by severe human rights violations, civil conflict, and persecution of ethnic and linguistic minorities. The military regime surrounded villages with landmines, forced slave labour among villagers, sexually assaulted women, and burned existing crops [1, 2]. Combined with inequity in food distribution, healthcare services, and education the situation has led to the displacement of millions; this includes the conflict-affected communities and internally displaced persons

(IDPs) in Burma's Eastern states as well as the approximately 1.5 million people living in Thailand as undocumented migrants or as residents of the nine "unofficial" refugee camps [1].

This overall context has had profound consequences for reproductive health. The maternal mortality ratio (MMR) in Eastern Burma is estimated at 700 to 1,200 [3, 4], more than three times the national average. The contraceptive prevalence rate in Burma as a whole has long hovered at less than 40% and is estimated to be significantly less in conflict affected areas [5]. One of the greatest markers of unmet contraceptive need in Eastern Burma is the prevalence of unsafe abortion. Under Burmese law, abortion is only legally permitted to save the life of the woman and this legal exception is narrowly interpreted [6]. These restrictions on abortion combined with heightened unintended pregnancy risk have devastating health consequences and may account for as much as 50% of maternal mortality in Eastern Burma [7].

Although the reproductive health context in Thailand is considerably less bleak than in Burma [8], women from Burma residing in Thailand also face significant barriers to accessing comprehensive services. Poverty, sexual violence and exploitation, restrictions on movement, precarious legal status, lack of trained providers, and socio-cultural taboos have resulted in considerable unmet contraceptive need and increased risk of unintended pregnancy [9]. In Thailand, abortion is legally permissible in order to protect the life, physical health, or mental health of the woman, if the pregnancy was the result of rape or incest, or if the woman became pregnant when she was 15 years of age or younger [10,11]. However, women from Burma are often unable to seek legal and safe abortion care, even if

they would otherwise be eligible [9, 12]. Consequently, unsafe abortion is common on both sides of the Thailand-Burma border.

Given this overall context, long-acting reversible contraception (LARC), such as the intra-uterine device (IUD) or the subdermal implant, shows considerable promise for improving reproductive health along the border. Safe, highly effective, and non-user dependent, LARC methods have the potential to mitigate some of the structural barriers that shape women's consistent and timely access to contraception. However, in the face of a dearth of trained providers, an inconsistent supply of contraceptive devices, and misinformation among both providers and communities, few women on the Thailand-Burma have adopted LARC methods [9]. We undertook this qualitative study in order to shed light on women's experiences with the IUD with the hope of informing service delivery in this long-term conflict setting.

Methods

In the summer of 2013, we conducted in-person in-depth open-ended interviews with women from Burma who had received an IUD at a clinic along the border. The objectives of our study were to 1) Understand better women's perceptions of and experiences with the IUD; 2) Explore women's knowledge of the IUD and the ways they talk about the method with friends, family, clinicians, and others; and 3) Identify strategies for improving the quality of IUD and other contraceptive service delivery on the border and expanding access to IUDs in this region. All of our interviews took place in Tak Province, Thailand. We received approval to conduct this study by the Health Sciences and Sciences

Research Ethics Board at the University of Ottawa (File #H02-13-08) as well as local research clearance from the Mae Tao Clinic (MTC), Mae Sot, Thailand.

Study design

Women were eligible to participate in the study if they were current or past users of an IUD that they had obtained from a clinic operating along the border, had used the IUD for at least six months, were over 18 years of age at the time of the interview, and were sufficiently fluent in English, Burmese, or Karen to complete an interview. We used a multi-modal recruitment strategy that included community-based posters and flyers, announcements (with permission) at two local providing facilities, circulation of study information through the personal networks of the members of the study team, and early participant referrals (snowball sampling). Prospective participants contacted the study team by phone at which point we confirmed eligibility, provided additional information about the project, and arranged a time and location for the in-person interview.

After answering any questions and obtaining informed consent JG conducted all interviews with the aid of an interpreter (SH or HM). Using an interview guide developed specifically for this study, we began the interview with general demographic questions before moving to questions related to the participant's sexual, contraceptive, reproductive and pregnancy history, and her experience(s) with the IUD, her knowledge of the IUD and contraception in general. We concluded the interview with a discussion of ways in which reproductive health services could be improved along the border. With participant permission, we audio-recorded interviews and took extensive field notes during and after the encounter; JG also formally memoed after each interview and regularly debriefed with

other study team members. Interviews lasted an average of one hour and took place in a quiet and secure location (either at one of the clinics or at a place of the participant's choosing). As a thank you for participating in the study and to cover any associated travel costs, each woman received 300 Thai Baht (approximately USD10) as well as snacks and drinks throughout the interview.

Data analysis

The analysis process was iterative, meaning that it was done simultaneously as the data came in [13]. The memos and regular team meetings allowed us to continuously review content and establish thematic saturation. At the conclusion of the data collection period, a member of the study team transcribed audio recordings verbatim and then translated all of the interviews into English. Using Atlas.TI to manage the data, we analyzed the interviews using *a priori* (pre-determined) codes and inductive techniques to find emerging themes, sub-themes and ideas. The content of the interviews combined with insights derived from the memos and fieldnotes allowed for the creation of an initial code book which one member of the study team (JG) used to code all data; AF reviewed coding and disagreements were resolved through discussion. Regular team meetings aided the analytic process and the interpretation of results. This article focuses on significant findings that emerged with quotes to illustrate major themes; we have removed and/or masked all personally identifying information of participants and have used pseudonyms throughout.

Results

Study participants

We conducted interviews with 31 women who met our eligibility requirements. Participants averaged 32 years in age and ranged from 21 to 55 years old. Twenty eight of our participants had received their IUDs at one of two health care organizations operating on the Thai side of the Thailand-Burma border; the other three participants received their IUDs in Burma. On average, women had used the IUD for two years; duration of use ranged from 6 months to 20 years. Consistent with the specific devices available along the border, all of our participants had used a Copper-T IUD. All of our participants were married at the time of the interview and had only obtained the IUD after getting married. Thirty of our 31 participants had at least one child at the time of the interview. At the time of the study, two of the women resided in Eastern Burma, eight of the women were migrants living in or around Mae Sot, and the remaining twenty-one were refugees from the Mae La refugee camp.

Women's experiences with the IUD are overwhelmingly positive

If we use the pill, we will have a lot of side effects. If we use depo, it makes us fat. And we don't want to be fat...Before using the IUD I had to worry all the time about whether or not I would get pregnant or when my menstruation would come...for the IUD you don't need to remember every day. So it is really good.
- Mai, age 32, refugee

The overwhelming majority of our respondents spoke very highly of the IUD. Women repeatedly described the IUD as being user-friendly, effective, and long-lasting, features that women considered to be extremely positive attributes of the device. Several women also mentioned return of baseline fertility immediately after removal as an especially important consideration. As stated by Siblut, a 23 year old refugee, "When you take out the IUD, you have a chance to get pregnant [again]."

Many of our participants had used hormonal methods of contraception at some point during their reproductive lives. According to the women we interviewed, commonly available hormonal contraceptives, such as oral contraceptive pills and Depo-Provera, resulted in side effects, including weight gain, dizziness, and irregular bleeding patterns. That women experience few side effects with the IUD was one of its most positive attributes.

If we use the IUD, menstruation comes every month so we don't have many side effects. But if we use other things, we have side effects...we get very fat or [have] muscle tension. [For us] the IUD is good and not bad.

- Yon, age 28, refugee

This is not to say that all aspects of the IUD were well received. Many of our participants reported that they had experienced pain and cramping in the first few days after insertion but felt prepared for these side effects because of the counseling they had received from clinicians. Women were especially appreciative of the quality of services provided by organizations serving Burmese populations living in Thailand. Further, some of the women who had experienced labor and delivery explained that the pain during childbirth is much more severe than the pain during an IUD insertion, thus putting pain and discomfort in a broader context.

Few women that we spoke with experienced significant side effects or complications; of the 31 women interviewed, one woman had her IUD removed after two years because of a "bad odor," one woman had her IUD removed because of persistent abdominal pain, and one woman experienced contraceptive failure and became pregnant

while using the IUD. However, all three of these women still spoke highly of the IUD and recommended the device to women in their communities.

Financial considerations and access to health facilities shape use

I think the IUD is good. We don't need to take it, like the depo, every 3 months. And even when we are putting the IUD in, there is no frustration. We don't need to worry about anything. If we are using depo, we have to go back every 3 months, and also when we are getting depo, it is painful to get every time.

- Eh Say Gay, age 32, refugee

In a setting with high unemployment and considerable poverty, the financial implications of unintended pregnancy emerged as a primary theme. Nearly all of our participants noted that use of a highly effective method of contraception was of paramount importance. As stated by Thaw Thaw, age 21, from Mae Sot, “[I decided to use] contraception because we both have no work...if we have kids and we have no job, our kids will be in trouble.” That IUDs are understood by users to be more effective than other non-permanent methods of contraception was critical. “If I didn't use the IUD, I would have had more than 10 children by now” (Myia, age 54). Many women talked to their husbands about the IUD prior to insertion and the majority reported that their husbands were supportive of the decision.

Women also referenced that use of the IUD eliminates the need for regular visits to a health care provider for contraception. For women living outside of refugee camps, this quality was especially important, as undocumented migrants face considerable barriers to accessing clinics. One participant discussed in detail the challenges that factory workers, most of whom are undocumented migrants and work long and inflexible hours, experience in obtaining health services.

I suffer from urine pain very often and I cannot take time off from work at the factory to go to the clinic.

- Lwin, age 22, migrant

Experiences of friends and family impact use

I [heard] some people say that if you use the IUD it can cause cancer in our uterus and I was scared to use it...But my sister, she explained that she used the IUD and that she was feeling good with no side effects, that's why I started using it and now I feel good!

- Kyaw, age 35, refugee

Women living along the border rely heavily on the opinions and experiences of their friends and family when making reproductive health decisions. Throughout the study, women overwhelmingly reported that their main sources of contraception information came from their close social networks. Indeed, most participants presented at the clinic having already made the decision to adopt an IUD. As Eh Htoo Ne explained, "I didn't know anything about this [the IUD]. But because my friends suggested to me that this is good, I went [to the clinic] and got it inserted." Exceptionally, the small number of our participants who were trained in health services had generally been exposed to the IUD through their formal education, in-service training, or work.

After adopting the IUD, many women in our study became resources in their own circles, sharing their experiences with friends and family. Participants repeatedly shared stories about how they answered women's questions and helped spread awareness of the method.

Whenever I meet with young women, I say "you know, you have never used the IUD, that's why you have more and more children. [I understand that] you are scared of putting in the IUD. But you can see that we have put in the IUD and we have stayed healthy. I have never heard of anyone putting in the IUD and dying. So you can put it in and not die...Here [in Thailand] you can put in the IUD for free...you don't have to worry about that.

- Myia, age 54, IDP

Use of the IUD along the border is rare

In Burma it is really rare that [women] use the IUD, and also it is expensive; they don't provide it in hospitals. So if you want to use the IUD, you have to search for a clinic that provides it.

- Wahksha, age 36, refugee

Despite the enthusiasm for the IUD among users, our participants reported that use of the IUD was extremely rare. Women explained that knowledge of the IUD is virtually non-existent in Eastern Burma and that most women only learned about the IUD once arriving in Thailand. In addition to the high cost associated with this contraceptive method, women explained that it was difficult to find a reliable and accessible clinic that offered the IUD. In stark contrast with the situation in Burma, several facilities operating on the Thai side of the border provide a full range of non-permanent methods of contraception at low or no cost. Lwin (age 22) expressed her appreciation of these services, "But here [in Thailand], even if you have no money, they [the Mae Tao Clinic] just provides a free service for us."

Although knowledge of the IUD is perceived as being low, our participants reported that negative rumors about the device are rampant. As explained by women in our study, popular misconceptions include beliefs that the IUD causes cancer or ectopic pregnancy, the device is not effective in preventing pregnancy, and that husbands do not like it. Further, a commonly cited rumor is that the device "wanders" throughout the body. As reported by Daylya, a 25 year old resident of Mae Sot, "They say that [the IUD] can move around the body through to the brain and arms." Many of our participants reported that they

actively engaged with women in the community to combat these rumors, correct misinformation, and allay fears.

More education and awareness about the IUD is needed

It would be better if we were able to enter the community and offer education about...reproductive health and also about contraception and explain the types of contraception...like the IUD; how it works, the negatives and positives...stuff like that.

- Wahksha, age 36, refugee

Nearly all of our participants discussed the importance of raising awareness about family planning in the community. The majority explicitly stated that these educational efforts should be targeted to both married and unmarried women. Some women suggested that holding focus groups to provide information about the IUD and debunk IUD-related myths would be an effective community based awareness raising strategy. Other women discussed how clinics could do a better job of “advertising” the IUD through posters with a picture and other patient education materials. Many participants referenced similar efforts that are currently underway that focus on other methods of contraception and suggested that this could serve as a model for comparable efforts related to the IUD.

Discussion

Until recently, few efforts have been undertaken to expand access to the IUD along the Thailand-Burma border [9, 14]. The limited published literature indicates that the IUD is not widely used in Burma due to a lack of trained providers and misinformation among both health care workers and communities [3, 9, 15]. Our findings are broadly consistent

with this larger body of work. However, no published work has explored women's experiences with the IUD and our study aimed to fill this gap.

That users of the IUD on the Thailand-Burma were overwhelmingly positive about their experiences suggests this modality of contraception may have cultural and social resonance and serves as an important addition to the mix of family planning methods that are currently available. Indeed, women's identification of effectiveness, ease and longevity of use, and safety as important features of the IUD is consistent with the global literature on acceptability and use [16-18]. The socio-cultural acceptability of the IUD (for use among married women) is also signaled by the supportive response women received from their husbands once making the decision to adopt this method.

Yet the reality of women's lives on the Thailand-Burma border may make the IUD an especially valuable addition to the existing methods mix. In this protracted conflict setting where women's freedom of movement is limited and fear arrest and deportation abounds [1, 19], a reversible contraceptive that only requires an initial visit to a trained provider has the potential to address significant structural barriers that impede many women's ability to contracept most effectively [9, 19]. Further, in a setting where abortion is severely legally restricted (Burma) and largely inaccessible to women from Burma (Thailand), the consequences of an unintended pregnancy can be dire; unsafe abortion carries a significant risk of reproductive morbidity and carrying the pregnancy to term and parenting can place families in a precarious financial position. That our participants identified the IUD as serving a mitigating role in addressing structural obstacles to pregnancy prevention suggests its utility in this setting.

Yet few women appear to be using the IUD and misinformation abounds. Consistent with the global literature [16, 18, 20, 21], pervasive myths about the IUD include the belief that the device increases the risk of cancer and ectopic pregnancy, moves around the body, and is ineffective at preventing pregnancy. That the IUD is inserted and is therefore hidden from sight fosters imagined and exaggerated medical risks. A study published by Russo et al. (2013) highlights and corrects the many myths and misconceptions found in the literature surrounding LARCs. Creation of culturally and linguistically tailored information about the IUD that could serve to combat myths in this setting appears warranted.

However, our findings suggests that it is women within the community that may have the most significant impact on social norms and perceptions of the IUD. Discussions about contraception among friends and family members had a profound impact on the women we interviewed and appeared to be more influential than counseling by health service providers or the values expressed by (largely male) religious leaders or community elders. This finding is again consistent with a global body of research dedicated to reproductive health decision making [23-26]. This suggests that identifying avenues for dissemination of evidence-based information through peer networks could be especially impactful in this context.

From these findings we hope to improve the contraceptive service delivery that takes place on the border. Doctors and clinicians can play a significant role in the administration of the IUD and the outlook that the community has on it. It is crucial for medical workers to know what the perception and experiences surrounding the IUD are among users along the border in order to better administer it to other women seeking family

planning or post-abortion care services. Furthermore, since many women rely on family and friends' opinions and advice, clinics can take advantage of women's perceptions of the device to advertise it or present it in a more targeted way as an option for family planning. Heeding the suggestions provided by our participants and supporting community-based educational workshops and user-friendly patient education materials about the IUD should be prioritized.

The results from this study have shed light on the features of the IUD that are the most salient with women living on the Thailand-Burma border. Taken together, the experiences of women who have used the IUD and their recommendations for how to address the misinformation about the IUD that is prominent among women and members of their communities offer health service providers insights into the ways in which contraceptive information, counseling, and service delivery could be improved.

Limitations

As is true with qualitative research in general, the findings of this study cannot be generalized to the population living on the Thailand-Burma border. The majority of our participants lived in or around Mae Sot, Thailand and we only conducted the study in English, Burmese, and Karen, thus the diversity of our participants was limited. However, we are confident that the themes that we identified are significant and that the credibility and trustworthiness of the findings were enhanced by our multi-disciplinary, multi-lingual study team.

Conclusion

Women's experiences with the IUD suggest that this modality of contraception is culturally acceptable and may be able to address structural barriers to accessing reproductive health services along the Thailand-Burma border. Ensuring that information provided by health facilities and among peers is evidence-based, a full range of contraceptive methods is available, and adoption of an IUD is affordable are priorities for expanding access to reproductive health services along the Thailand-Burma border. The lessons learned from this project provide insight into women's experiences on the Thailand-Burma and may suggest avenues for improving reproductive health services in other protracted conflict and refugee settings.

List of abbreviations

IDP	Internally displaced person
IUD	Intra-uterine device
LARC	Long-acting reversible contraception
MMR	Maternal mortality ratio
MTC	Mae Tao Clinic

Competing interests

The author(s) have no competing interests, financial or otherwise, to disclose.

Authors' contributions

JG is the Principal Investigator of the study and was responsible for all phases of the project, including study design, data collection and analysis, and interpretation of the findings. SH served as the overall Study Coordinator and contributed to recruitment, study

logistics, data collection, and translation, interpretation, and transcription. MW and CS served as Co-Investigators on this study. They contributed to the conceptualization of the project, study design and implementation, and analysis and interpretation. HM served as a Research Assistant and contributed to recruitment, data collection, and translation/transcription. AF supervised the overall project and contributed to all phases of the study including conceptualization and design of the study, development of the study instruments, study implementation, data analysis, and interpretation of the findings. JG led the drafting of the article. All co-authors reviewed, contributed to, and approved the final manuscript.

Authors' information

JG completed this project as part of her MSc degree in Interdisciplinary Health Sciences at the University of Ottawa. In 2014-2015 she will be based in Mae Sot, Thailand where she will continue to work on LARC-related research and programming through a Fellowship with Cambridge Reproductive Health Consultants.

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ⁱThe country will be referred to as “Burma” throughout this article because the name “Myanmar” was determined by the military junta in 1989. Use of this name is perceived by many ethnic minority group and organizations operating along the border as legitimizing the ruling military and its authority to rename the country.

Chapter 4: Article #2

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Title

“I came by the bicycle so we can avoid the police”: Exploring structural, systems, and sociocultural factors influencing reproductive health decision-making on the Thailand-Burma border

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Abstract

For over half a century, ethnic minority populations in Burma have been subjected to severe human rights violations by the military junta, resulting in the displacement of millions of people both within Eastern Burma and to neighbouring Thailand. The overall situation has wreaked havoc on women’s health in the region and women face tremendous challenges in trying to obtain high quality, comprehensive reproductive health services. Drawing from interviews we conducted in Tak, Thailand with 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 person’s place of living mixed with

their 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 programming and suggests that an increase in multi-lingual education efforts and identifying and expanding initiatives can help improve reproductive health services more broadly in this protracted conflict setting.

Keywords

Myanmar; family planning; abortion; refugees; migrants

Introduction

Eastern Burma represents one of the longest conflict affected regions in the world. For over half a century, ethnic minority populations have been subjected to severe human rights violations by the military junta.⁸ Recent political openings notwithstanding, the population in this region has long been subjected to torture and extrajudicial killings, sexual assault, forced labour, and trafficking.[1-3] The targeted destruction of villages through the burning of crops and the placement of landmines has characterized this volatile region.

Infrastructure and services in Eastern Burma have been purposively neglected, impeding movement and creating enormous disparities in education, healthcare, and income generating opportunities.

⁸ 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.

These overall dynamics have resulted in the displacement of millions of people both within Eastern Burma and to neighbouring Thailand.[3,4] 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.[5] Populations 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.⁹

Consistent with conflict-affected populations around the world, the overall situation has wreaked havoc on 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.[7-8] 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 responsible for as much as 50% of maternal mortality in Eastern states.[9] Women in Burma residing in Thailand – as either refugees or as migrants – also face tremendous challenges to obtaining high quality, comprehensive reproductive health services and are at heightened risk of sexual exploitation and violence.[1, 2, 10, 11] 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. [3, 5, 12, 13]

⁹ 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).

That women in this context face structural, systems, legal, policy, and socio-cultural barriers to accessing desired health services has been well documented. 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.

Methods

In the summer of 2013, we conducted a qualitative study dedicated to understanding women's experiences with the IUD on the Thailand-Burma border, a relatively rare and new technology in this setting. 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 (see Chapter 3, this thesis).

However, our interviews with women from Burma explored a range of issues beyond the IUD and initial study questions. Participants provided extraordinarily detailed accounts of their lives, including reflections on major reproductive health-related decision 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.

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 five kilometres from the Burmese border, Mae Sot is largely inhabited by individuals who fled Burma during the civil strife 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 cross-border, migrant, and refugee populations and serves a catchment area of more than 200,000. 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 [14], otherwise known as “persons of concern” or as displaced populations. [15]

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 intrauterine device (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, a migrant, or a 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 (SH) who provided additional information about the study, confirmed eligibility, and scheduled the interview at a mutually convenient time and location.

We obtained informed consent before commencing and audio-recording each interview.

Using an interview guide developed specifically for this study, JG conducted the interviews with the aid of 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 the Shoklo Malaria Research Unit's reproductive health clinic 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 CAD10 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 (File #H02-13-08) approved this study, as did the research committee at Mae Tao Clinic, Mae Sot, Thailand.

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. JG 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. We conducted content and thematic analyses of the data using both *a priori* (pre-determined) codes and categories based on our study questions and the interview guide as well inductive techniques to identify emergent themes. Moreover, we used a sequenced approach to coding and 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.

Findings

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).¹⁰ Consistent with the population of women from Burma

¹⁰ There is considerable fluidity in the way in which women living on the border identify their residence. For example, a woman may typically reside on the Burma side of the border but may engage in season 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.

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).

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 [USD 3] 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. Undocumented migrants and cross-border residents “visiting” Thailand are at risk of deportation and are vulnerable to the demands of Thai police who may levy “fines” which are often onerous. 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

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 confrontations with Thai authorities.

Women are aware of these risks and some have developed strategies to navigate them, as revealed by 30 year old Lwin, “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.”

However, 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.

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 in care 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. Some 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 being forged out of necessity. For example, Myia, a 54 old who resided in Eastern Burma at the time of interview, delivered her son in her village in

Mon State, Burma. 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 give 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 report that the availability of health facilities also directly influenced women’s 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 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.

Direct and indirect financial costs of obtaining services

“I got pregnant with my young daughter because I cannot afford to buy the pill. So after I delivered my first daughter I took the pill for two years and eight months but in that period

I didn't take the pill regularly because I didn't have money to buy it, so the menstruation came back and then I became pregnant."

- *Khin, age 33, migrant*

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 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." A number of women, as illustrated by Khin's quote above, described scenarios where they were unable to continue using oral contraceptive pills or hormonal injections or chose to deliver in their village with a lay provider because of costs.

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 appeared to 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 migrant woman working in a factory explained, “[Each week I have one] day off, on Sunday. We have regular working hours [at the factory]. We usually start at 8am and [go] until 10pm or sometimes...they keep us working until 12 midnight.”

Socio-cultural stigma associated with sex before marriage

“I deliberately aborted my pregnancy because I don’t want it and I [didn’t] want to get married. However I failed at doing it. When I tried to abort my pregnancy [myself] it didn’t work...So I went to a woman in Myawaddy [Burma] and she treated me with a medicine...After 15 and 20 days the foetus is 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 will happen [to me]”

- *Sie Sie, age 27, migrant*

Irrespective of women’s ethnic or religious identification, all 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. Women briefly reported that broader social stigma restricted information and service delivery to adolescent populations and added to community pressure towards early marriage. Internalized stigma impacted unmarried women’s ability to ask questions or seek

services when needed, a 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. In both cases, as illustrated in Sie Sie’s quote (above), 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. Although there were only two women in our study who disclosed induced abortion experiences, their stories showcase legal status, service availability, financial and socio-cultural dynamics shaping decision-making along the border.

Discussion

Women’s reproductive health decision-making along the Thailand-Burma border are 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, 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.[16, 17] 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 their legal status and financial resources. Combined with socio-cultural taboos and externalized and internalized stigma, these dynamics combine 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 is also a multitude 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 in order to receive the care they need. If and when a clinic is not nearby, women make the effort to ask friends and family members for reproductive health advice and support which often leads them to a traditional birth attendant in or near their village or community. In desperate situations, women will find themselves inducing their own abortion if legal, structural, and/or socio-cultural barriers stand in the way of much needed abortion services.

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 signal 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.[6, 18]

Yet as is evidenced from the experience 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 experience. Rather, culturally- and context-specific educational programs that explicitly acknowledge the confluences of forces shaping decisions and access are likely to have more resonance. Further, identifying and expanding initiatives, such as the accommodation 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 emerge 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. 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.

Limitations

Because of the qualitative nature of this study, this study is not meant to be representative or generalizable. Rather it is to provide insight into the reproductive decisions and experiences of women living in this protracted conflict setting. 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 (Chapter 3, this thesis). Use of the IUD is rare along the border and, until recently, few health care facilities have offered this modality of contraception.[5] 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 choose not to contracept would not be reflected in our study. Finally, 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.

Conclusion

Women's experiences with health services along the 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 in the area of reproductive health can help mitigate these barriers, and the improvement of the availability and accessibility of these much needed health services appears warranted. This study sheds light on the complex, intertwining factors that can shape women's reproductive health and career 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.

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Chapter 5: Discussion

This final chapter begins with a discussion of how the two articles relate to each other and the broader field of reproductive health. I also dive into the intersectional issues that affect women's overall reproductive health along the border by relating these issues to the findings from this study as well as from other studies. The chapter then turns to a reflection on reproductive justice and its importance in studies that explore LARCs, including the IUD. I then explore the significance and implications of the study for local stakeholders and health service providers. Finally, this chapter includes a piece on reflexivity, the limitations associated with the study, a statement of contribution for the overall study and for each of the written articles, and the conclusion.

Discussion and integration of the results

When combining the results from the first and second articles, we can see that this study overall highlights the intersectional issues affecting women's reproductive health, their reproductive careers, and their lives. The combination of educational background, minority and legal status, family income, socio-cultural-religious dynamics, gender status, and access to resources affect women's experiences and perceptions with reproductive health services and technologies and in turn affect their reproductive career as a whole.

Education and awareness

Qualitative analytic techniques in this study helped us understand that women with little or no knowledge about reproductive health services and technologies are at a

disadvantage and cannot optimize their opportunity to control their reproductive career. As demonstrated by the first article, women rely heavily on the experiences of friends and family members for information about contraception, such as the IUD. The second article touches upon this and further adds that the lack of information available to women living along the border affects the way in which they look at pre-natal care, pregnancy, and post-natal care.

A woman's education level is directly proportional to her health, the health of her family, and the health of her community (World Health Organization, 2009). Leaving a country due to internal strife often means the interruption of education among Burmese nationals. Although the level of education varies among migrants, access to education for children or for adults to continue their learning is minimal along the border; attendance is highly dependent on their legal status, the environment in which they live, as well as total household income (Women's Commission for Refugee Women and Children, 2006). Knowledge of general reproductive health concepts have been shown to be determined by education level, among other factors, and education about contraception plays a large role in adoption and adherence (Whitaker et al., 2008). The findings from this study are consistent with a larger body of research that demonstrated that the lack of access to health information can have a negative effect on the women's overall reproductive health care outcomes.

Reports show that new refugees and migrants who enter the camps along the border have very poor knowledge on HIV/AIDS as well as family planning (Women's Commission for Refugee Women and Children, 2006). A study conducted by the Planned Parenthood Association of Thailand (PPAT) within the Mae La refugee camp also found

that the majority of women and youth living within the camp did not know about STIs or about the dangers related to unsafe abortion (Planned Parenthood Association of Thailand, 1999). Access to education and awareness programs related to SRH can be very limited along the border, a deficit that has an especially harmful impact on youth. Young and unmarried Burmese migrants have a very limited knowledge on reproductive health due to the lack of access to education and health resources, and a study by Benner et al. (2010) shows that married youth living in the camps have up to six times higher knowledge on reproductive health issues compared to unmarried youth.

A woman's access to reproductive health on the border is highly dependent on her ability to access quality and judgment-free SRH services that provide comprehensive and medically accurate health information. Barriers to such services have the potential to reduce levels of knowledge on reproductive health among women which in turn can increase maternal morbidity and mortality.

Minority and legal status

Having access to health services, in general, along the border is seen as a barrier for many, but the few Burmese-friendly clinics that are available appear to have a significant impact on Burmese populations in need. As can be seen in both articles, legal status, ethnic background, and access to health care services all play a part in making personal health care decisions, including SRH related decisions.

A Burmese woman's legal and/or minority status plays a large role on both sides of the Thailand-Burma border due to the historical events that have taken place in the past century. Shortly after Burma's independence in 1948, ethnic states started to rebel against

the Burmese government for their own independence, which resulted in the military junta taking over to suppress the insurgencies (Falco, 2003). As a result, individuals who belonged to one of the more than 100 ethnic minorities present in the nation were at risk of slave labour, forced displacement, and death (Back Pack Health Worker Team, 2006). Thus ethnic identification played a major role in the way Burmese individuals were perceived within the walls of the nation and affected the health care services that were made available to them (Back Pack Health Worker Team, 2012).

In Thailand, there are “unfavourable cultural attitudes towards the Burmese” and thus it is the intersection of national, ethnic, and legal status that acts as a barrier to health care for many (Crawford, 2005, p. 822). Many Burmese women live in Thailand as undocumented migrants meaning that they are at risk for deportation if caught by Thai police (Crawford, 2005; Women's Commission for Refugee Women and Children, 2006). Additionally, those with precarious legal status cannot benefit from the Thai national health care system, as they lack the identity card required for subsidized care in the public sector. Burmese migrants face barriers to the health care system because of the difference in language, the high costs, and the fear of arrest during transportation, even if they are registered with the Thai government (Global Alliance Against Traffic in Women, 2007). Being in this position presents great difficulty and forces many men and women living along the border to take significant risks if they want to take care of their health. As highlighted in the research articles, the clinics within Thailand that serve Burmese populations are greatly appreciated because they help reduce cost, language and security barriers.

Income and job status

Migration can provide individuals with the opportunity to start a new life and a new job in a different environment. However, gender, ethnic, and racial discrimination can act as barriers to establishing financial stability through employment (Piper, 2006). One's ability to work along the Thailand-Burma border is highly dependent on their legal and minority status which can make them vulnerable to exploitation and/or trafficking (Crawford, 2005). Migrants generally have more difficulty in securing employment opportunities, but migrant women are always found at the "bottom strata" of the labour market which further impedes their ability to establish themselves, their health, and their families in their new location. In times of need, and when they are not depending on others for income, women living along the border take advantage of any employment opportunity that crosses their path, including working in the sex industry for low wages (ALTSEAN, 2003; Women's Commission for Refugee Women and Children, 2006). Additionally, many migrants living along the border are mobile when looking for work which makes it much more difficult for them to access consistent, good quality health care (ALTSEAN, 2003; SMRU, 2013). As highlighted in this study, the combination of gender, race, ethnicity, and job status can have a negative impact on maternal health along the Thailand-Burma border.

The financial status of a woman's household may also affect her decision to seek family planning services as well as the types of technologies she chooses to use. The findings from this study indicate that many women opted for a contraceptive method with the knowledge that raising a child can be costly, and wanted to hold off until they were in the best financial position to grow their families. Additionally, the cost of the contraceptive methods and services affected whether or not they would be able to make such a decision to

control their reproductive health. Availability of affordable contraceptive technologies often determined how a woman chose to control her reproductive destiny giving reason to why the majority of the women spoke highly about the IUD. The cost-effectiveness that accompanies the IUD is what made it an ideal contraceptive method for the women interviewed in this study.

Socio-cultural and religious dynamics

The different social norms, sub-cultures and religions along the border create localized socio-cultural and religious dynamics that can affect a woman's overall reproductive health status. In Burmese culture, pre-marital sexual activity is highly stigmatized which limits unmarried people's ability to seek SRH services (Su-Ann Oh & Stouwe, 2008; Women's Commission for Refugee Women and Children, 2006). For example, camp leaders in the camps in Mae Hong Son were concerned that the distribution of condoms would increase the prevalence of sexual activity among youth (International Rescue Committee, 2001). Additionally, there is a widespread belief among unmarried individuals living in the camps that ante-natal, post-natal, and family planning services are only available for married couples. Thus women face socio-cultural pressure to marry at a young age. Consistent with this broader cultural norm, all of the women in this study were married and had never used reproductive health services prior to marriage. The notion that SRH services are linked to one's marital status is a common cultural theme that surfaced in all of the interviews.

Moreover, "traditional" norms and local interpretations of dominant religions have the potential to influence migrants' day to day life. Religious leaders often pressure

individuals not to practice family planning based on their interpretations of permissibility citing thus placing women and men in a very difficult situation (IRIN News, 2014; Women's Commission for Refugee Women and Children, 2006). Though few migrants view religion as a barrier to family planning, the use of contraception is done discreetly among some Burmese men and women because it conflicts with their traditions (Women's Commission for Refugee Women and Children, 2006).

Gender and resource accessibility

Patriarchal social dynamics have been reinforced, compounded, and exacerbated by years of dictatorship from the military junta (Crawford, 2005). This “hierarchy of domination” was experienced by women in the form of slave labour, rape, forced marriage, and forced sexual work during the civil conflict in Burma (ALTSEAN, 2003). The iconic and political Daw Aung San Suu Kyi highlighted the gender inequality that exists on the political level in her nation in June of 2002 by saying, “Our women are rarely allowed to achieve decision-making positions even though they are able and well qualified. This means they are neither assured of their right to security nor their right to shape their own destiny.” (ALTSEAN, 2003; BBC News, 2002). Suu Kyi is one of the few female political leaders in Burma.

In addition to political inequality, women are at a disadvantage on the economic stage as well. Early marriage and childbearing in adolescents (among either married or unmarried women) drives many young women out of school, making it harder for them to continue their education and gain the valuable skills required for high-earning jobs (Su-Ann Oh & Stouwe, 2008). Burmese women also generally earn less than their male

counterparts due to the gender inequality that is very present in this region (Women's Commission for Refugee Women and Children, 2006). Household income can affect a woman's reproductive career by determining when and if she can obtain family planning resources, a finding borne out in this study.

Socially, women are at a very high risk for gender-based violence. Protracted conflict settings, scarcity of resources, and alcohol abuse can all increase the prevalence of intimate partner violence (Freccero & Seelinger, 2013). Though I only interviewed one participant who reported personal experiences of domestic violence, we need to acknowledge that accurate statistics on the prevalence of abuse are extremely hard to get. Additionally, the limited economic opportunities available on the border mixed with the undocumented legal status of many of these women puts them in a vulnerable position and increases their risk for trafficking, sexual exploitation, and abuse by employers, Thai officials, and others in the community (Crawford, 2005). The psychological and physical distress associated with such degrading treatment often goes unreported in these communities for fear of identity exposure which might render the women arrested or deported back to Burma. Though the few existing women's shelters on the border offer women refuge, the services are generally regarded as inadequate in meeting community needs (Freccero & Seelinger, 2013). Furthermore, lack of support from camp leaders plays a significant role in the effectiveness of these shelters and contribute to the stigma associated with reporting domestic violence (Freccero & Seelinger, 2013). Such an environment prevents community members from learning more about women's rights, reproductive freedom, and social justice. Finally, women who are a part of the LGBTQ community are completely excluded from existing health services because of overarching

stigma, further reducing their ability to realize their reproductive rights and freedoms (Freccero & Seelinger, 2013). Human Rights Centre researchers interviewed staff and women from 15 shelters that span across 3 refugee camps and several cities along the Thailand-Burma border and found that many staff refuse to acknowledge the existence of members in the LGBTQ community. Moreover, none of the shelters involved in the study had tailored their services to meet the needs of the community (Freccero & Seelinger, 2013).

After extensive research of the history of this region as well as the lived experiences of the individuals living on the border, the intervention study introducing the IUD to MTC was put in place to help improve the SRH services that were available to women. The United Nations declared access to family planning as a human right, and part of this right is having options and choices for contraception (Greene et al., 2012). Before this intervention, women only really used three contraceptive methods: the condom, the oral contraceptive pill, and depo-provera (Back Pack Health Worker Team, 2012; Burma Medical Association et al., 2010). The interventional study that preceded my project allowed women to have an additional option for contraception that has the potential to meet their unique needs when living along the border.

Having reproductive health clinicians at MTC trained in insertions and removals of the IUD as well as learn the extensive medical details associated with this contraceptive technology gives clinic patients the freedom to make a contraceptive decision that better suits their lifestyle. The overarching study helps women realize their reproductive rights by

introducing them to a contraceptive method that is highly effective, extremely safe, and non-permanent.¹¹

Reproductive justice and its role in this study

As a researcher working with reproductive health among vulnerable communities, I need to be aware of the history of abuse that has taken place with LARCs, and particularly with IUDs, in order to approach this study with sensitivity. This section looks at reproductive justice by defining the term and providing a brief explanation about its history. This section also highlights the importance of reproductive justice and research in relation to the Thailand-Burma border.

Definition and brief history on reproductive justice

Reproductive justice is informed by decades of slavery, violations of civil rights, and coercion related to contraception and sterilization that has been documented among women of diverse communities in the United States (Gilliam, Neustadt, & Gordon, 2009). In the 20th century, women of colour wanted to take control of their own reproductive health decisions and thus decided to join the existing movements that were mainly dominated by white women and feminists. At that time, the dominant feminist movements centered on the fight for legal abortion to the exclusion of other reproductive health and rights issues. Motivated by their lived experiences, women of a minority status created a new movement that pushed for a more complex reproductive rights discourse (Nelson, 2003; Price, 2010). Their movement wanted to give a voice to immigrant women, poor women, younger women, incarcerated women, women with disabilities, Indigenous women

¹¹ Although IUDs are non-permanent methods, one of the participants had the IUD for 20 years and chose not to have it removed because the clinic was far and she was not looking to contracept anymore. She was in her mid-50s at the time of the interview.

and women of colour who had all faced discrimination and oppression in relation to their reproductive rights (Gilliam et al., 2009). As a result, the notion of reproductive justice emerged in the late 20th century where reproductive rights issues that were being vocalized were placed within a social justice framework. Reproductive justice is defined as “the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women’s human rights” (Ross, 2006, p. 1).

The reproductive justice movement extends beyond the reproductive rights that every woman is entitled to and looks at how history mixed with political, social and economic inequalities can infringe on women’s empowerment (Gilliam et al., 2009). Complex identities comprised of ethnicity, gender, age, education level, job status, immigration status, mental or physical health status, and/or social status, all can contribute to barriers toward access to reproductive health services which violate a woman’s reproductive rights, and more broadly, her human rights. Reproductive justice is also informed by the theoretical concept of intersectionality, which examines how the various facets of women’s identities interact in complex and simultaneous ways, creating unique and diverse experiences (Crenshaw, 1991).

The interaction between these different determinants of health mixed with a minority status can significantly shape a woman’s lived experiences in many different ways; women of colour or of a marginalized community can face different forms of oppression that can hinder her reproductive destiny (Crenshaw, 1991; Ross, 2006). To help with the advancement of the well-being of women and girls and by allowing them to fight for the right to have a child, the right not to have a child, and the right to parent the child,

the research community must use a reproductive justice framework as a tool to answer questions and to create solutions (Ross, 2006).

In order to understand the purpose and value of a reproductive justice framework, it needs to be looked at within a larger historical context of reproductive rights in the 1900s. Throughout history in North America there has been a vested interest by white populations to control the fertility and population growth of non-white populations due to the perceived threat of losing power of the white-nation state (Nelson, 2003; Roberts, 1997). Documented cases of women from various groups and communities highlight the atrocities that women faced. For example, it has been documented that black women were believed to be “intellectually inferior” and experienced coerced and forced contraception provision with the purpose of controlling the population (Roberts, 1997, p. 63). Use of long-acting contraception such as the IUD, the implant, and tubal ligation were forced upon women of colour, women who used drugs, and women who had disabilities for the purposes of eugenics and population control (Hunker, 2005; Nelson, 2003; Roberts, 1997). Government programs that funded the insertion of LARCs targeted women of a minority status and would not fund the removal of these technologies; women were coerced into opting for these methods in an unjust way (Schoen, 2009). Users of these long-acting contraceptives were dependent on physicians for insertion, removal, and administration which put them in a state of vulnerability and low control over their own bodies (Schoen, 2009).

Moreover, harsh legal consequences for seeking an abortion rendered abortion services nearly inaccessible and federally funded sterilization programs were targeting these same women of colour, women of Native descent, and women with disabilities (Stern, 2005). The majority of the 20th century was a time where these women had little control

over their reproductive health and destiny (Nelson, 2003; Schoen, 2009). Imposing any forced population control efforts with either eugenics or economics in mind had large negative impacts on the society as a whole (Hunker, 2005; Price, 2010; Schoen, 2009; Stern, 2005). Basic human rights were violated by stripping women from the reproductive control of their own bodies through restricted abortion services and forced contraception and sterilization (Hunker, 2005). Since then, many efforts through movements, protests, and political reforms have been made to shape women's reproductive health services in the United States to be more accessible and comprehensive for all (Schoen, 2009). These same dynamics also shaped international family planning programs sponsored by countries in the Global North.

In light of all of these historical events, reproductive justice continues to use the theoretical concept of intersectionality to understand how different experiences of oppression and social injustice in the context of complex and multi-faceted individual identities can affect one's reproductive autonomy. Globally, women are still fighting for their reproductive rights and scholars and researchers continue to explore the different environmental, social, and political barriers that define reproductive justice.

Reproductive justice and research

Using a reproductive justice framework is crucial when conducting research in the area of reproductive and sexual health because it gives "context and perspective to the underlying social injustices" that the women in the community of study have faced or are currently facing (Gilliam et al., 2009). Women's experiences with SRH are a combination of their varying identities mixed with the multi-level systems that exist in their society. The

complexities of women's lives affect their upbringing and social context and need to be acknowledged while doing research. In revisiting the definition of reproductive justice, it is the political, economic, and social inequalities that infringe on a woman's ability to realizing her reproductive rights (Gilliam et al., 2009) and this notion could be further understood using the social ecology theory that was first developed by psychologist Urie Bronfenbrenner.

The social ecology theory demonstrates how different system levels can affect an individual's upbringing and development, including his/her health (Crosby, Salazar, & DiClemente, 2011). There are four main environmental systems that exist in this theory (see **Appendix D**). The closest system to the individual is the *microsystem*, which is influenced by family, peers, religious organizations, health services, and any other factors that directly affect the individual. If two factors within the microsystem interact with one another, the resulting reinforcement is classified into the *mesosystem*. The next level up is the *exosystem*, a system that does not "directly" affect the individual but still influences his or her experiences such as mass media, social services, local politics, and the industry. Finally, the *macrosystem* looks at the larger cultural context and includes the cultural values, customs, and laws that shape the society or cultural group (Bronfenbrenner, 1992; Crosby et al., 2011). Mixing this theory with a reproductive justice framework can guide researchers towards understanding the SRH situation in a particular population.

The reproductive justice framework is particularly important when conducting research internationally and/or with vulnerable communities. In order to remain culturally appropriate and sensitive towards the participant population, it is important to use this framework throughout the entire research process. In addition to providing a deeper

understanding of the phenomenon being studied, awareness of the historical roots and social context of the target population can help ease the rapport and build the trust between the researcher and the community members (Seidman, 2012).

Reproductive justice along the Thailand-Burma border

My thesis project looked at experiences and perceptions with the IUD among users living in a protracted conflict as well as an international setting. Long-acting yet reversible contraceptives, such as the IUD and the implant, have historically been instruments of “population control” among minority populations in the United States (Schoen, 2009) and in international family planning programming. Doing any type of research that involves these devices needs to be approached with sensitivity and primacy of autonomy due to the violent and unethical practices that took place in the 1900s.

By aiming to understand women’s experiences with the IUD, we also explore their experiences with contraceptive service delivery more broadly along the border which sheds light on the various barriers to reproductive health services. Indeed, this project was motivated, in part, to ensure that the larger interventional study was not creating a dynamic of coercion and that women who opted to use the IUD were doing so voluntarily. Using a reproductive justice framework to inform my analysis, I understand that Burmese refugees and migrants living along the border lack the resources and the power on political, social, and economic levels to fully exercise their reproductive rights. The many existing factors that impede on women’s ability to make reproductive health related decisions, such as their educational status, their legal/minority status, their income levels, their culture and/or

religion, as well as their gender and access to resources were studied and examined during all of the phases of this research project.

Significance, Implications, and Future plans

Given that the intervention study has only just recently been completed, my thesis project is especially timely. Prior to this thesis project, we had no data or records from the border describing women's perceptions of the IUD compared to other contraceptive methods. There is also a major gap in the literature on reproductive health in refugee, crisis, conflict, and emergency settings and the specific role of LARCs in addressing unmet contraceptive need.

The information that we collected through this qualitative study promises to inform MTC and other local stakeholders, which currently offer reproductive health services along the border, on the impact that IUDs had on women who decided to adopt this method. This thesis coupled with a follow-up for the intervention study will give way to the expansion of the intervention study in other areas along the Thailand-Burma border. Additionally, we hope to use the results to help improve contraceptive service provision both at MTC and at SMRU. We also hope to use these results to help expand access to and use of different reproductive health technologies among Burmese refugees and migrants who reside along the Thailand-Burma border.

I anticipate that the results will be used by those in the humanitarian relief sector to advocate for changes in protocols and service provision. Unsafe abortion can put a woman at serious risk for complications, or even death (Grimes et al., 2006; Hobstetter et al., 2012; Sietstra, 2012), and the availability of LARCs could provide women with a crucial

mechanism for preventing unwanted pregnancy. Other non-government organizations (NGO) and reproductive health clinics can also benefit from this evaluative study to help them better provide comprehensive services to women along the Thailand-Burma border through existing and upcoming programs.

This research project highlights MTC and SMRU's role in aiding women along the border who seek family planning advice. Knowledge of these women's reproductive health influences also gives us a better understanding as to how accessible these crucial services are to this vulnerable population.

Reflexivity

One of qualitative research's strength is the researcher's position in creating a relationship with the participant to deeply explore a phenomenon. However, the subjectivities of individual researchers must be acknowledged throughout the research process. Through extensive interview training, I was prepared to collect the data in an appropriate and ethical manner through the creation of a "welcoming, non-threatening environment in which the interviewees are willing to share personal experiences and beliefs" (Karnieli-Miller, Strier, & Pessach, 2009, p. 280). However, as a Western health researcher studying a relatively rare reproductive health technology along the border, participants might have perceived a power imbalance through my presence, creating a complex dynamic that could have had an effect on participant responses (Finlay, 2002; Karnieli-Miller et al., 2009). This imbalance can alter the relationship that is trying to be created during the interview process and might make the participants weary of disclosing certain responses. For example, although women were assured of the confidentiality of their

responses, few women shared details with me about their reasons for coming to the border region, likely as a result of profound and longstanding fear of the military junta in Burma and the consequences of sharing details to a Westerner. In order to minimize the impact that my presence had on the research, I made sure to work with an established team that my supervisor had worked with previously. I also debriefed my supervisor and sought her expertise and opinions on the research project as it unfolded, and I worked with local research assistants who provided me with guidance throughout the study. Having a local interpreter present during the interviews helped mitigate this power dynamic and helped me to successfully collect necessary information from 31 women who live along the Thailand-Burma border.

Furthermore, as a qualitative researcher, I am aware that my positionality can influence the analysis. The process of memoing allowed me to explore and reflect on these influences and helped me recognize and acknowledge my personal subjectivity throughout the data collection, thereby enhancing the credibility and trustworthiness of the research. As a women's researcher, a feminist, and a Lebanese minority living in Canada, it was important for me to acknowledge that my knowledge, background, and view of the world and women's health impacted the way I interpreted the responses from the interviews. The practice of reflection helped with the analysis in allowing me to identify and minimize initial assumptions and subjectivities in the interview context (Finlay, 2002). It was also through this lens of reflexivity that I was able to design specific interview questions to help "inform and clarify [my] understanding" in women's reproductive health experiences along the Thailand-Burma border outside of my existing knowledge and assumptions of the subject (Roller, 2012, p. 4). The act of reflection on one's own position and views about the

research is paramount in qualitative research and can help readers understand where the researcher is coming from when sharing results.

Limitations

Being a Westerner who does not speak relevant languages limited my ability to engage in certain recruitment efforts and required that I relied on interpreters during the data collection phase. This likely impacted my ability to understand the nuances of language and dialect. However, by working with highly trained local partners, both during the interviews and in the review of the transcripts, we attempted to address this challenge.

The Thailand-Burma border region is one of incredible linguistic, ethnic, and cultural diversity. However, due to financial and time constraints, we focused our research on Burmese- and Karen-speaking populations living on the border. Although these languages groups are the most dominant, women who were not sufficiently comfortable completing an interview in Burmese, Karen, or English were not able to participate in the study. Further, although we implemented a multi-faceted recruitment system, we were only able to develop recruitment posters in Burmese and English. However, we tried to mitigate this limitation by discussing the content of the poster with local vendors prior to posting them, such that they would then be able to provide additional information to clients and customers in their respective language. In addition, walking around and explaining the research project also helped us explain the project details to individuals who were not literate.

As is true with qualitative research in general, these findings cannot be generalized to all Burmese refugees or migrants living along the Thailand-Burma border. The in-depth interviews provide us with a thorough understanding of women's experiences with

reproductive health technologies and services and give us insight into the influences and factors that play a role in women's health in this region. We are confident that the themes we have identified are meaningful but caution against using these findings to determine broader patterns or trends.

Statement of contribution

As the Principal Investigator (PI) of the study, I completed this study in partial fulfillment of the requirements for the Master of Science in Interdisciplinary Health Sciences program at the University of Ottawa. Consistent with my role as PI, I conceptualized the study, designed the study instruments, collected and analyzed the qualitative data, and led the development of both manuscripts.

However, this project also involved other members of the study team. My supervisor, Dr. Angel M. Foster, worked with me to design a feasible project that built on the larger interventional study. She guided me throughout the research process in helping to create the proposal, getting approval from the REB, connecting me with study team members on the Thailand-Burma border, and providing me feedback and guidance on the study instruments and tools. She oversaw the project in its entirety including reading over the memos and the transcripts and approving the code books and the overall analysis of the study.

Saw Nanda Hsue was one of the local study team members hired to interpret the interviews during the data collection process and also served as a translator for documents such as the consent form and the recruitment posters. He served as the contact person for women interested in the study and arranged the interview times and locations with our

participants. He also reviewed all of the transcripts for accuracy in translation. Hay MarSan was our second local research assistant and played a significant role in the recruitment process. She recruited participants from the Mae La camp, from Mae Sot, and from the outskirts of Mae Sot. She also interpreted many of the interviews that took place throughout the data collection phase of the study.

Meredith Walsh and Cari Sietstra also contributed to this project. Ms. Walsh played a major role in helping me establish myself in the field and gave me the necessary foundation to create important connections with local stakeholders and community members. As one of the PIs of the larger interventional study, Ms. Walsh also contributed to the conceptualization and design of this thesis project. Finally, Cari Sietstra, a Co-Investigator in the larger interventional study, played a significant role in the conceptualization, design, implementation, and administration of this project. All members of the study team also contributed to the interpretation of the findings and the generation of recommendations.

As the PI of the project I led the writing of both manuscripts. We determined authorship and authorship order for each article based on discussions as a team. All listed authors for each article meet the criteria for authorship as outlined by the individual journal. The listed co-authors of each manuscript reviewed early drafts and provided substantive and editorial feedback. All co-authors have approved the manuscripts included in this thesis.

Conclusion

Burma has seen some of the world's worst human rights violations and its inhabitants, particularly those who belong to ethnic minority groups, have suffered for decades. The forced displacement of millions toward the Thailand-Burma border has resulted in extremely poor health outcomes among cross-border populations, migrants, and refugees and reflects the high maternal mortality and morbidity, low contraceptive use, and high rates of unintended and unwanted pregnancy. One of the most effective and cost-efficient way to address women's reproductive health needs is through increasing accessibility, affordability, availability, and quality of contraceptives, with the IUD being a valuable technology in this region. Structural, political, informational and geographical barriers to health care services contribute to the unmet need of family planning services, but the IUD's properties of being long-acting, reversible, low-maintenance, extremely effective, and safe have the potential to address women's needs and enhance their reproductive autonomy. This study demonstrated that the technology is culturally acceptable and has the potential to reduce barriers to contraception that women on the border routinely experience. The positive experience of users of the IUD suggests that there is a need for increased efforts to expand this technology in this protracted refugee and conflict setting.

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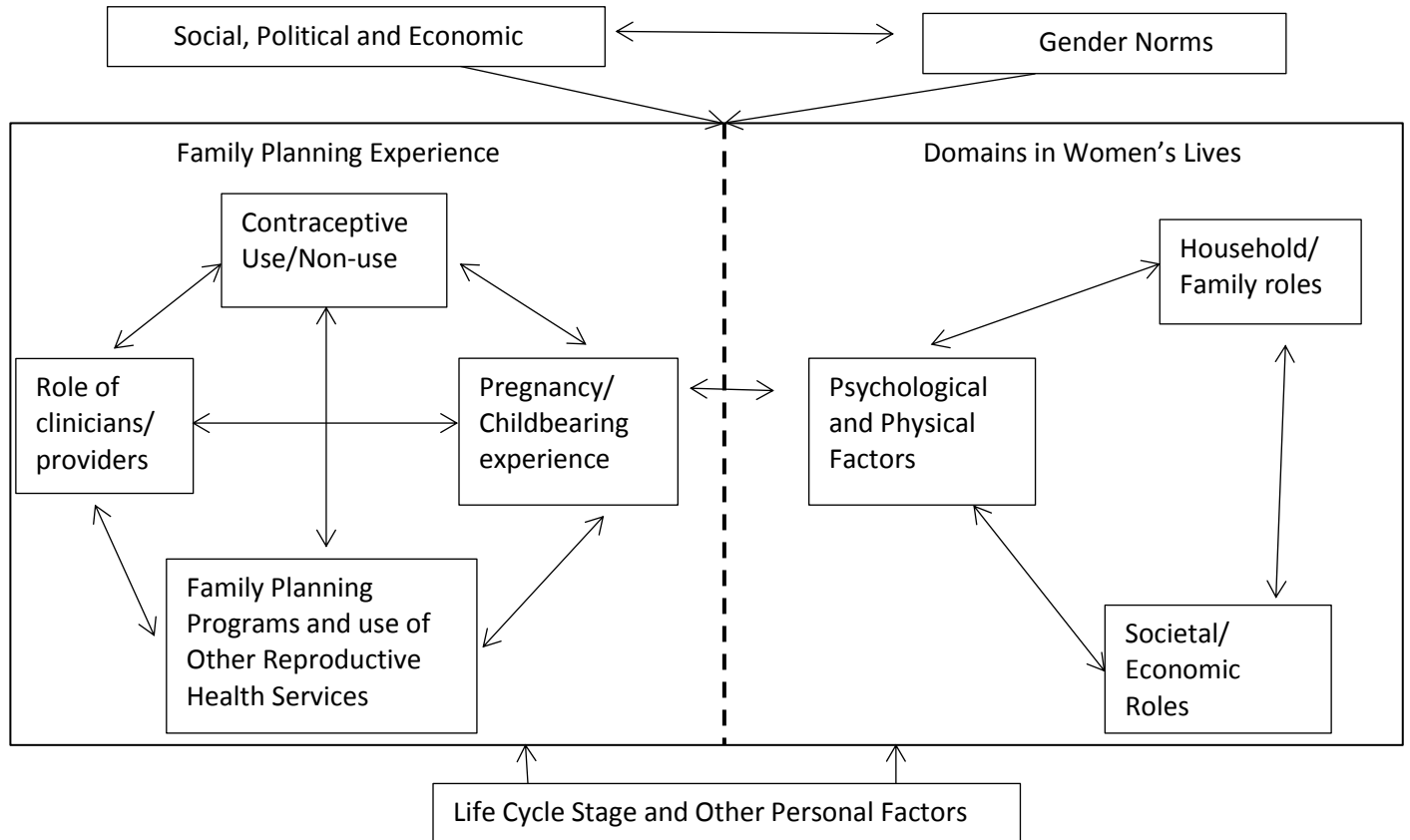
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Appendix A: Map of the Thailand-Burma border



Source: Sussman & Jones, 2008

Appendix B: Conceptual framework



Adapted from Hardee et al., 1996

Appendix C: REB Approval Letter

File Number: H02-13-08

Date (mm/dd/yyyy): 06/26/2013



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

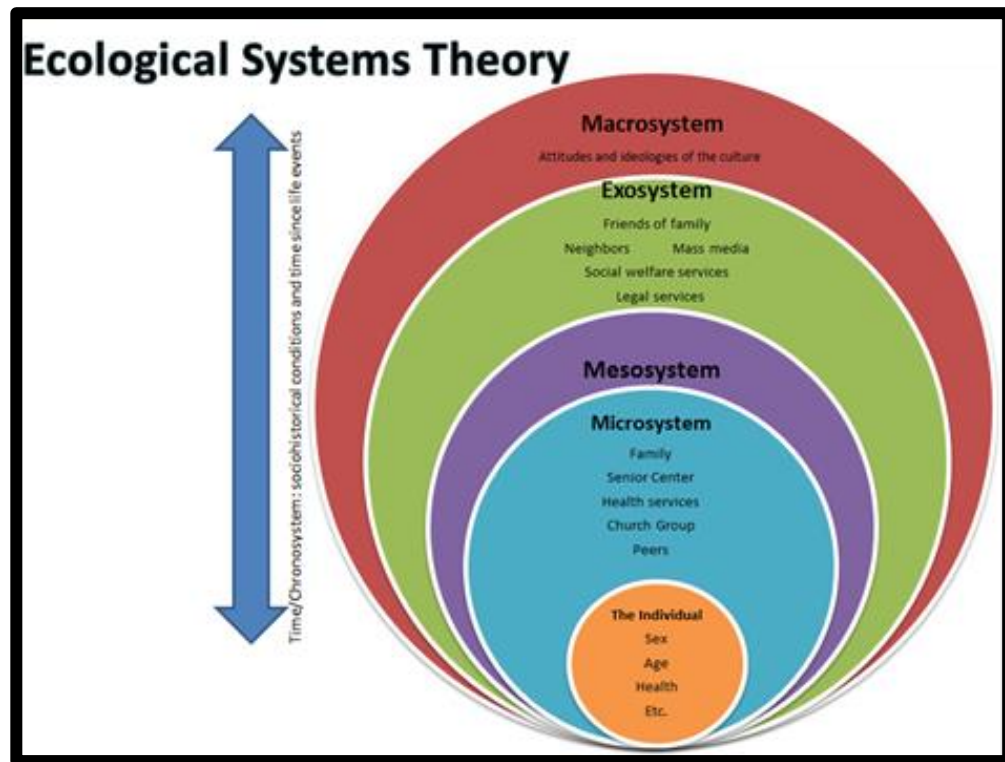
If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at ethics@uOttawa.ca.

Signature:

A large black rectangular box redacting the signature of the Protocol Officer.

Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB

Appendix D: Ecological Systems Theory diagram



As presented in Bronfenbrenner, 1992