Establishing a Referral System for Safe and Legal Abortion Care: A Pilot Project on the Thailand-Burma Border

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The decades-long conflict in Eastern Burma,* and the continued human rights violations and lack of development and economic opportunities there, have led to the displacement of millions of people in the region. Some have been internally displaced, others live in conflict-affected communities in Eastern Burma, and approximately 1.5 million are either residents of nine unofficial refugee camps along the border with Thailand or undocumented migrants concentrated in Tak Province in northern Thailand.[1–3] For these displaced populations, the overarching political, development and human rights context has had a significant impact on health in general, and on reproductive and maternal health in particular.[4]

Individuals in the affected regions of Thailand and Burma face significant barriers to accessing reproductive health services on both sides of the border, and are at an increased risk of rape and sexual exploitation.[5–10] Although the maternal mortality ratio for Burma overall has remained relatively constant over the last decade (at 320 deaths per 100,000 live births), it is estimated to be substantially higher (approximately 1,000) in conflict-affected Eastern Burma.[11] Limited access to contraceptives and the consequent risk of unintended pregnancy continue to be public health issues for women living in Eastern Burma.[5] Although the national contraceptive prevalence rate is only 34%, the rate is likely much lower in conflict-affected areas;[12–14] some reports suggest that 80% of women in Eastern Burma have never used a modern method.[11,15]

Abortion has long been severely legally restricted in Burma. The 1860 Burma Penal Code—incorporated into the law of independent Burma in 1947 and still in effect—is based on British law and prohibits abortion unless the procedure is performed to save the life of the woman; this exception is narrowly interpreted.[16] A person who performs an unauthorized abortion and the woman herself may face imprisonment, fines or both; both criminal and civil penalties increase if the abortion takes place after "quickening,"[17] an archaic term for when a pregnant woman first perceives fetal movement. Like women in other settings where abortion is legally restricted, women in Burma who want to terminate a pregnancy often resort to unsafe methods.[6,7,16,18,19] The national restrictions on abortion, combined with the heightened unintended pregnancy risk, have had devastating health consequences for women in the border region: Evidence suggests that unsafe abortion is a leading cause of maternal death there.[6,16]

In contrast, legal restrictions on abortion are less severe in Thailand. Unchanged since 1957, Section 305 of the Thai Criminal Code permits induced abortion if the pregnancy endangers the health of the woman or if it resulted from a criminal offense.[20,21] In recent years, the Thai Medical Council has defined the ambiguous term "health" to include both physical and mental health. Moreover, the presence of a fetal anomaly is presumed to affect a woman's mental health and, therefore, abortion is legally permissible in such cases as well. The criminal offense provision allows for an abortion to be carried out in cases in which the pregnancy resulted from rape or incest, as well as those in which the woman became pregnant at or before age 15.[20] The Thai Medical Council, which regulates abortion procedures, stipulates that they must be provided by a physician, certified or approved by a second physician and detailed in the medical record.

These restrictions on abortion have resulted in disparities in access to safe and legal services within Thailand. In Bangkok and Chiang Mai, there are well-known, highly trained medical providers who interpret the mental health exception broadly and argue that an unwanted pregnancy—in and of itself—can result in such great stress that a woman with an unwanted pregnancy is eligible for legal care. As a result, Thai women living in major urban areas or with adequate financial means are more able to obtain safe and legal services than are their rural and poor counterparts.[20–22] However, women from Burma living in Thailand are generally unable to access safe abortion care—even for cases that clearly fall within the legal exceptions—because of a lack of knowledge of the Thai medical and legal systems, restrictions on travel and movement, the costs associated with the procedure, a dearth of culturally and linguistically compatible providers, and externalized and internalized stigma.[6,7,23,24] As a consequence, women from Burma on both sides of the border suffer significant reproductive health morbidities as a result of unsafe abortion.[6,16,19,24]

This context motivated the pilot project described in this report. We detail the three-year, collaborative effort by the Mae Tao Clinic in Mae Sot, Thailand, and a multidisciplinary team of North American reproductive health specialists to determine the feasibility of establishing a referral system for abortion care. We then present the outcomes of more than two dozen cases in which women from Burma who met the criteria for a safe, legal abortion were referred to a qualified and legal Thai provider.

*Although the country was officially renamed Myanmar more than 25 years ago, we use "Burma" throughout this report for consistency with the terminology used by refugee and migrant communities in Thailand.

Situation Analysis and Stakeholder Engagement

The foundation of the pilot project began in September 2010 with the initiation of situation analysis research. During this phase, which ultimately took nearly 18 months, we collected and reviewed published studies, legal statutes, medical society guidelines and individual hospital policies to gain a better sense of the dynamics shaping legal abortion care in Thailand in general and in Tak province in particular. In addition, we conducted interviews with more than two dozen stakeholders over a six-month period in 2010–2011 to discuss hospital- and clinic-based abortion provision in Mae Sot, Chiang Mai and Bangkok; existing Thai referral systems for safe and legal abortion care in Chiang Mai and Bangkok; and models of referral for refugees and undocumented migrants from Burma to Thai facilities for health care in Tak province and Chiang Mai. The interviews also focused on the facilitators of and barriers to establishing an abortion referral system in Tak province.

As part of the situation analysis, we also hosted a series of community discussions and engagement meetings in Mae Sot and Chiang Mai to explore the reactions of health care workers, representatives from Burmese community-based organizations (CBOs), adult women and adolescents to a hypothetical referral system for safe and legal abortion care. Finally, we attended a number of meetings of the Choice Network, a Thai consortium of more than 50 organizations and medical facilities dedicated to ensuring that women facing an unplanned pregnancy are offered a full range of options and resources. Participation allowed us to become familiar with the different ways in which referral systems are operationalized for Thai women.

The results of our situation analysis suggested that development of a pilot referral project would be feasible, but challenging. According to stakeholder interviews, misinformation about the legal status of abortion in Thailand was widespread, especially among CBOs working on the border. Indeed, many stakeholders from Burma—including health service providers—assumed that the legal status of abortion was the same in the two countries and had difficulty conceptualizing a safe procedure. Thus, any efforts to create a referral program would require significant awareness-raising campaigns.

We also discovered that a number of existing referral programs had successfully navigated documentation, transportation and financial barriers so that undocumented migrants from Burma could receive health care at Thai government facilities. In addition, several CBOs in Tak province had established systems of referral to specialized or tertiary facilities in Chiang Mai and Bangkok. Our interviews and discussions, however, demonstrated that "piggy backing" on existing referral systems would be impossible because of the politicized nature of abortion in the border region, the religious affiliation of a number of CBOs and restrictions on abortion services imposed by both bilateral aid agencies and private foundations. Thus, establishing a referral system for abortion care would require a de novo effort with dedicated funding.

Finally, we found that several clinicians at the public Mae Sot Hospital who provided postabortion care also provided first-trimester and early second-trimester abortion care to Thai women for a limited range of conditions and indications. Discussions with hospital staff indicated that they were open to accepting referrals from local CBOs, which would allow patients to avoid the checkpoints and police interactions that often impede travel of undocumented populations to Chiang Mai or Bangkok; however, the high cost of abortion care for undocumented migrants (US$200–500 per procedure, depending on gestational age) would be prohibitive for most women from Burma. Local CBOs were open to referring women to Mae Sot Hospital for abortion care, but wanted assurance that patients would receive culturally and linguistically appropriate treatment, and that undocumented women would not be at increased risk of arrest or deportation. Thus, for a local referral system to be successful, relationship building and establishing trust between partnering organizations would be of paramount importance.

Project Components

On the basis of the results of our situation analysis, we decided to develop the pilot project. We identified a number of project components that would need to be undertaken, including identifying and cultivating champions; providing training on both abortion-related topics and counseling skills; creating a referral system that guided health care workers through the various stages of the process; making efforts to continuously engage with stakeholders to respond to challenges, address questions and provide additional training; and establishing a tracking system to evaluate referral outcomes. Below, we provide additional detail about the mechanisms undertaken to accomplish each of these project components.

- *Values clarification workshop*. The six months following the situation analysis centered on establishing the logistic elements of the referral program, securing funding to subsidize the cost of the procedures and developing the training curriculum. Furthermore, our research with stakeholders in Mae Sot indicated that helping reproductive health care workers at Burmese CBOs to improve their counseling skills and explore their feelings about abortion would be an essential element of the program. In the fall of 2011, we partnered with the Choice Network to host a weeklong values clarification, counseling and self-care workshop. We identified eight CBO representatives who were able to travel to Chiang Mai for the workshop. Expert facilitators from the Choice Network worked with us and two interpreters to modify and adapt the workshop for cultural resonance. The workshop itself was held in Thai, English, Burmese and Karen, and workshop participants became champions of the referral system and key contributors to future trainings.
- *Training and launch*. In February 2012, we coordinated a four-day training in advance of the launch of the referral program. The purposes of the training were

to educate participants on medical and legal issues surrounding abortion care in Thailand; clarify individual and institutional values related to abortion; provide an opportunity for participants to develop nondirective, nonjudgmental counseling skills to help women with unintended or unwanted pregnancies; and review the logistics of the referral system. The 30 participants included members of the Mae Tao Clinic's reproductive health outpatient and inpatient departments, staff from Mae Sot Hospital and representatives from several Burmese CBOs. The training consisted of a series of modules dedicated to a range of topics and skills, and incorporated both didactic and interactive teaching and learning techniques. In addition, two Mae Tao Clinic staff members were trained in system navigation advocacy to help women presenting at Mae Sot Hospital for safe abortion. The safe-referral program itself launched immediately after the conclusion of the training.

• *Implementation.* To guide the implementation practices of Mae Tao Clinic staff and participating CBOs, we created a comprehensive diagram that indicated the various pathways through which a woman could be eligible for referral. This visual tool enabled counselors and front-line personnel to determine if a woman qualified for a legal abortion through a series of if/then questions. If a woman was deemed eligible for a referral, the diagram guided the counselor through a predetermined sequence of activities, including documentation, contacting Mae Sot Hospital and reaching out to the project team to trigger the release of funds. If a woman was deemed ineligible, the tool directed the counselor to provide other services, including empowerment counseling and referrals to area social services for families and children and support networks for women.

Mae Tao Clinic health care workers recorded in a logbook information on all pregnant women presenting at the reproductive health outpatient department; data included anonymous demographic information, gestational age of the pregnancy and whether the pregnancy was wanted. In addition, health care workers included logbook entries for whether women with an unwanted pregnancy were provided with options counseling and offered referrals. Participating CBOs recorded standardized information about all women who were referred to Mae Sot Hospital, including indication for abortion, gestational age of the pregnancy, referral outcome and procedure cost.

• *Monitoring and assessment.* We used multiple techniques to monitor program implementation on an ongoing basis. Our aim was to assess health care workers' provision of compassionate counseling, aptitude at assessing a woman's eligibility for a referral and ability to provide a referral. We collected feedback forms from training participants and held one-on-one meetings with all participants 1–2 months after the training to discuss their early experiences. Senior supervisors in the reproductive health departments at the Mae Tao Clinic observed counseling sessions and shared their feedback with the project team. We also held quarterly group meetings with Mae Tao Clinic staff to review cases, answer questions and discuss ways in which the system could be improved. As a result of our monitoring efforts, we held an additional three-day, in-service training for 18 Mae Tao Clinic staff members six months after the launch of the project. Midway through the project, the Mae Tao Clinic established a dedicated counseling room in response to the staff's suggestion that counseling women on pregnancy options requires privacy.

In addition, we assessed the impact of the program. Final outcomes of the pilot project were measured by the number of safe abortion referrals from Mae Tao Clinic to Mae Sot Hospital, the number of patients referred from other CBOs and the outcome of all referrals. A secondary measure centered on the number of participants who were trained and on how effectively the Mae Tao Clinic incorporated Thai legal criteria for abortion into counseling and service delivery. We posted Thai legal documents outlining the eligibility criteria around the reproductive health departments to promote their use.

Provision of Counseling and Referrals

From March 2012 through February 2013, more than 5,000 pregnant women presented at the Mae Tao Clinic's reproductive health outpatient department and provided information that included gestational age and wantedness of the pregnancy. Women with unwanted pregnancies were offered options counseling, and six were deemed eligible for a referral—all for physical health indications (Table 1). During the same period, two other participating CBOs—Social Action for Women and another organization that has requested that its name not be used—referred an additional 21 women for safe and legal abortion care at Mae Sot Hospital. Of those, 13 were referred because their pregnancy was the result of rape or incest, five because of mental health indications, two because they were younger than 15, and one for a physical health indication.

The three CBOs serve women from Eastern Burma who cross the border temporarily (typically referred to as "cross-border populations"), refugees and undocumented migrants residing in Thailand. All three are staffed primarily by people from Burma, and routinely provide services and counseling in Burmese and Karen (the dominant languages of those on the border), as well as other languages spoken by specific ethnic minority populations, when needed. When the pilot project began, women were informed of the referral program only after they presented at a participating organization and identified themselves as having an unwanted pregnancy or were diagnosed with a health condition; however, as the referral system became established and women in the community learned about it, some women with an unwanted pregnancy presented with a specific request for a referral.

Of the 27 women who were referred through the program to Mae Sot Hospital for safe and legal abortion care,

TABLE 1. Selected information on 27 women referred to Mae Sot Hospital for an abortion through pilot project, Thailand, 2012–2013

Case no.	Reason for referral	Referral source	Outcome
1	Physical health (heart condition)	MTC	Successful
2	Physical health (diabetes)	MTC	Successful
3	Physical health (HIV)	MTC	Successful
4	Physical health (heart condition)	MTC	Successful
5	Physical health (hypothyroidism)	MTC	Unsuccessful*
6	Physical health (not specified)	MTC	Unsuccessful†
7	Younger than 15	SAW	Successful
8	Younger than 15	SAW	Successful
9	Rape	SAW	Successful
10	Rape	SAW	Successful
11	Rape	SAW	Successful
12	Rape	SAW	Successful
13	Rape	SAW	Successful
14	Rape	SAW	Successful
15	Rape	SAW	Successful
16	Rape	SAW	Successful
17	Incest	SAW	Successful
18	Incest	SAW	Successful
19	Incest	SAW	Successful
20	Incest	SAW	Successful
21	Incest	SAW	Successful
22	Physical health (heart condition)	SAW	Successful
23	Mental health	SAW	Successful
24	Mental health	SAW	Unsuccessful†
25	Mental health	Anonymous	Successful
26	Mental health	Anonymous	Successful
27	Mental health	Anonymous	Successful

*Deemed ineligible. †Woman did not follow up. *Notes*: MTC=Mae Tao Clinic. SAW=Social Action for Women.

24 received an abortion. All 24 were 10–17 weeks pregnant at the time of the procedure; the majority of terminations took place at gestational ages of 12–14 weeks, and all were performed without complications. Women referred by Social Action for Women generally obtained an abortion within a week of their initial presentation; those referred by the other two organizations obtained an abortion within two weeks, on average.

The program covered all abortion care costs, including those for counseling and consultations, the abortion procedure, all medications and postabortion contraception (all methods, including tubal ligation); on average, costs totaled US$350. For women who were referred with physical health indications, the referral program also covered the costs related to immediate treatment of the condition, but not ongoing medical expenses for chronic or longstanding health problems. In some cases, the program also covered women's travel expenses to and from Mae Sot Hospital.

Of the 24 successful cases, five women were referred for physical health indications (i.e., cardiac conditions, HIV infection, diabetes and hypothyroidism). In almost all cases, clinicians at Mae Sot Hospital repeated all tests and examinations performed at the referring facility prior to approving an abortion. Four women were successfully referred for mental health indications; in all these cases, documentation by the referring facility combined with an interview between the patient and a Mae Sot Hospital clinician was sufficient for approval. Of the 13 women who were referred for pregnancies resulting from rape or incest, the patient's statement was sufficient for approval; no police reports or medical documentation were required. Finally, both women referred because of being younger than age 15 were asked to provide their official birth certificate; one young woman could not do so, but Mae Sot Hospital accepted her national Burmese identification card instead.

Three women referred to Mae Sot Hospital did not obtain an abortion. In one case, the patient was referred from the Mae Tao Clinic because of an untreated thyroid condition that could lead to fetal abnormalities. However, Mae Sot Hospital did not deem this physical health condition sufficiently serious to merit an abortion and opted to "watch and wait" for signs of fetal anomaly. No definitive evidence emerged and, eventually, the patient's pregnancy was beyond the gestational age limit for an abortion at the hospital. The patient returned to Burma, and no information about the outcome of her pregnancy is available, despite multiple attempts by Mae Tao Clinic staff to reach her. In the other two cases, the women were referred to Mae Sot Hospital, but never presented there for an abortion. Social Action for Women staff were unsuccessful at contacting them, and no information about their pregnancy outcomes is available.

Our engagement with participating health care workers revealed persistent confusion and uncertainty about eligibility criteria for both the physical and the mental health indications. Mae Tao Clinic staff in particular remained unsure throughout the pilot project as to what documentation was required for "proof" that the pregnancy posed a threat to mental health. Furthermore, a number of clinic staff reported continued discomfort and difficulty with asking women about their feelings regarding their pregnancy. Women who said they had an unwanted pregnancy were often "passed on" to another counselor or staff member so that the original staff member did not have to take responsibility for "causing" the abortion. Finally, health care workers repeatedly expressed frustration about not being able to direct women with unwanted pregnancies who did not meet the eligibility criteria to alternative resources. The lack of access to safe abortion care for all women and the lack of adoption services limited the scope of pregnancy options counseling. Counselors were demoralized by the knowledge that women with unwanted pregnancies would likely seek an unsafe abortion or carry the pregnancy to term and abandon the newborn after delivery.

Lessons Learned

As of late 2015, only six countries prohibited abortion in all circumstances;[25] in all other nations around the world, abortion is legally permissible for at least some indications. Identifying mechanisms that work within existing legal constraints to expand access to safe abortion care can have a significant impact on women's health in regions where unsafe abortion is common. This is especially important in refugee, crisis, conflict and emergency settings, where it has long been estimated that a substantial proportion of maternal deaths are directly attributable to complications from unsafe abortion.[26,27]

Our experience with the pilot project indicates that creation of a safe and legal referral program is feasible, even in a context characterized by protracted displacement and conflict. Although the total number of referral cases was small (an average of just two per month in the first year), the pilot project still succeeded in meeting its initial objectives. The experiences of individual women provided additional information about the interpretation of the eligibility requirements in Thailand, and confirm that navigating the complex and sometimes ambiguous legal parameters of abortion care is possible. Expanding the referral program in Mae Sot and scaling up the initiative to other areas in northern Thailand with large populations from Burma appear warranted.

However, our review of the pilot program indicates that there is much room for improvement. Notably, the three participating CBOs referred women for widely differing indications. Despite continued engagement with stakeholders and creation of formal opportunities for representatives from participating organizations to share their experiences, CBOs exhibited different levels of comfort with the exceptions, and interpretations of the mental health exception varied. Providing additional opportunities for debriefing, exchanging experiences, clarifying institutional values and reviewing successful cases with staff may help standardize the referral process.

Yet, as is the case with health care workers in a variety of other settings, individuals' values shaped the referral process. In particular, even after extensive training on values clarification and pregnancy options counseling, Mae Tao Clinic staff expressed a range of opinions about and comfort with discussing unwanted pregnancies. Health care workers who were identified by other staff as having greater comfort were often tasked with counseling women with unwanted pregnancies and discussing the referral system. Although some individuals welcomed this role, others expressed frustration at always having to serve in this capacity, even if they were champions of the project. Holding an in-service training session and convening regular group meetings to give staff space to discuss these issues resulted in improvements during the second half of the pilot year, but ongoing monitoring and program adjustments are required.

Perhaps the greatest challenge in implementing this project involved the limited options available to women with an unwanted pregnancy in northern Thailand. During the one-year pilot project, more than 500 women with an unwanted pregnancy presented at the three participating CBOs, yet only 27 were deemed eligible for referral. Although pregnancy options counseling is a mainstay of safe abortion care worldwide, the restrictions on safe abortion care and the lack of adoption services in the region limit the options that counselors are able to discuss. In this setting, women with an unwanted pregnancy who are unable to obtain safe abortion care often turn to unsafe alternatives.[5,6,23,24] It is important to identify ways to increase access to safe and legal abortion care and reduce harm from unsafe abortion.

Although our monitoring and assessment plan included various methods, it did not include direct input from women who received referrals. Future efforts would benefit from having patients' perspectives and using such information to improve counseling and the referral system. Furthermore, we did not assess the pregnancy outcomes of women who were denied a referral or ultimately denied a safe and legal abortion by Mae Sot Hospital. Finally, we were able to undertake this project only because a funder was willing to pay for the abortion care women received. Given the current restrictions on funding by many bilateral agencies and private foundations, securing this type of support may prove difficult for future initiatives and, therefore, limit the replicability of this project.

Conclusion

Identifying ways to expand access to abortion services within existing legal frameworks represents an innovative and underexplored area within the global reproductive health arena. The assessment of this pilot project demonstrates that it is possible to increase a marginalized and conflict-affected population's access to safe and legal abortion care within the existing legal and service delivery context. Expansion and scale-up of the referral program in northern Thailand and exploration of ways to adapt and replicate the program in similar settings appear warranted.

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