Asylum Seekers from Burma in Thailand[1]

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Introduction

The situation of asylum seekers[2] in Thailand has changed markedly over the last decade. In the 1980s and into the early 1990s, the focus was on Cambodians who had taken refuge near the eastern border of Thailand. In addition there were a significant number of persons displaced from Laos and living in camps in the northeast of the country. By the end of 1999, all Cambodians had been repatriated and only a handful of Laotians remained.

The western border of Thailand has remained throughout the 1990s as a haven for over one hundred thousand persons, mainly of Karen ethnicity, displaced through fighting inside Myanmar. This population has not, however, been static. The numbers of displaced persons involved, their ethnic composition, location, and relationships with the Thai government have all undergone significant changes over the last ten years. For example, of asylum seekers of Mon ethnicity have returned to Myanmar after making a political settlement with the government. This did not diminish the number of displaced persons, however, because of increased numbers of Karen and Karenni, who fled fighting in Myanmar. Because of increased security threats for camp residents along the border, the Thai government has adopted a policy of amalgamation of camps and moved them further away from the border area. The Thai government has also invited UNHCR to become involved in assisting in the registration of camp residents.

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The short-term outlook suggests there will not be a rapid repatriation of camp dwellers. Indeed, conditions exist for an increase in numbers if fighting intensifies. The situation of displaced persons has been of concern to the Thai government for a number of reasons. One obvious reason for concern is related to national security. However, the issue of health care has also been raised. The health situation of the displaced persons, the burden of health care that is placed on the Thai community, the transmission of communicable diseases, and policies that can be instituted to cater for the health needs of the of displaced persons are all issues that need to be examined.

This paper will provide a documentary review of the health situation of asylum seekers or refugees living in camps in Thailand. The paper relies on the collection of secondary data from a variety of sources, including interviews with displaced persons in the camps, and from previous research undertaken by members of the project. The paper will consist of six main sections: a brief literature review of issues related to health and displaced persons, policy related to displaced persons, an overview of the situation of displaced persons in Thailand, a review of the health situation of camp members, a discussion of current mechanisms for providing health services, and policies for health services.

Migration and Health

The public health and policy implications of mobility-related disease have not been assessed in any depth, although there has traditionally been a concern with mobility and disease as evidenced by the development of quarantine laws. Population movement of any type can result in the transmission and spread of communicable diseases. Factors contributing to increased communicable disease morbidity and mortality among migrants and the communities they enter are; 1) breakdown of individual access to the existing health infrastructure reduces diseases control and treatment capabilities, 2) movement of populations into zones with different microbial ecologies exposes those with low immunity to new agents, 3) crowding in relief camps leads to increased opportunities for disease

transmission, and 4) high rates of malnutrition increase susceptibility to communicable diseases (Gellert, 1993).

The major concern of host governments related to mobile persons has been the fear of the spread of communicable diseases (IOM, 1997). This includes malaria, tuberculosis, and HIV/AIDS and other sexually transmitted infections (STIs). The fear has been that mobile populations would contribute to the spread of these diseases. For example, while in most of Southeast Asia considerable success has been achieved in control of malaria over the past several decades, in other parts drug resistant falciparum malaria has increased dramatically. Population movement has the capability to contribute to the spread of the drug resistant malaria strains into settled host populations. For example, when gem mining in western Cambodia near the Thai border reopened in 1988, it attracted many miners from Thailand, Myanmar, and even from India and Bangladesh. Malaria transmission in this area is intensive. The daily movement of population is estimated to involve approximately 3,000 persons with low levels of immunity (Wernsdorfer et. al. 1994). Some estimates place malaria infection in the flow of persons crossing between Bo Rai, Thailand and Pailin, Cambodia through one crossing point at approximately 40 percent (Kidson, 1993). There has also been concern about the spread of malaria along the Myanmar-Thai border.

The health concerns of refugees and displaced persons are often different from those of other mobile populations. This is mainly because of differences in composition of the populations. For example, while migrants are typically young and healthy adults pursuing economic advancement, displaced persons are often negatively selected. They tend to be drawn from the poorer and most vulnerable segments of the community and there is a much wider range of ages than found in most mobile populations. Many displaced persons move as part of family groups and continue to live as a family after arrival in their host communities.

Therefore the reproductive health of refugees and displaced persons is now being focused upon as an area of special concern. Based on a review of available literature, including several studies of refugee populations along the Thai-Cambodian border, Family

Health International (1995) concluded that contraceptives were rarely made available to these groups. Although data on the fertility of displaced persons are few, it is observed that women in refugee sites throughout the world have large numbers of pregnancies at closely spaced intervals, resulting in high levels of infant and maternal mortality. The FHI report notes that a major problem in addressing the reproductive health needs of refugees is that this is rarely considered an emergency need. Contraceptives are considered a luxury rather than a necessity.

While many host governments have focused on the possible spread of HIV into host communities from mobile populations, others have argues that refugees, particularly women, are vulnerable to contracting HIV and other sexually transmitted diseases. For example, refugee women may find themselves forced into sex in order to gain access even to basic needs, such as food (Population Reports, 1996). Long (1994) points out the three risks associated with HIV infection among refugee women. They are: 1) refugee women run very high risks of being raped, often by men who themselves are in high risk HIV groups; 2) because of poverty, and the consequent need to ensure their own and their families survival, refugee women are also pressed into providing sexual services to men. This can be in form of commercial sexual services or more institutionalized forms of serial monogamy; and 3) health services to combat cofactors of HIV such as STDs, or IEC campaigns to promote understanding of HIV are often missing from camps.

Policies Related to Displaced Persons

The term 'displaced persons' as used to describe persons fleeing fighting or other danger in Myanmar is somewhat controversial. Normally, the term displaced persons is used to describe those persons who are forced to move within a country, either through their own choice or through the actions of others.[3] Those forced to move across international boundaries are usually referred to as refugees or asylum seekers. Thailand does not use the word refugees to describe the persons who have fled across the border. Instead it uses a Thai word that can translated as 'temporarily displaced'. Furthermore, the 'temporarily displaced' refer specifically to those that are either residing in camps set up to

house the displaced, or who are waiting to be processed into those camps. There are many thousands, probably hundreds of thousands of others feeling human rights abuses who are not treated as 'temporarily displaced'.

There are several different methods of calculating the number of displaced persons living along the Thai-Myanmar border. There are significant numbers of displaced persons living in Thai villages along the border. For example, it has been estimated that tens of thousands of Shan have crossed the Thai border to avoid fighting. Also, in an interview with a Thai-Karen NGO worker in Mae Sot in December 1999, we were told that there were as many 60,000 displaced Karens living in Thai villages along the border. Although, in the absence of confirmatory data, this might be an overestimate, there is a sufficient number in the communities for a Thai NGO to be currently undertaking a survey of several of these communities in order to document the characteristics of this group. One report in 1997 estimated that there were approximately 350,000 displaced persons from Myanmar living in Thailand (Human Rights Watch, 1998).

The avoidance of the word 'refugee' to describe those fleeing into Thailand is probably related to the desire of the government to avoid being seen to be accepting the displaced as refugees and with the internationally recognized protections that go along with such recognition. In fact, Thailand has not ratified the 1951 United Nations Convention Relating to the Status of Refugees and the subsequent 1967 Protocol Relating to the Status of Refugees. Hence, the government has limited legal obligations under international law regarding the treatment of the displaced persons. In fact, the displaced persons under Thai law are legally equivalent to illegal immigrants and subject to deportation.

The Thai government, has offered refuge to those fleeing Myanmar for over 16 years, with only relatively isolated cases of those fleeing being pushed back across the border. However, conditions under which refuge has been offered have varied widely depending on the period and on the location along the border. These variations have been related to political relationships with the government in Myanmar and with the various ethnic groups that have been involved in armed struggle with the Myanmar government.[4] For the past two years the Thai government has had a policy that only those persons fleeing

fighting could live in the camps along the border. In 1998 the government invited the United Nations High Commissioner for Refugees (UNHCR) to assist in the establishment of a registration system for camp residents. This system became fully operational in 1999. This policy, for example, mean the Shan and members of other ethnic groups who flee across the border to escape human rights violations are not recognized as being temporarily displaced.

In addition to those displaced persons living in camps or in Thai communities along the border there is also a very large number of internally displaced persons inside Myanmar. There are four camps on the Burmese side of the border that house a total of 13.278 refugees (BBC 1999). The Burmese Ethnic Research Group (BERG) estimates that in Karen State and in Tenasserim Division alone, between one and two hundred thousand Karen has been displaced. In Shan State over 55,000 households have been displaced, and there have been displacements of large numbers of people in Karenni State, Mon State and Kachin State (BERG, 1999). These displaced populations are a potential source of refugees for Thailand, as well as requiring assistance from NGOs working in Thailand.

In this paper we concentrate on the situation of those displaced persons living in camps along the border. This restriction is made on both practical and substantive grounds. Practically, there is currently a lack of reliable information, especially relating to health, for those displaced persons living outside the camps. Substantively, the concentration on the camps is reasonable as our main focus is on analyzing the interaction between the Thai medical infrastructure and that available in the camps.

Since 1984 the Ministry of Interior (MOI) has worked with NGOs, mainly international NGOs, to provide humanitarian assistance for persons fleeing Myanmar into Thailand. Since 1991 the NGOs, operating under an umbrella organization called the Committee for Co-ordination of Services to Displaced persons in Thailand (CCSDPT), has operated under a formal agreement with MOI to provide assistance. The MOI regulations, issued in 1991, although amended over the last nine years, remain basically as they were in 1991. The Burmese Border Consortium (BBC) provides most of the food relief. Although the Ministry of Interior has formal responsibilities for the camps, because the issue of

displaced persons has important security implications, both the National Security Council and the army are both involved in setting and implementing policy related to the camps.

Demographic and Social Composition of Refugees from Burma

BBC, which now bases its refugee caseload on registration figures,[5] had a caseload living in camps inside Thailand in June 1997 of approximately 104,000. The majority, almost 90,000, of these are living in what are classified as Karen camps, most in Tak, while the remainder are living in what are classified as Karenni camps in Mae Hong Son. BBC states that 10,600 displaced persons entered the camps during the first six months of 1999. They also project that they will receive 1,000 extra persons per month during the year 2000 (BBC, 1999).

For several years the Thai government has followed a policy of consolidation of camps. This has been undertaken for security reasons. Consolidation has resulted in several large camps. For example, the camp of Mae La, located a one-hour drive north of Mae Sot is home to approximately 32,000 displaced persons. Wangka and Mawker camps were consolidated into a new camp at Umpiem Mai in late 1999. Although these new larger camps are undoubtedly more secure in terms of attacks from forces inside Myanmar, they also have very high population densities. This places a strain on providing adequate sanitation and land for gardening. As of the start of 2000 there were 10 camps where UNHCR-assisted registration has taken place. Three camps are listed as Karenni and are located in Mae Hong Son, While the other seven camps are listed as Karen and are mainly located in Tak province (see Map 1).

Official data contain little information about the composition of the population of displaced persons in the camps inside Thailand. However, a number of surveys have been undertaken along the border and these can be used to provide an overview of the situation. One of the most comprehensive of these surveys was coordinated in 1995 by the Burmese Border Consortium (BBC).[6] Representative household surveys of the populations in the major camps in the Mon, Karen and Karenni areas were conducted. The main purpose of the surveys was to obtain information about the education situation in the camps. The surveys also provided valuable information on the demographic and social composition of the displaced persons. While it can be expected that there has been some

change since 1995, the major patterns are likely to have persisted. Pertinent features of these patterns are described below.

The population of displaced persons was very young with approximately 50 percent of the population aged below 19, and around 35 percent at ages 5-19. Most of the population consisted of families with young children, with approximately 44 percent of the members of Buddhist households being unmarried children. Approximately 50 percent of the Karen refugees had been living in camps for over three years, with well over 10 percent living in camps over 8 years. There were more females than males.

The level of literacy was quite high among some groups of displaced persons. For the Christian Karen, literacy exceeded 80 percent for almost all age groups between 15 and 49, and there was little difference in levels of literacy between males and females. A similar situation was observed for the Karenni. However, among the Buddhist Karen population no age group for either sex had over 80 percent literacy, and the levels of literacy were significantly lower for females than for males.[7] Within the camps, educational enrollment at primary level is almost universal although enrollment rates start to decline rapidly after age 14 when students are in middle school.

At the time of the survey in 1995, almost all the Karen refugees aged 15 and over engaged in some form of economic activity. The majority worked in agriculture or gardening, and some of this work involved day labor outside the camps. In most camps gardening and agriculture were conducted on a very small scale because of a lack of land. The median amount of land used for agricultural purposes in the 301 households sampled was only 30 square meters. Income was very low, with the monthly household income of the Karen sample being only 166 Baht. Most households lived in absolute poverty, surviving on the basic necessities provided by BBC.

Since 1994, changes that have probably occurred include more young males living in camps as active armed resistance has diminished. The November, 1999 report of the Karen Refugee Committee (KRC) lists 88,002 persons living in camps with the sex distribution almost equal (KRC, 1999). Income earning opportunities have also

diminished as control on movement outside the camps has increased, and as camp consolidation has reduced the amount of land available for gardening.

Health Situation

As might be expected from members of a rural population fleeing ethnic conflict, living in crowded camps, and surviving on a minimum diet, there are significant health problems among the displaced persons living in camps. Significant investment in emergency health services has meant that infectious disease control has been effective. For example, malaria has often been cited as a major disease in the camps. Indeed in the early 1990s malaria could be considered the major health problem in the camps. A primary health care survey of displaced persons residing on the Thai-Myanmar border in 1994 indicates that even though respondents demonstrate fair knowledge about using mosquito nets and malaria treatment, malaria was the most widespread disease in the camps (American Refugee Committee, 1994).

The Shoklo Malaria Research Unit (SMRU) has been providing malaria and diagnostic treatment services to the Karen camps since the 1986 and to all displaced persons living in camps since 1995. In an interview conducted with a doctor working with SMRU we were told that the burden of malaria has been reduced considerably in the camps because of early diagnosis, appropriate treatment under supervised conditions, and control of the mosquito vector. Where early diagnosis and treatment occurs the chance of the spread of the disease is minimized. Where treatment is supervised the use of anti-malarial drugs can be more closely controlled and hence the development of drug-resistant malaria types retarded. In fact, it is other mobile populations, especially migrant workers, which pose a greater risk of the spread of malaria than do the population of displaced workers. For this reason, SMRU has started working with migrant populations in Tak and have a proposal to scale-up their activities with this population.

Another disease, whose spread has been attributed, in part, to migration, either directly or indirectly through the relationship between HIV and tuberculosis, is

tuberculosis. Although findings from the 1994 survey conducted by ARC in the camps along the Thai-Myanmar border show that the prevalence rate of tuberculosis during one year before the survey was low, only a small percent of respondents knew that tuberculosis can be spread through coughing, spitting, or crowding living conditions.

The risk of HIV and other STI infections, however, seems relatively low among members of the camps along the border.[8] As Bennett (1997) points out, whether people on the move pose a potential threat for the spread of HIV depends upon their risk behavior and the environments that they encounter. Camp life has been closely controlled by the respective refugee committees. However, there is growing concern in the Karen Refugee Committee, and by camp members themselves, about the possible introduction of HIV into the camps though a few young camp members returning to camp after being exposed to HIV while illegally working in other places in Thailand.[9]

Concerns related to STIs, particularly HIV, are much more relevant to the population of migrant workers from Myanmar.[10] Some of these workers are found in the sex industry, especially in places along the border, and there are reports that HIV levels among these women are particularly high. The vulnerability of these young women is especially high because of language barriers that hamper their access to information and services and their poor economic situation. There is also reported to be significant levels of unprotected sex among young migrant factory workers in the Mae Sot area.[11] Although the recent crackdown on illegal migrants has resulted in the repatriation of most of the factory workers, there have been recent reports that this has resulted in a swelling of the number of ex-factory workers who have crossed back into Thailand and are now working in the sex industry. At the moment there seems to be limited interaction among the illegal migrant population and displaced persons, but this type of interaction is one possible way for STIs to become a more major factor in the camp health situation.

In other areas of reproductive health, however, there are urgent and important needs for the camp population (see Carouette et al. 1999). Fertility, especially compared to the surrounding Thai population is high. This evidenced by the fact that more than half of married women in reproductive age (MWRA) in the survey undertaken by ARC had a

current or recent pregnancy (within 24 months). The contraceptive prevalence rate for this group was only 8.2 percent. The knowledge level of family planning among refugees was low. Only 32 percent of them indicated they knew at least one method of family planning (American Refugee Committee, 1994).

More detailed demographic data is available from the IRC for the Karenni camps. In 1998 the crude birth rate was estimated at 33.4 and the crude death rate was 5.5.[12] This translates into a rate of natural increase of approximately 2.8 percent. Or put another way, if there were no migration into or out of the camps, the natural increase of the population would result in a doubling of the camp population in approximately 24 years. In comparison, the time for the Thai population to double, based on current demographic conditions is about 70 years. If the crude birth rate of the Karenni camp was similar for the other camps there would be between 3,300 and 3,400 births per year in the camps. It should also be noted that the infant mortality rate in the Karenni camps in 1998 was 27.2, a rate that is very similar to the Thai rate.

In 1994 only one out of five sampled camps of displaced persons on the Thai-Myanmar borders has a maternal care program established where basic antenatal care was provided. However, only a small percentage of women received care at the MCH clinic (American Refugee Committee, 1994). Suksinchai (1999) undertook a survey of 1,053 women of reproductive age living in two camps in Tak in 1999. Her study focused on miscarriage as the outcome variable. She found that the number of reported miscarriages was 74 per 1000 pregnancies. An important finding of her study was that time lived in the camp did not significantly affect the likelihood that a pregnancy would end in a miscarriage. This may suggest that the health services provided in the camps are not sufficient to overcome the poor living conditions faced by the women in the camps. Suksinchai did find that women faced a large number of health problems, and had a low level of contraceptive use. She suggests an urgent need to upgrade the provision of reproductive health services in the camps.

The Reproductive Health for Refugees Consortium (RHR, 1997), conducted a rapid assessment of reproductive health services in Karen camps in late 1997. Although

they state that the delivery of reproductive services have improved considerably in the camps since the early 1990s, they make a number of recommendations related to improvement of services. These recommendations include strengthening STD counseling, targeting men in reproductive health education and more of a focus on post-partum health and family planning. The report, however, also notes that it is the reproductive health of illegal migrant workers that needs more attention than that of the displaced persons.

Other needs, not mentioned in the RHR report, but indicated by interviews that we have conducted with service providers in the camps include the following. First, the need for a consistent and varied supply of contraceptives. The Thai government had provided supplies of contraceptives, however, the recent economic crisis has meant that NGOs providing contraceptive services have had to reply on their own resources, or continually seek outside funding, to obtain contraceptive supplies. Second, more attention is required to train health workers about issues of reproductive health. Finally, work needs to be undertaken with the displaced communities to develop appropriate STI prevention and counseling services.

Provision of Health Services

The provision of health services for displaced persons can be viewed as involving an interaction between NGOs and the Thai government. The bulk of organized health services in the camps are provided by NGOs. In the Karenni camps, the International Rescue Committee (IRC), works with the Karenni authorities to provide primary and preventive health services. The IRC is particularly well organized in terms of providing training to health workers. These workers include Medics, MCH staff, traditional birth attendants (TBAs), and community health educators. They have a clearly defined system of evaluation and are currently implementing a survey to help them monitor health knowledge and the quality of services provided.

Services for the Karen camps are mostly provided by Medicines Sans Frontiers (MSF), although American Refugee Committee (ARC), Aide Medicale Internationale

(AMI) and Malteser-Hifsdienst Auslandsdient E.V (MHD), SMRU and IRC are also involved. For this review interviews were conducted with staff of MSF, IRC, MHD and SMRU. BBC provides the food for all camps. Training of health workers at Karen camps seems to have been more limited than at Karenni camps. Organized training of health staff by MSF ceased in 1995, it appears because of lack of funds.

The Thai government provides services through its hospital health service. Although the NGOs provide for most of the health care needs of the population, severe cases need to be referred to the local hospitals. MSF undertakes this referral through a well-organized system that centers around a staging clinic in the town of Mae Sot. At this clinic patients being referred to the Mae Sot hospital are logged in and may stay on if follow-up services are required. The numbers referred to the Mae Sot Hospital by MSF averages from 100 to 200 a month. On the night of 18 December, 1999 there were 15 MSF referred patients in Mae Sot provincial hospital. The main reasons for referral are fractures and obstetric cases. MSF pays for all the costs associated with the provision of health care services by the hospital.

MHD follows a similar policies in making payments to the hospitals for cases were camp members need to be referred to the local hospitals. IRC does not provide payment for these services. However, both organizations also make donations of equipment to the hospitals and this has resulted in reductions in charges that are made for medical care. Female sterilization services are provided by government hospitals. In all our interviews it was stated that cooperation with the hospital authorities was very good.

In Mae La, which contains one-third of the displaced persons living in Thailand camps, MSF provides the basic health services. There are three hospitals in the camp. The basic health staff are displaced persons, some trained inside Myanmar before fleeing, and some who have received training from MSF or other organizations. The staff also include laboratory technicians. Expatriate doctors on short-term contracts who, by Ministry of Interior regulations, are not allowed to stay overnight in the camp, provide professional services. Both inpatient and outpatient services are provided. These services are provided to both persons living in the camps and Thai living in surrounding communities. Most of

the persons using camp medical services who were not displaced persons living in the camps were Thai Karen, some of whom come up to 40 kilometers for the services. Table 1 provides a breakdown of services provided for the month of November, 1999 in one of the Mae La hospitals.

Table 1: Number of patients at one MSF clinic for in-and outpatient services by age and origin: November, 1999.

Characteristics	***Origin***	
	Camp	Outside Camp
Outpatient		
Aged less than five	1,129	60
Aged five and more	3,705	359
Inpatient		
Aged less than five	60	18
Aged five and more	97	17
Total	4,991	454

Source: MSF Clinic records, Mae Sot District of Tak province, November 1999.

It can be seen that non-camp patients made up a higher proportion of inpatients than outpatients. Over 20 percent of inpatients were from Thai communities outside the camp. We were told that the persons coming from outside the camp generally had more serious conditions than those from inside the camp. Consequently deaths, as a proportion of patients receiving services, is higher for the non-camp than for the camp patients. In November, five patients died, two being from outside communities.

The other major provider of health services is SMRU. Originally SMRU provided services related to malaria. As pregnant women, and their unborn babies, are particularly vulnerable to the effects of malaria, a major component of their work was a comprehensive weekly screening of pregnant women for malaria, integrated within a system of antenatal clinics and delivery services. In conducting this program it was

observed that there was a high unmet need for reproductive health services. This resulted in the introduction in 1995 of a reproductive health service stressing family planning and knowledge of STIs, especially HIV. There is an extremely high demand for the services, with well over 800 women receiving services in 1999, a doubling on the number from 1997.[13] Services are also provided to people from outside the camp, mainly Thai Karen.

It should be noted that SMRU does not see itself as the appropriate organization for providing reproductive health services to displaced services. It has taken on this role because no other organization was active in this area and yet there was a high demand from women living in the camps. Because it is not part of their normal activities outside funding is required and is continually being sought. There is hope that other organizations specializing in this work would take over the role that SMRU plays in providing reproductive health services. We were told on our visit to Mae La camp that the Planned Parenthood Association of Thailand (PPAT) a local Thai NGO, is assessing how to provide reproductive health services to camp members.

Within the camps some community health education is provided by camp-based organization, For example, in Mae La there is an educational working group for HIV/AIDS. This group provides HIV/AIDS education services and distributes condoms. They receive support from SMRU and MSF in their efforts.

In the Mae Sot area there are two main sources of health care for migrant Burmese workers. These are the government health services and the Mae Tao Clinic. The burden on the Thai health system of providing services to non-thais has been well documented. For example, one of our informants noted that almost two-thirds of outpatient consultations in Mae Sot hospital were to non-thais. The role of the Mae Tao Clinic, run by Dr. Cynthia Maung, a Karen doctor trained in Burma, is less well known. The clinic, which has been operating since 1989, provides a comprehensive set of health services. It has three doctors and approximately 60 medical staff. Most of its patients are migrant workers from Myanmar, but it estimates that approximately one-quarter are from inside Myanmar.

Approximately 15-20 cases are referred to Mae Sot hospital every month from the clinic. Most are obstetric cases. The clinic provides 1,000-2,000 baht for each referral to help defray costs as this is all that it can afford. Immunization is also supported free of charge by the Thai health system. The clinic also has a comprehensive training program for primary health care workers. This course, which takes one year, includes participants from both inside Myanmar and from refugee-related organizations within Thailand. They also have a series of short-course training in a number of areas.

Health Policies

Health conditions for displaced persons living in camps in Thailand are far from ideal. However, there has been significant investments in resources, both human and financial, to provide high quality medical care in context that is not conducive to good health. All camp members have access to free health care in the camps and, in the relatively small number of cases where it is required, there is referral available to the Thai health system. This referral does not place a large burden on the Thai health system. In return, the camps provide services to Thais living in communities surrounding the camps.

There does appear to be a continued need to improve reproductive health services for displaced persons. While this is not an emergency need, it does meet a demand of the camp populations and is in the long terms interests of the Thai government to support these services. Helping camp members with the means and skills to plan and control their sexual and reproductive lives will reduce the long-term population growth of the camp populations and also reduce the potential for the spread of STIs, including HIV.

Some preventive health policies related to displaced persons can be considered more generally as social and economic policies. For example, a burgeoning problem of drug use among young adults and the potential for a significant increase in the problems related to STIs can be related to the lack of opportunities for young persons in the camps. The majority of displaced persons are young, and significant proportions are young adults who have spent most of their lives in the camps. They are exposed daily to messages

related to the consumerism of middle-class Thai life. However, they have little opportunity for furthering their own life – either in terms of education or employment. The majority has received at least a middle school level of education and have no incentive, or ability, to engage in agriculture or gardening. Programs_designed to provide these youth with appropriate education and employment opportunities within the camps would significantly reduce the pressures for drug and other undesirable behaviors.

The review of the situation of displaced persons living in camps in Thailand suggests that the main focus of Thai health policy should be on other populations, including displaced persons living in Thai communities along the border and on illegal workers from Myanmar. It is these latter groups, compared to displaced persons in camps, that have more limited access to high quality health services and who are more vulnerable to disease. To service these populations requires the cooperation of both the Thai government, NGOs and organizations such as the Mae Tao clinic. For example, the NGOs now have a wealth of experience in working along the border. This experience could be tapped by the government in helping organize health services to other non-Thai populations. In turn, the Thai government has the technical resources and infrastructure to provide training and technically sophisticated services.

A coordinated response between both government and non-government sectors, with efforts to mobilize resources outside the Thai government budget, would be the best opportunity to improve the health of the non-Thai population along the border and, consequently, improve the health conditions of the Thai population by reducing the opportunities for the spread of disease and freeing up Thai government health resources.

Conclusion

This paper has provided a brief review of displaced persons in Thailand. The focus has been on those persons living in camps, although it has been noted that many displaced persons live outside the camps. Almost all displaced persons in camps live along the Thai-Myanmar border. There are over 100,000 in camps, most of who belong to the

Karen ethnic minority. The camp populations are young, with many camp members born and raised inside the camps.

Health services in the camps are provided by NGOs, mainly using camp members who they have trained as health workers. Cases that cannot be handled by the camp medical system are referred to Thai health services. Over the years there has been a steady improvement in camp health conditions, particularly with regard to reproductive health services. While there could be even more improvement in this area, the achievements have been considerable.

Camps are however, not completely cut off from the surrounding populations. These populations include other groups from Myanmar and the local Thai communities. Because of mixing of these populations, poor health care in one community can lead to a worsening of the health situation in other communities. This paper has identified the illegal worker community as being of particular concern. Although the government has gone to considerable effort to reduce the size of this community, it cannot be completely eliminated and enforced policing may even make the provision of health services to this community even more difficult.

This paper has identified collaboration between the Government, NGOs, and other community groups as being essential in providing comprehensive health services to the migrant communities. Lessons learned in the camps can be used with migrant groups in order to improve the health of all – Thais and non-thais.

Notes

1 A research report submitted to Health System Research Institute of Thailand in February 2000.

2 In this paper, the terms 'displaced persons' are used to call refugees or asylum seekers as it is an official terms used by Government of Thailand (see discussion in section 3).

3 Normally these are referred to as internally displaced persons.

4 See Human Rights Watch (1998) for a description of these variations.

5 BBC also includes in its caseload approximately 10,600 Mon who have returned to live inside Myanmar and another 2,600 Karen living in camps inside Myanmar. These have not been registered.

6 The survey was implemented by one of the authors of this paper. The descriptions provided in this paper are drawn from both the report and additional analysis of the survey data (subtracting the Mon component of the surveys).

7 A more recent survey (1999) in two camps in Mae Sot among women of reproductive age found that slightly over one-half had no schooling (Suksinchai, 1999). Approximately 40 percent of the sample were Buddhist.

8 There is a screening of the blood of pregnant women in Mae La camp and only a very few cases of HIV have been detected. The prevalence rate, which is much less than one percent, is significantly lower than what would be expected among pregnant women in the Thai population of Tak.

9 Although it is now become very difficult for persons to work outside of the camp there are enduring pressures for young camp residents to seek jobs. Within the camps there are few opportunities for higher education and no work opportunities. This leads to boredom. In an interview with a member of the Karen Refugee Committee conducted in December, 1999 the problem of drug use, mainly the use of amphetamines, among the young was listed as a major and growing concern. Drug use was also related to other activities – namely the need for cash and hence the pressure to seek work outside the camps. There is also a problem of brokers who come to look for young people, offering them jobs outside the camps. Deception often is the outcome. In Mae La camp several young people who have suffered from deception are used to help educate other young people about some of the situations they might face.

10 The percentage of pregnant women HIV positive at the Mae Tao clinic in the first half of 1999 was 1 percent.

11 A major portion of the caseload of the Mae Tao clinic in Mae Sot, which deals primarily with migrant workers, is management of the outcomes of induced abortion. Between January and June, 1999 the ratio of abortion management cases to deliveries was about 1 to 1 (143 deliveries and 135 abortions). A staff member interviewed at the clinic said that while the majority of the women presenting with abortions were married, there were also a significant number of unmarried women.

12 Both the relatively high crude birth rate and very low crude death rate are a direct result of the young population of the camps.

13 A rough estimate of the number of women of reproductive age in Mae La camp would be 8,000. Many of these, however, would not be currently married. A conservative estimate would be that 20-25 percent of reproductive aged women with at least one pregnancy received reproductive health services in the antenatal program in 1999.

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