

Original research article

“It is just like having a period with back pain”: exploring women’s experiences with community-based distribution of misoprostol for early abortion on the Thailand–Burma border[☆]

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Received 26 April 2017; revised 20 June 2017; accepted 25 June 2017

Abstract

Introduction: The lack of economic development and longstanding conflict in Burma have led to mass population displacement. Unintended pregnancy and unsafe abortion are common and contribute to maternal death and disability. In 2011, stakeholders operating along the Thailand–Burma border established a community-based distribution program of misoprostol for early abortion, with the aim of providing safe and free abortion care in this low-resource and legally restricted setting.

Methods: We conducted 16 in-depth, in-person interviews with women from Burma residing on both sides of the border who accessed misoprostol through the community-based distribution initiative. We analyzed interviews for content and themes using deductive and inductive methods.

Results: Overall, women felt positively about their abortion experiences and the initiative. Previous abortion experiences and the recommendations of others shaped women’s access. All participants, including those who remained pregnant after taking the misoprostol, would recommend the initiative to others.

Conclusion: Community-based distribution of misoprostol is an effective and culturally appropriate method of improving safe abortion care on the Thailand–Burma border. Supporting efforts to expand the harm reduction program to more communities and provide regular reproductive health and safe abortion trainings appears warranted.

Implications: In recent years, a number of organizations have launched programs dedicated to misoprostol-alone for early abortion. However, few have documented the experiences and perspectives of women. Our findings indicate providing misoprostol through lay provision in a legally restricted context is not only safe and effective but also culturally resonant.

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Keywords: Abortion; Misoprostol; Reproductive health; Refugee; Migrant; Myanmar

1. Introduction

The lack of education and employment opportunities and the sequelae of a decades-long conflict and human rights abuses in Burma¹ have led to the relocation of millions of people. Approximately 230,000 people are internally

displaced within Burma [1] and over 100,000 live in refugee camps along the Thailand–Burma border [2]. Additionally, neighboring Thailand is home to 2–3 million migrant workers, an estimated 80% of whom are from Burma [3]. Roughly half of refugees and migrants in Thailand are unregistered [2,4]. These three populations — cross-border

[☆] Conflicts of interest: The authors declare that they have no conflicts of interest, financial or otherwise.

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¹ The military junta officially renamed the country Myanmar in 1989. For many ethnic minority groups, using “Myanmar” legitimizes the ruling military and its authority to rename the country. Out of respect for CBOs and stakeholders operating along the border and the women participating in this study, we use “Burma” throughout this article.

residents, refugees, and migrants — often lack ready access to essential healthcare [5]. Despite the many efforts of international non-governmental organizations (NGOs) and local community-based organizations (CBOs) [4,6,7], displaced women along the Thailand-Burma border have unmet contraceptive needs, are at considerable risk of sexual assault, and lack knowledge of and access to a comprehensive range of reproductive health services [4,8–12].

In this region, women with unwanted pregnancies have limited options. In Burma, abortion is legally prohibited unless it is necessary to save the woman's life; this exception has long been narrowly interpreted [10,13]. In Thailand, abortion is legally permissible if the pregnancy endangers the life or health of the woman, results from rape or incest, occurs before the woman is 16 years old, or involves a fetal abnormality [14,15]. Notably, women engaging in unauthorized abortion in Thailand do not risk imprisonment [15]. However, despite the broader availability of legal abortion in Thailand as compared to Burma, tremendous disparities in access exist throughout the country [15,16]. Those living in eastern Burma as well as refugees and migrants residing in Thailand face significant hurdles in obtaining affordable and timely abortion care and often resort to unsafe methods [4,13,17–21].

Over the last decade NGOs and CBOs have launched a number of efforts in the border region to increase cross-border, refugee, and migrant women's access to safe and legal abortion care and reduce harm from unsafe abortion [20–23]. One of these efforts centered on the development of a community-based distribution program of misoprostol for early abortion [23]. Both mifepristone and misoprostol are restricted to hospital use in Thailand [14]. However, mifepristone, which Thai authorities registered as of late 2014, is highly regulated and unavailable in northern Thailand. In contrast, misoprostol is widely available in the border region through clinics, pharmacies, and drug shops and health care workers routinely use the medication for post-partum hemorrhage prevention and treatment and incomplete abortion management in both northern Thailand and eastern Burma. Although not as effective as the gold standard medication abortion regimen of mifepristone and misoprostol, misoprostol-alone is 75–90% effective in inducing an early abortion and is recommended when mifepristone is unavailable [24].

Motivated by this overarching context, in 2011 a multidisciplinary team of researchers in North America collaborated with members of several CBOs to establish two Networks to facilitate the community-based distribution of misoprostol. Over a 3-year period, 918 cross-border, refugee, and migrant women accessed the Networks and received pregnancy options counseling, information about medication abortion, and a free supply of misoprostol. The outcomes of the initiative as documented through a formal evaluation were reassuring; over 96% of the women who received misoprostol were not pregnant at follow-up and program leaders reported no complications or hospitalizations [23]. However, the original evaluation of the program did not include the perspectives of

women using the services. In this article, we aim to fill this gap. Through in-depth interviews with those who obtained misoprostol through the initiative, we explore women's experiences using misoprostol and their perspectives on ways to improve the community-based distribution program.

2. Methods

We have described the formation and activities of the Networks previously [23]. In brief, using a train-the-trainer model, leaders of two Networks received information on the legal status of abortion in Thailand and Burma, training on the use, side effects, and complications associated with misoprostol for early abortion, quality-verified misoprostol, and ongoing technical and logistical support. Network providers, most of whom were social workers and counselors, employed a “no touch” protocol² and offered women with a self-reported pregnancy of 9 weeks or less a three 800-mcg dose regimen of misoprostol for vaginal use. Network providers were available if women had questions or concerns and followed-up with women regarding the outcome within 4 weeks of taking the initial dose of misoprostol; due to legal and privacy considerations for both Network providers and women Network leaders kept only limited records.

In order to understand better women's experiences with the program, in December 2016 we conducted a qualitative study. Working with the Network leaders we invited women who had obtained misoprostol through the initiative to participate in an in-person interview in Mae Sot, Thailand. We purposively recruited women who identified as cross-border, refugee, and migrant as well as women who remained pregnant after using misoprostol. Once women expressed an interest in participating, we arranged to meet at a mutually convenient time at a secure and private location.

E.T., a Canadian national with a background in health sciences, led all in-depth, open-ended, semi-structured interviews after receiving training from A.M.F., an American medical doctor and medical anthropologist who has led reproductive health projects in the border region for nearly a decade. Using an interview guide developed specifically for this project by G.A., E.T. worked closely with S.N.H.G.M., an interpreter from Burma fluent in Burmese, Karen, and English. After reviewing a consent form with S.N.H.G.M., participants provided verbal consent to both participate in the interview and for E.T. to audio-record the interactions.

The interviews began by learning about the participant's general background, daily life, and past and present living situation. Next, we gathered information about the participant's overall reproductive, contraceptive, and pregnancy history, including where in Thailand and Burma she receives

² This program is based on self-reported information, including pregnancy status and gestational age. Network providers did not perform a physical examination or a confirmatory pregnancy test and did not require women to obtain an ultrasound prior to the receipt of misoprostol [23].

or has received reproductive healthcare. We then asked about the circumstances surrounding the unintended pregnancy, her experience accessing the Network for medication abortion, and her feelings about the abortion care she received. We concluded each interview by exploring ways in which the program could be improved and how reproductive health services in general, and safe abortion care in particular, could be enhanced in the border region.

Interviews averaged 45 min. We provided interviewees with snacks and drinks throughout the interview, reimbursement for any associated travel costs, and THB300 (roughly USD9) as a thank you for participating. E.T. took notes during the interview, debriefed with S.N.H.G.M after each conversation and with A.M.F. regularly, and formally memoed to reflect on the interviewer–interpreter–participant dynamic and initiate the analytic process. We transcribed verbatim and translated into English all interviews.

We analyzed data for content and themes using both pre-determined and emergent codes [25]. The analytic process began during data collection and helped us establish thematic saturation, the point at which additional interviews did not result in new themes. We suspected we had reached thematic saturation after 10 interviews with women who were not pregnant after taking misoprostol and, guided by previous research [26], conducted four interviews as confirmation. Our two interviews with women who remained pregnant after taking misoprostol were outliers but most themes overlapped. Team meetings guided our interpretation of the results; we resolved all disagreements through discussion. We organize our results around key themes.

The Steering Committee of a local CBO approved the community distribution program and both this CBO Steering Committee and the Research Ethics Board at the University of Ottawa approved the evaluation. To protect individuals and organizations involved with the Networks, we have removed and/or masked all personally identifiable information and use pseudonyms throughout.

3. Results

3.1. Study participants

We interviewed 16 women who accessed misoprostol through the community-based distribution program to terminate 20 pregnancies. At the time of the interview, our study participants were 28–45 years of age (average 37.5). After taking the recommended three-dose misoprostol regimen, 14 of our interviewees were not pregnant within 1 month within 1 month after using the drug 18 times; none experienced complications or required follow-up treatment. The other two interviewees remained pregnant after taking the misoprostol; both women carried their pregnancies to term and delivered healthy babies. Per self-report, all participants were between 4 and 9 weeks' gestation when they took the first dose of misoprostol. Five of our participants had never used any modern method of contraception; the remaining 11 had used

oral contraceptive pills, Depo-Provera, and/or the IUD at some point in their reproductive lives. Four participants had used a contraceptive method (condoms or oral contraceptives) in the month surrounding the unintended pregnancy. At the time of the interview, all of the women were living along the Thailand–Burma border, 10 in Thailand and 6 in Burma.

3.2. Women reflected positively on their misoprostol-alone abortion experiences

As reflected in Nat Nat's experience (Fig. 1), women were overwhelmingly satisfied with their experiences using misoprostol through the program. The safety of the misoprostol-alone regimen emerged as one of the most positive aspects of the process; nearly all of the interviewees remarked on how use of the medication resulted in tolerable side effects and no complications. Given the pervasiveness of unsafe abortion in their communities, women routinely compared the ease of use and “harmlessness” of misoprostol with their own or others' experiences with sharp sticks, pummel massage, and self-injurious behaviors. As explained by Htu Lum, a 43-year-old cross-border participant,

People who did [the abortion] with the traditional birth attendant [TBA] [had procedures that] are so dangerous that some of them died. The TBA inserts stick in [the uterus]... This medicine [misoprostol] is not dangerous. It is just like having a period with back pain.

Women's positive feelings about their experiences were intertwined with their reasons for seeking an abortion. For many, having an abortion allowed them to circumvent the financial burden of having another child, continue working to support their families, and/or avoid exacerbating existing health conditions. As Hkaing Hkaing, a 33-year-old migrant worker explained, “I had problems so I took it [the misoprostol] as the abortion would allow me to work more for a better life.” Obtaining a safe and inexpensive abortion not only allowed women control over their fertility, but allowed them to do so in a way that could be timed with work and other responsibilities.

As showcased in Fig. 1, many of our participants also spoke highly of their encounter with the Network provider and were grateful to have received kind, compassionate support and options counseling as part of their abortion care. As De Paw Ra, a 28-year-old migrant, stated, “[T]he provider treated me warmly...it was the moment when I could restart my life anew. She mostly gave counseling and encouraged me a lot.” Cho Lone, age 38, echoed this sentiment, saying, “The baby from the abortion went down easily. I then realized that [the provider] actually helped me with my problem.” The majority of our participants found the Network easy to access and had no trouble contacting or meeting the Network provider. However, for several the travel and transportation expenses were a hurdle in accessing care. For example, Ah San spent THB200 (USD6), as much as she typically makes in one day, to cross the river dividing Thailand and Burma by boat to access the Network.

Nat Nat is a 45-year-old woman who lives in the border region in Myawaddy, Burma. Nat Nat has three daughters in their 20s and 13-year-old twin sons. Nat Nat's unintended pregnancy occurred when she was 43 years old. Before learning she was pregnant, her husband left her and re-married. Because of her financial struggles and divorce she decided to terminate the pregnancy. Nat Nat confided in her niece who by chance lived in the same community as one of the misoprostol Network providers. Nat Nat explained, "I didn't consult with anyone, because I'd only make them feel sad...But I consulted my niece about my pregnancy and the situation...my niece helped me with the plan and asked me to come to Mae Sot [Thailand] if I wanted to do it. I was introduced to [the provider] and she said it was no problem to do it for me." Nat Nat traveled across the border to meet with the provider and receive care. She paid MMK4000 plus THB250 (roughly USD12 total) in transportation and border fees. These costs were significant, but not unexpected; Nat Nat regularly crosses into Thailand to shop, access healthcare, and visit family.

Nat Nat is pleased with the sympathetic care she received from the provider. "[The provider] treats me with kindness and says it's a good deed for her to be able to help others. As I had difficulties, I relied on her and she helped me with everything...the two of us had a counseling [session]. She asked me how I felt and what I needed. I told her that I didn't feel that much, only anger when the problem started. And I was happy that everything went well after I took the medication."

Nat Nat compares her experience with the unsafe abortions that other women experience and hopes more women will choose safe medication abortions like she did.

My abortion went easily and I thanked [the provider] very much because I didn't have to suffer any pain like others...The medications are safe to consume...Honestly, since this way is safer I want everyone to use it...unsafe abortion can be dangerous...Now that I have known the goodness of using the medications here, I want them to come [to Thailand] and take them.

Fig. 1. Nat Nat's story.

3.3. Previous abortions shape women's experiences with and perceptions of the network

Five of our 16 participants had multiple abortions over the course of their lives; three of these women's previous abortions were performed with unsafe methods. As illustrated in Eh Mi Bo's story (Fig. 2), women's prior experiences

with unsafe abortion methods motivated them to seek a safer option. Nan Ar Me, whose first abortion was performed by a traditional birth attendant, explained, "[The TBA] dug into my womb...It was more painful than delivering a baby." Regarding her second abortion, she stated, "I do not dare to do that [unsafe] method again...I don't feel any pain with using [misoprostol] and it's easy."

Eh Mi Bo is a 42-year-old woman, originally from Bago region, Burma. She has lived in Mae Sot, Thailand for 10 years. She has 3 children and works as a tailor. Eh Mi Bo has had 3 abortions. The first 2 were performed in Burma by a TBA who inserted a metal rod into her uterus. For the first abortion Eh Mi Bo did not have enough money to pay the entire fee, which impacted the quality of care. As Eh Mi Bo explains,

It was seriously painful!...At that time, we were poor...the 3000 kyats (about USD3) was worth a lot. We didn't even have that amount. So, when we only gave half to the TBA she left the work and told me come again [when I could pay the rest]. But I decided not to return as my menstruation cycle was running...I thought I had aborted but I was wrong. That TBA left the work for the next time! This was the main reason why I became seriously ill. So, I had to go to her again and she did the rest. Only then the abortion was successful.

Eh Mi Bo's second abortion with the same TBA was more traumatic than the first.

It was that time I felt I was dying...I was extremely sick and didn't eat, although she asked me to. The blood was running down but the baby was not aborted. So, I was asked to lie down and she put her hands inside me...I felt a ball of something cramp up suddenly. The roof's color was green and all I could see was blue, as if I was bitten by a very poisonous snake! And the liquid ran through my mouth and felt that the ball of air was choking in my throat. That's when I went unconscious. This experience was so terrifying.

Although Eh Mi Bo was ill for some time after both abortions, she suffered no long-term health consequences. However, her unsafe abortion experiences led her to seek a safer option for her third unwanted pregnancy. Through members of the migrant community, Eh Mi Bo learned she could obtain misoprostol free-of-charge from a Network provider. Her medication abortion occurred easily and without complication. Reflecting on her different abortion experiences, Eh Mi Bo explains,

I had no problem with [the misoprostol]...when I arrived home, I could immediately start working. So, it's good...[With the other abortions] I had to lie down in bed the whole day and couldn't get up until the baby was completely gone from the womb. But this time, it wasn't like that – it has an advantage. I even recommended [misoprostol] to my friends."

Fig. 2. Eh Mi Bo's story.

Three of our participants also had more than one abortion with misoprostol obtained through the Networks. The success and safety of this method, along with the care they received, influenced these women to return and obtain misoprostol for subsequent unwanted pregnancies. Ah San, who terminated two pregnancies with misoprostol from the community-based distribution program explained, “[The provider] was very nice. She was the one who gave me information and she also did it for me [gave pills]. That was why I contacted her for the next abortion.”

3.4. *Women's social networks play an important role in their access to misoprostol*

Time and again we heard that cross-border, refugee, and migrant populations rely primarily on each other for information and advice about unwanted pregnancy and abortion. When Di Chaw Ma got pregnant she was living in a refugee camp near the border. She sought support from the women around her.

I had to think about all the circumstances such as, my children are going to school and we were in [financial] difficulty, and also, I have one child with special needs. So I thought [I would] end [the pregnancy] with whatever methods it took..I happened to [consult with] five women. We talked and discussed about our problems in the camp since we share a lot.

These social networks proved critical to getting the word out about the community-based distribution program. Indeed, nearly all of our participants, as showcased in both Nat Nat’s and Eh Mi Bo’s stories, learned about the misoprostol Networks from work colleagues, neighbors, friends, or family members. Daa, age 30, explained that she learned about misoprostol distribution in her community when she encountered unfamiliar women in her small town:

It felt strange for me to see new faces in town, you know. When I asked them where they were going, they replied [the provider’s] house. “Why,” I asked, and they said, “To do this and that.” “Oh really!” That’s when I found out about it.

3.5. *Women would recommend misoprostol to other women, sort of*

All of our participants, including those who did not have a successful abortion after using misoprostol, indicated they would recommend the community-based distribution program to other women with unwanted pregnancies. Nan Ar Me, age 33, articulated the feelings of most interviewees:

I want to share about how good the medicine is and tell them that there are no bad effects. I want them to receive what I received since many women died from [unsafe] abortion. In the village, many women don’t know about how to abort in a safe way..So, I want the information to reach women who lack knowledge about it.

However, nearly half of the women we spoke to also expressed reservations about recommending misoprostol for

early abortion. Because of the legal restrictions on abortion in both countries, and in Burma in particular, several participants expressed concern that the Network providers or women who recommended the Networks could be punished for their involvement. One participant explained that news spreads quickly in migrant communities and thus recommending the Networks could bring too much attention. Several women feared that they could be held responsible if a woman they recommended the Networks to suffered a complication.

Several women reported that they would recommend the Networks to other women, but only to those who would otherwise use unsafe methods or who have a “good” reason for wanting to terminate a pregnancy. As Myar Aye Mai, age 33, explained,

Actually, I don’t want to tell [women about the Networks] but I will tell them if they are going to use sticks or something other than the pills to make abortion..For example, if married women got pregnant I would ask them the reason, “Why do you want to take misoprostol?” If I just recommend her to go on with the abortion [it could be] a sin..I would recommend [misoprostol] for those who have many babies, whose ages are very close with each other.

Women’s hesitations about recommending misoprostol to others – and their rationale for which women should be informed of the option – were intertwined with socio-cultural and religious beliefs on the permissibility of abortion as well as their own experiences. For several women this resulted in some internal contradictions, as reflected in Myar Neh’s story (Fig. 3).

Although women reported that the “ease” of use of misoprostol was one of the most positive features of the process, some women felt that the process was “too easy.” Participants unanimously wanted to see the Networks expand so that more women could benefit from safe abortion care. However, a sub-set of interviewees expressed concern that the availability of misoprostol could undermine pregnancy prevention efforts. As explained, by Hkaing Hkaing, age 33:

I think it is not good to make this service well known..Good point is that women who really need to work and save money for a future baby can solve their problem and can freely work [by having a safe abortion]. Bad point is if this program is well known, many people will do abortion and will do it often..And even if the medicine doesn’t have many negative side effects I think having abortion often can damage the womb. People will not be careful about getting pregnant because they know they can do abortion at any time easily.

Although some women raised questions about who should be able to obtain abortion care with misoprostol and how often and how easily, there was consensus among participants that the misoprostol Networks are needed and reduced considerable harms from unsafe abortion in this setting. As Daa’s story (Fig. 4) highlights, the two women who did not have a successful abortion with misoprostol still felt efforts to expand the initiative should be supported.

Myar Neh is a 43-year-old woman who has lived on the Thai side of the border for ten years. She is married with five children and two grandchildren. Her family has, for a long time, suffered financially. Myar Neh cannot work due to kidney disease and four of her five children stopped school in grade 5 in order to support the family.

When Myar Neh became pregnant at age 38, she decided to seek abortion care. Considering her poor health and financial difficulties, she knew she could not support another child. Through a friend, she learned about the misoprostol Network. She is glad the abortion went smoothly and without complications.

I get to know the goodness of the medicine. I have never use another method so I [can't compare] but this medicine is very good and I did not suffer any difficulties. I have heard of other people who use different kinds of medicine, they suffered a lot. Also they did not get a successful result. This medicine is really good. It doesn't give any problem.

Although Myar Neh knows her abortion was safe and she feels she made the right decision at the time, she found process emotionally difficult. "As a mother you feel bad to end it but if you did not end it, the baby will face problems and you will also face problems...our economic situation is not good so this baby will add a burden to our family."

Because she does not want other women to hurt emotionally, she is hesitant to recommend misoprostol. She explains,

[When asked] I say don't do the abortion. If you don't want the baby, prevent it by taking the pill or the injection. After you get pregnant and you end it, it is a shame...I will let people who are desperate know about this medicine. People who have problems like me, for example. But I have to look at their situation. If they can afford to deliver the baby, I will [try to] stop them from ending the pregnancy. If they have the capacity to deliver and raise the baby, I will encourage them not to end it. I will allow only people [to have an abortion] who have problems and are struggling with their family. Those who do not have a beautiful life, such people, I have to help them.

Fig. 3. Myar Neh.

4. Discussion

A wealth of global evidence demonstrates that misoprostol is an effective method of early medication abortion and that provision of the drug has the potential to reduce harm from unsafe abortion [24,27,28]. Over the last decade, a number of organizations around the world have launched

programs dedicated to the use of misoprostol-alone including passive efforts to raise awareness about evidence-based regimens as well as more active strategies that involve counseling and/or provision of the medication [23,29–31]. However, few reports have explored women's experiences obtaining safe and effective abortion care outside of a health system setting.

Daa is 30 years old and moved to Mae Sot, Thailand from Burma when she was a teenager. She holds a Bachelor of Law and currently works in a school. She is married and has two toddlers.

Daa has never used a modern method of contraception and has been pregnant twice. Her second pregnancy was unintended. Daa wanted to have an abortion because her first baby was only 14 months old when she learned she was pregnant and she had wanted there to be five years between her children. Additionally, she had no family members nearby to support her with two children.

Daa obtained misoprostol through a Network provider in the community. She had some back pain and bleeding after administering the medication, but ultimately the abortion was unsuccessful. Daa subsequently went to the Mae Tao Clinic and, without telling staff she had used misoprostol, informed them that she was miscarrying. When clinic staff performed an ultrasound, they informed her they could not complete the termination because the fetus was alive and healthy. Daa was extremely upset that her abortion was unsuccessful. However, knowing the risks of other methods of termination, she decided to carry the pregnancy to term. She was worried about possible negative effects of the misoprostol on the fetus, but her baby was born healthy.

Although her abortion was unsuccessful, Daa has seen other women in the community successfully terminate pregnancies with misoprostol. Combined with the realities of unsafe abortion in her community, she recommends this safe method to others. Daa also hopes knowledge of the misoprostol Networks will spread further into migrant communities:

What I want to suggest is that if you could place a provider from a small community, [a community] away [from] others, and let them know the information, it is a way to spread information about [misoprostol]. As you know, information [spreads] very fast among people...By placing one community leader who is knowledgeable or providing an information center, they will know more about it."

Fig. 4. Daa's story.

Our study sheds light on women's experiences using misoprostol through lay provision in a legally restricted context. That women were overwhelmingly satisfied with the community-based distribution program is hardly surprising given the prevalence of unsafe abortion in this region. However, our findings indicate that this strategy of providing misoprostol is not only safe and effective but also culturally resonant. Women reported the warmth of Network providers, free supply of the medication, and ease of access and use as the most positive aspects of the program.

In cross-border, refugee, and migrant communities, women themselves are the primary messengers of information about the community-based distribution of misoprostol. This appears to have increased the trustworthiness of the overall initiative, despite ongoing concerns of some women about the legal risks to themselves and providers, but does limit the reach of the program. Continuing to empower women with accurate, sensitive, and culturally appropriate information on reproductive health and safe abortion as well as identifying ways to increase awareness about the initiative should be prioritized.

The “ease” of access and use of misoprostol through this program appears to be a double-edged sword; although women unanimously characterized these features as positive, some women also expressed concern that the process was “too easy” and could result in “overuse” by the community. This likely reflects both externalized and internalized abortion stigma [32]. Working with Network providers to communicate to women obtaining misoprostol through the initiative that all women, regardless of reason, deserve access to safe and effective abortion care may help counter some of these broader socio-cultural-religious taboos.

Given the successful outcomes of the initiative and women's overall satisfaction with the initiative, exploring avenues for expanding the Networks to additional communities along the Thailand-Burma border appears warranted. Delivering regular community workshops on safe abortion and the community-based distribution program could help improve utilization; these efforts would need to be tailored to the legal situation on both sides of the border. Securing funding to contribute to women's abortion-related travel expenses, particularly those crossing the border from Burma, could also reduce barriers to access. As the initiative expands, recruiting Network providers from a wider array of ethnic and linguistic backgrounds could prove useful in meeting the needs of a broader range of women. Finally, ensuring that women who remain pregnant after taking misoprostol have access to health and social services is critical. This could be facilitated by formally linking the community-based distribution initiative with efforts in this region to refer eligible women from Burma to Thai government facilities for legal abortion care [15,20,21].

Our study has several limitations. As is true of qualitative research in general, our findings are not generalizable. Further, although we achieved thematic saturation with women who were not pregnant after using misoprostol through the initiative,

because so few women remained pregnant after using misoprostol, we only spoke with two of these women. These are outlier cases and although informative, we did not reach saturation of themes. Finally, the positionality of our study team members, including national origin, educational level, and language and dialect employed undoubtedly influenced interviewer-participant-interpreter interactions. Through debriefings, regular team meetings, and formal memos, we believe that we were able to understand these influences and enhance the credibility and trustworthiness of the study.

Despite these limitations, our findings show that community-based distribution of misoprostol is an effective and culturally-appropriate method of improving safe abortion care on the Thailand–Burma border. Given the success of the initiative and women's satisfaction with the care provided, efforts should be made to expand the reach of the Networks.

Acknowledgements

We received funding for this project from an anonymous individual donor and the Society of Family Planning. The Ontario Ministry of Health and Long-Term Care funded AF's 2011–2016 Endowed Chair in Women's Health Research and we appreciate the general support for her time that made this project possible. We would also like to thank Dingo for his help with translations. The conclusions and opinions expressed in this article are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

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