Overseas
PUBLIC HEALTH DEVELOPMENTS ABROAD
Observer

Reproductive Health in Southeast Asia

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People may think we are stupid, selling our young bodies. We don't think so. It is a struggle to stay alive. We cannot bear to see our parents suffer. They brought us up. They didn't force us into it. And we have no other way of repaying them, because we have no good education and we don't come from rich or influential families who can find decent jobs for us. Our young bodies are all we have to improve the family's economic status.[1]

I tell every girl who wants to know what it's like in the sex trade. I tell them not to do what I have done. I tell my story with tears in my eyes. But they don't listen.[1]

On March 8, 1999, International Women's Day, public health practitioners from Southeast Asia and the US gathered in Bangkok to launch a month-long intensive reproductive health course called TARGET (*T*he *A*sian *R*eproductive Health *G*raduate *E*ducation and *T*raining Program). A joint project of the Schools of Public Health at Bangkok's Mahidol University and the University of North Carolina at Chapel Hill, the course drew participants from Cambodia, Lao People's Democratic Republic, Burma, the Philippines, Thailand, and Vietnam as well as North Carolina. The young Thai village women quoted above, whose experiences in the sex trade were documented by researchers from a Thai nongovernmental organization,[1] represent the cycle of poverty, filial duty, and disillusionment that is common throughout the region where the TARGET course participants work and live.

Since 1997, the Asian economic crisis has increased the number of women resorting to, or being deceived into, prostitution and has decreased their ability to protect themselves from sexually transmitted diseases (STDs). During a recent tour of Southeast Asia, Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), warned that the region is becoming the next global "hot spot" of the AIDS epidemic. Rates of infection are escalating rapidly as economies crash and sexual exploitation feeds upon the desperation of impoverished young women, their families, and communities. Thailand recently legislated compulsory education through grade 12 as a strategy to prevent young girls from being sold into prostitution.

Universal education into adulthood seems a laudable goal, but sadly not a substitute for immediate economic viability for hungry and aspiring families in the face of lost income and government cutbacks.

Globalization of health is being forced to the forefront of Westerners' consciousness due to HIV/AIDS and the threat of other emerging viruses. Among the public health leaders attending the course in Bangkok, global concerns were prominent. In discussions moving through different levels of health risks and outcomes (individual, couple, family, community, nation), supranational issues emerged with great clarity. Common concerns related to international trade, in- and out-migration, tourism, sex trafficking, and military deployment as promoters of sexual transmission of disease. Inequitable distribution of the world's resources, with increasing disparities between rich and poor countries, was seen as the overriding barrier to health improvements. Significant differences among our Asian colleagues' home countries in economic development, political stability, health infrastructure, health and social welfare policy, and technological resources did not impair their shared understanding that regional cooperation was required to meet daunting public health challenges and move all of their countries forward.

It was embarrassing to be called "*Ajarn*" (loosely translated as "Esteemed Teacher") during my two-week sojourn in Bangkok, because participants in the reproductive health course taught me so much from their knowledge and experience, their courage, and their humanity. Before we left North Carolina, my colleague and co-instructor Jane Stein and I received many warnings that we should not rely on participatory teaching methods because the students would be accustomed to lecture-style classes in which respect for teachers was expressed through silence and passive receptivity. The actual situation could hardly have been more different. While politeness, kindness, and generosity were in great abundance, the participants were eagerly responsive to every solicitation of information or opinion. Despite the burden imposed on them by sessions conducted in English, the only common language, they consistently moved discussions to higher levels of critical analysis and practical application.

Teaching at a school of public health in the US, I have found that an integrative reproductive health paradigm often requires a conceptual shift for students trained in categorical service models. In both the public and private health sectors in the US, family planning, infertility treatment, STD prevention and treatment, prenatal care, well child care, psychosocial counseling, and primary care for older women are offered in separate settings with different providers. Out of necessity, scarcity of resources, and the influence of the 1994 International Conference on Population and Development (ICPD) in Cairo, a broad and integrated range of reproductive health services was intuitive to our Southeast Asian colleagues. Course participants were hard pressed to identify any aspect of women's health that could legitimately be placed outside the boundary of reproductive health services, although many of their health systems (like ours) still suffer from fragmentation of services.

Many concerns voiced by these Southeast Asian health professionals had an echo of familiarity. Adolescent pregnancy is a growing source of alarm in most countries. Health services are struggling to address the reproductive health needs of immigrant and refugee women. Growing numbers of elders are raising young children whose mothers are unable to care for them due to disease or poverty or because they are living in isolation and under duress in the cities that have lured them away from home. In Thailand and the Philippines, health reform has meant devolution of services to state and local levels. In these more developed countries, imbalances of specialists versus primary care providers exist, and the need for quality assurance in health services is emerging. There is also a "brain-drain" problem of highly trained health professionals moving from public service into the private sector.

On the other hand, many problems were unimaginable to us. A colleague at Mahidol University was diagnosed with dengue hemorrhagic fever during our stay, and we nervously brushed away the afternoon clouds of mosquitoes. We were told that plague is still endemic in Rangoon. Two physicians from Cambodia's national Reproductive Health Program described how their country had been destroyed and is being rebuilt from the ground. Less than a third of the Cambodian population has access to safe water.[2] Only 23% of adult women in Cambodia and 28% in Lao are literate.[2] In 1996, per capita gross national product ranged in US dollars from $200 in Burma to $2960 in Thailand.[2] The legacy of American military involvement in Vietnam, Lao, and Cambodia is a landscape of unexploded mines, both literal and figurative. Long histories of foreign domination and intervention, combined with complex cultural and political dynamics, have laid the groundwork for explosive health crises in the midst of some remarkable achievements in the region.

The standard epidemiological transition from infectious to chronic disease has been stymied in South-

east Asia by the emergence and resurgence of communicable diseases at the same time that chronic diseases have begun to impose a large burden. The expected reductions in fertility have been uneven throughout the region due to variations in access to contraception and abortion as well as the influence of wartime devastation and population losses.[3–5] Vietnam has lowered its maternal mortality rate to 160 per 100,000 live births[2]; the total fertility rate (TFR) per woman is 3.2,[3] and 60% of the population use contraception with abortion available on request.[4,5] In Thailand, where abortion is legally available only on medical grounds or in cases of rape or incest,[5] the prevalence of contraceptive use is remarkably high at 74% among women who are married or in other consensual relationships,[4] and the TFR is quite low at 2.2.[3] In contrast, the comparable rate of contraceptive use is 17% in Burma and 19% in Lao[4]; the TFR is 6.4 in Lao and 5.2 in Cambodia.[3] Cambodia has the highest maternal mortality rate in the region (900 deaths per 100,000 live births)[3]; the impact of the 1997 legalization of abortion on women's health remains to be seen.[5] The completeness and accuracy of these statistics vary, but clearly tremendous problems persist while successful models can also be seen.

Efforts to combat AIDS and to promote women's control of their fertility provide examples both tragic and hopeful. After an initial period of denial about the spread of HIV/AIDS cases in Thailand, condom distribution and other aggressive public health measures achieved an increase in condom use from 14% to 94% of commercial sex patrons from 1989 to 1993.[6] Condom use also resulted in a 79% decline in cases of other major STDs.[7] In March 1999, the Cambodian government followed Thailand's lead by launching a "100% Condom Use" campaign among patrons of sex workers (estimated to be more than 60% of Cambodian men).

After six years of promoting sterilization as a permanent mode of contraception for married women, the Vietnamese government has also begun to encourage condom use for disease prevention. In Vietnam, where abortion is legal on demand, one-fifth of all abortions are performed on women younger than age 20. Teen abortions in Vietnam, as in the US, may be a sign of coercive or commercial sex, lack of empowerment for young women, or lack of available contraception.

One of our Cambodian counterparts explained the challenge that she and other public health workers face in addressing the needs of women in the two remaining regions of the country controlled by the Khmer Rouge. Unable to extend the national Reproductive Health Program to these areas, health providers suppress nightmare memories to visit the Khmer territories on a regular basis and provide family planning services.

December 1998 marked the 50th anniversary of the Universal Declaration of Human Rights, yet women throughout the world are still striving to attain basic rights to reproductive health and autonomy. In Burma, for example, as human rights violations by the military junta continue to mount, campaigns of violence against ethnic villages drive many women and girls across the Thai border in search of better lives. Crowded refugee camps or conscription into the sex industry await them instead.[7] Commercial sex profiteers reward such women with disease and, if they return home, disgrace. This tragic situation is a reminder that reproductive health, like other human rights, requires interventions on many fronts—and ultimately broad social change.

In a message for World AIDS Day in 1998, Burmese democratic opposition leader Daw Aung San Suu Kyi, winner of the Nobel Peace Prize, stated that "control of the human immunodeficiency virus is about the control of our future. The battle against AIDS is not merely a health issue, it is a battle against ignorance, poverty, indifference, prejudice and callousness." This understanding, shared by reproductive health workers from throughout Southeast Asia, sets an example of the kind of leadership needed to achieve global health in the next millennium.

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