Cultural Programming: Reproductive Health Challenges and Strategies in East and South-East Asia

UNFPA Country Technical Services Team for East and South-East Asia, Bangkok, Thailand

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FOREWORD

It is my pleasure to present this paper on Cultural Programming: Reproductive Health Challenges and Strategies in East and South-East Asia written by Ms. Mere N. Kisekka, Adviser for Gender and Socio-cultural Research in CST Bangkok, with inputs from a former CST colleague Ms. Pia Laine and a consultant Ms. Anne Harmer.

Development practitioners have long recognized the crucial role of community participation and involvement in creating a sense of ownership in order to achieve meaningful results. This calls for a more inclusive programming approach that is sensitive to culture, tradition and understanding of local power structures. Such broad-based participation often significantly influences the creation of an enabling environment in which local resources can be mobilized and used effectively. Experience indicates that demonstrating cultural sensitivity is always appreciated by all stakeholders, including the beneficiaries in particular.

As a development agency, the United Nations Population Fund (UNFPA) is committed to collaborating with partner agencies to build capacity in understanding the complexities of formulating and implementing culturally sensitive programmes, including communication skills and language. A recent review of the situation in selected Country Offices indicated that these Country Programmes played an effective role as facilitators of change in contexts where positive change on sensitive issues was a challenge.

We hope that this paper will contribute to the dialogues, development of programming tools and other initiatives implemented by UNFPA in the area of culture, gender and human rights and more specifically add value to these efforts in countries of East and South-East Asia. I acknowledge with appreciation Ms. Kisekka's initiative in preparing this paper. As always, we would welcome feedback from our readers.

G. Giridhar
Director, CST for East and South-East Asia and   Bangkok
UNFPA Representative in Thailand   August 2005

CONTENTS

ACRONYMS

AFPPD	Asian Forum of Parliamentarians on Population and Development
ARSH	Adolescent Reproductive and Sexual Health
BCC	Behavioural Change Communication
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
EC	European Commission
ESEA	East and South-East Asia
FC	Female Circumcision
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FWCW	Fourth World Conference on Women
GBV	Gender-Based Violence
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MSM	Men who have sex with men
NGO	Non-government Organization
RH	Reproductive Health
RHIYA	Reproductive Health Initiative for Youth in Asia
RSH	Reproductive and Sexual Health
RTIs	Reproductive Tract Infections
STD	Sexually Transmitted Disease
SW	Sex Workers
TBAs	Traditional Birth Attendants
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNIAP	United Nations Inter-Agency Project on Human Trafficking in the Greater Mekong Sub-region
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization
VAW	Violence Against Women

1 INTRODUCTION

1.1 Culture

Culture refers to beliefs, attitudes, values, behaviours and traditions that are learned and shared by virtue of membership and socialization in groups. Since these constituents of culture are not ascribed or sacrosanct, they are dynamic and are therefore prone to changes at the individual or group level as a result of exposure to new information and contexts, or acquisition of new needs or goals. Among the most determinative groups are the family, religion, ethnic and national groups.

In addition to culture being learned and dynamic, an important element that is often contested is the extent of homogeneity of culture. Societies are comprised of groups varying on a range of socio-economic factors such as geographic location, religion, occupation, age and class categories, attesting to cultural diversity. So, for example, there are youth cultures, sports cultures and women's cultures. The determinative factors are membership, or even aspiration to membership in a group, and sharing the group's values and behaviours. The reality of the contemporary world is that most societies are not only heterogeneous and multi-cultural but even individuals themselves embrace and exhibit multiple cultural identities through membership in different groups. Among other influences, globalization and information technology have contributed to this trend of multi-culturalism.

Culture is complex and all-encompassing. It needs to be taken into consideration in all areas of social development, particularly when looking at education, economics, health and gender. As a subject matter, culture has been and remains a topic of extensive theoretical, applied and policy research in many fields. To this end all development practitioners, including UN agencies, highlight cultural issues in their work and address it in their programming. Recent examples of this include the UNDP 2004 Human Development Report[55], UNESCO's development of a comprehensive toolkit to address the issue of building cultural competence in health research and health delivery in varied programming contexts[56], UNFPA 2004 document on Culture Matters[60], and the UNIFEM ESEA 2004-2007 programme, which will facilitate the implementation of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) through varied approaches including 'cultural channels'.

Additionally, the UNDP/UNFPA/WHO/World Bank Special Programme of Research has recently launched a new cross-cutting activity to promote optimal sexual health and an

affirmative view of sexuality for women, men and young people. One of its two specific objectives is "to increase knowledge and understanding of the social and cultural factors related to harmful sexual practices in order to develop strategies to abolish these practices."[74]

1.2 UNFPA Focus

Since the International Conference on Population and Development (ICPD) in 1994, UNFPA focus on culture has intensified and broadened, especially its linkage to issues of gender and reproductive health. Culture, along with gender and human rights, has increasingly become an important analytical and programming tool. These three elements are closely interlinked and constitute an end as well as a powerful means to address the respective issues of gender inequality and inequity, human and reproductive rights, and cultural values and practices that are inimical to attainment of sustainable human development.

> **Statement of Thoraya Ahmed Obaid, UNFPA Executive Director to the Executive Board Meeting of February 4, 2002:**
>
> "Cultural and religious beliefs are the very essence of our individual and collective identities. They manifest themselves in different ways in the countries in which we work and in the lives and behaviour of the people who are the real stakeholders in development. We therefore need to better understand the parameters of cross-cultural encounters in the context of our development and humanitarian programmes. And we must understand the opportunities and constraints that the differences in cultural values bring and how this understanding can inform our programmes. UNFPA must therefore respond to increasing cultural challenges by helping countries, communities and individuals to link universal principles with their cultural values and by designing culturally-sensitive programmes in systematic and well conceptualized ways that fit into different religious and cultural identities and understandings"

UNFPA[57-62] views culture as a window of opportunity for the implementation of ICPD through partnerships with local power structures and institutions, to address issues of gender, human rights and reproductive health that are rooted in religion, traditions, customs and social practices. UNFPA 2004-2007 Multi-Year Funding Framework specifies, "Institutional mechanisms and socio-cultural practices promote and protect the rights of women and girls and advance gender equity" as one of its six outcomes towards achievement of ICPD and the MDGs.

1.3 Scope and Objectives

This review is narrowly focused on illustrating the interface between culture, gender and reproductive health issues addressed by UNFPA. It draws attention to challenges and opportunities in terms of both issues and strategies that have implications for programming interventions.

There is need to understand that operationally, religion is just but one dimension of culture which may sometimes be so intertwined with other cultural traditions that it is not easy or
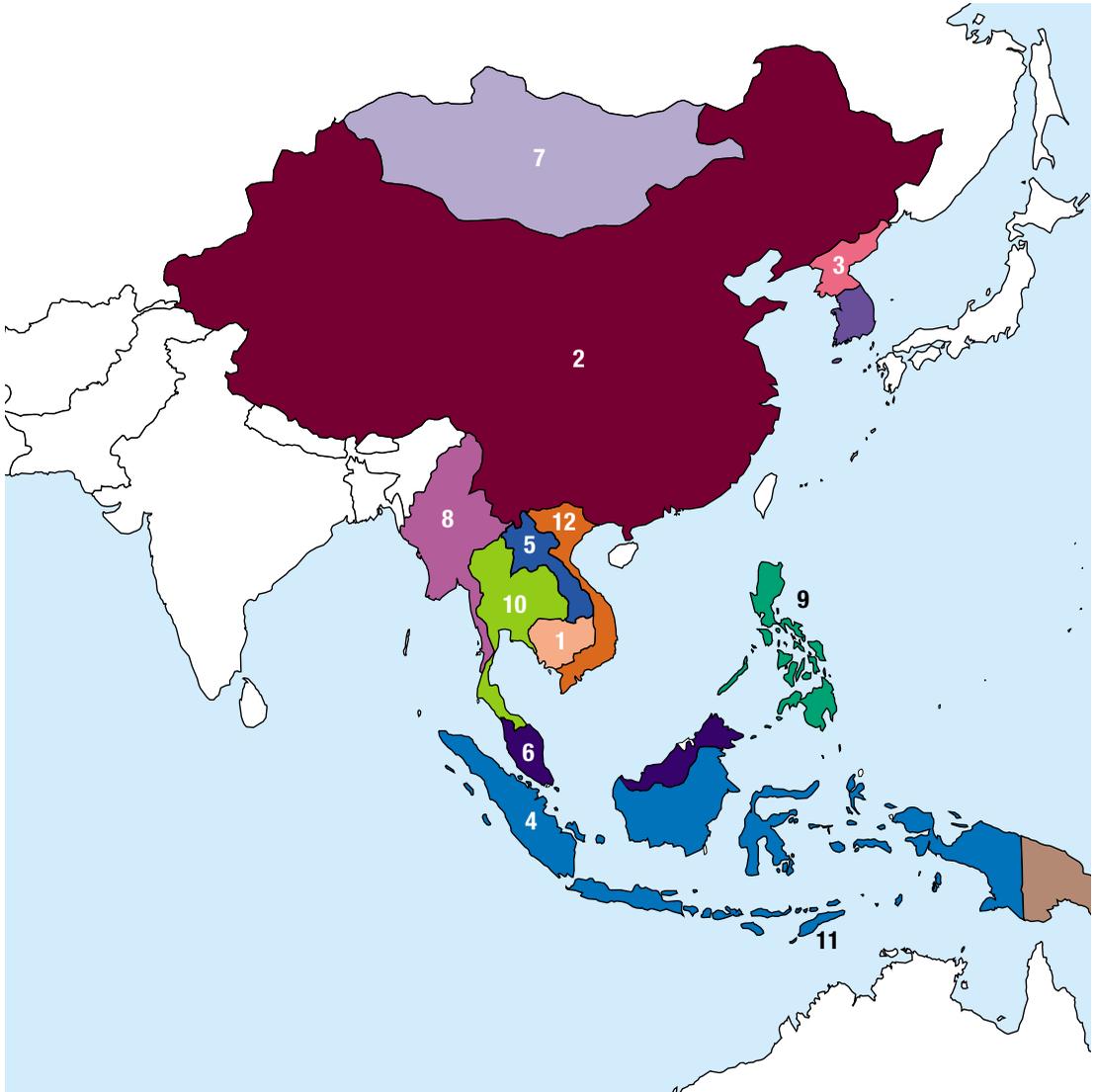
1. Cambodia
2. China
3. Democratic People's Republic of Korea
4. Indonesia
5. Lao People's Democratic Republic
6. Malaysia
7. Mongolia
8. Myanmar
9. Philippines
10. Thailand
11. Timor-Leste
12. Viet Nam

possible to discern their respective influences. This is especially true in theocratic states while in others, which are secular, the distinction is clearer. Another important clarification is that reference to "cultural factors" for programming, focuses on two elements: i) marginalization, discrimination, or stigmatization of groups on the basis of their unique cultural attributes and ii) the cultural beliefs and practices of those groups which make them vulnerable to poor reproductive health status.

In this regard, the paper contains references to a selected number of published and unpublished materials on those cultural factors of gender inequality and cultural vulnerability as they impact on RH in East and South-East Asia (ESEA). Some of the materials are from UNFPA – supported projects whilst others come from academia, government, NGOs and development agencies. Broadening the *scope* of resources beyond UNFPA provides the opportunity to consult studies and materials containing information and observations of relevance to project design and implementation, which are usually not always readily accessible to UNFPA programme managers. In the main, the review is intended to increase understanding of the challenges of applying cultural lens to addressing gender and RH issues in ESEA, especially among marginalized groups, and to share examples of good or innovative practice.

Assumptions about Culture and Cultural Approaches

- Culture is a set of values and norms that constrain and permit action by establishing ideological parameters, offering reference points of rational decision-making…
- Many RH and gender issues are "sensitive" or controversial because they are subject to different interpretations, some of which are considered divine or sacrosanct and hence cannot be subject to change. They thus attract many vocal allies and adversaries.
- Culturally sensitive issues are best addressed in the context of health: technical or scientific perspective can make discussion and acceptance of such issues easier.
- Cultural norms are not fixed, but can be contested and adapted, shaped by changes in political, economical systems and even technological and scientific developments.
- In modern times, almost all societies are heterogeneous and hence there is a diversity of cultures or "sub-cultures" articulating positions congruent with or opposed to the official dogma or mainstream norm on any particular issue.
- The sensitive nature of the issues that UNFPA deals with such as reproductive and sexual health (RSH) and reproductive rights (RR) and gender equality impinge on people's private space and their cultural norms, beliefs and practices.

Some cultural issues require more political than cultural sensitivity because politicians may not wish them to be addressed for fear of antagonising a political constituency or losing votes.

Source: Adapted from UNFPA, Cultural Matter, 2004.

The paper covers four broad topics namely: gender inequality and cultural vulnerability as key challenges; harmful beliefs and practices; cultural barriers in provision of reproductive health services and strategies in cultural programming.

The choice of these topics has been guided by UNFPA mandate on reproductive and sexual health and the recognition that these issues are linked to, among others, broad issues of economic, political, technological, and medical developments. The paper sets out to demonstrate that it is imperative to recognize and address cultural dimensions in gender inequalities on one hand and cultural vulnerability on the other, in order to attain the global development targets and goals.

UNFPA programmes are directed at addressing the constraints and obstacles that lead, for example, to poor reproductive health outcomes such as maternal mortality, STDs/HIV/AIDS, abortion, unwanted pregnancies, and sexual pain and dysfunctions. At the cultural level, the entry point is on identification, prevention and mitigation of factors such as harmful beliefs and practices, as well as promoting positive health seeking behaviour and providing high quality reproductive health information and services in culturally sensitive and equitable manner. In this regard, the paper seeks to demonstrate how incorporation of certain cultural factors, such as partnerships with key stakeholders in different cultural settings, can facilitate delivery of desired reproductive health and sexual health outcomes.

2 GENDER INEQUALITY AND CULTURAL VULNERABILITY: KEY CHALLENGES

The shared vision of a much-improved world by 2015 is articulated in the Millennium Development Goals, which are based on various global consensuses of the 1990s including the International Conference on Population and Development (ICPD), Fourth World Conference on Women (FWCW) and the human rights framework and CEDAW. Cultural dimensions are at the heart of these agreements and need to be fully addressed if their goals are to be achieved. Whatever issue or goal is examined – whether it be access to reproductive health services, elimination of gender disparities in education, employment, and political participation, or eradication of poverty – cultural factors can either act as constraints, or can be harnessed to bring about change for the better.

Gender inequality and cultural vulnerability are two issues that constitute particular challenges to achieving the eight MDGs all of which are inextricably linked to reproductive health. Until gender equality and women's rights are realized, progress is going to be severely constrained. The existence of a goal to promote gender equality and empower women is evidence of international commitment to the issue, although the key MDG target for this goal specifies only elimination of gender disparities in primary and secondary education. However, the status of women also affects realization of the other goals, including those that fit most closely with the UNFPA mandate: to eradicate extreme poverty and hunger, improve maternal health, combat HIV/AIDS and reduce child mortality. Significantly, several of the MDGs goals and targets are inextricably linked to components of reproductive health.

Cultural issues are behind the observed differentials between men and women in terms of participation in the different spheres of development. Gender factors such as stereotyping, socialization practices, and lack of power at the household, community and national levels account for these differences. A combination of cultural and institutional barriers is implicated in the root causes of poverty, reproductive ill-health and indicators of the poor socio-economic status of women. The association between women's empowerment and improved reproductive health and child health – through education, employment, decision-making, access to social services and credit facilities, for example – is strong testimony to the dividends that accrue from investing in gender equality.

Regarding cultural vulnerability, reference is made to: i) ethnic and religious minorities, two of the key groups that are often outside of the mainstream socio-cultural setting in a country and ii) groups which practise or are exposed to risky reproductive and sexual beliefs and practices. These two sets of groups are often subject to discrimination of some form or

another. In this regard, it is significant to note that despite progress already made towards achieving the MDG targets in a number of ESEA countries, regional disparities exist within most countries. This is demonstrated in every country by health indicators that are worse for such marginalized groups than the national averages. Often living outside the mainstream population, such groups tend to constitute the poorest in society and more often than not, they also have least access to reproductive health services and information.

For example, despite the differing overall HIV prevalence rates in Thailand, China, Indonesia, Viet Nam and Malaysia, intravenous drug users in all of these countries have been identified as under-served population groups with high rates of infection, comprising 'concentrated epidemics'. The same is the case with sex workers, and men who have sex with men. All these groups require focused interventions if the epidemic is to be prevented from spreading further or into the general population.

Likewise, ethnic minority groups in many ESEA countries, the majority of whom live in geographically remote and difficult environments, have higher maternal mortality, and less access to education and health services, than the majority populations. Among indigenous Papuans in Indonesia, MMR is 1,025 per 100,00 live births, compared to 307 for those living in Central Java. In China the overall MMR is 43 but amongst Tibetans it is 399. In southern Lao PDR, inhabited mainly by ethnic minorities, MMR is 700 per 100,000 live births, compared with the national average of 540. The national MMR in Thailand is 24, whilst MMR in the southern provinces of Satun and Pattani, inhabited primarily by Muslims, are 90 and 49 respectively per 100,000 live births.

These indicators point to some of the differentials that are likely to hinder achievement of the MDGs, unless cultural factors, including gender issues, are taken into consideration in development planning and implementation. There is no doubt that cultural factors combined with non-availability and inadequacy of services, are issues at the heart of socio-economic stagnation of these groups. Undoubtedly, this situation requires building alliances with under-served people so as to ensure that their needs are prioritized.

The section below examines more closely how gender inequality and cultural vulnerability are central issues to the social development agenda generally and with particular reference to the ICPD and its close links to the MDGs.

2.1 Gender Inequality

Gender is a socio-cultural construct par excellence. Gender is defined as society's traditional expectations, explanations, justifications and prescriptions of what men and women are, what they can and should be, and how they should act, in different spheres of life. These prescriptions and proscriptions are characterized by inequality and inequity in the division of labour, power relations and allocation of status and privileges. Gender is thus structured hierarchically with men dominating the public domain, senior positions and reaping most benefits, while women predominate in the domestic domain and lower ranks at the same time

as carrying a disproportionate share of burden and responsibility in social reproduction. These unequal and inequitable gender norms are internalized by both men and women, often accepted as 'natural' and therefore sacrosanct, and are manifested in all spheres of life.

Sexual and reproductive health is strongly affected by these hierarchical norms. For example, son preference and women's economic dependence on men contribute to high rates of fertility in many settings. Inability to negotiate sex on equal terms, or to use contraception leaves the majority of women and girls at risk of unwanted pregnancy, illness and death from pregnancy-related causes and STDs. Some of the negative practices impacting on women's physical and psychological well-being are described below.

Table 1. Gender-related development index

Country	Gender-related development index (GDI)		Life expectancy at birth (years) 2002		Adult literacy rate (% ages 15 and above) 2002		Combined gross enrolment ratio for primary, secondary and tertiary level school 2001/02		Estimated earned income (PPP US$) 2002		HDI rank minus GDI rank
	Rank	Value	Female	Male	Female	Male	Female	Male	Female	Male	
Cambodia	105	0.557	59.4	55.2	59.3	80.8	53	64	1 622	2 177	-1
China	71	0.741	73.2	68.6	86.5	95.1	64	69	3 571	5 435	5
DPR Korea	..	..	..	..	..	..	..	..	..	..	..
Indonesia	90	0.685	68.6	64.6	83.4	92.5	64	66	2 138	4 161	-1
Lao PDR	107	0.528	55.6	53.1	55.5	77.4	53	65	1 358	2 082	0
Malaysia	52	0.786	75.6	70.7	85.4	92	72	69	5 219	13 157	-1
Mongolia	94	0.664	65.7	61.7	97.5	98	76	64	1 316	1 955	1
Myanmar	..	..	60.1	54.5	81.4	89.2	48	47	..	..	..
Philippines	66	0.751	71.6	67.9	92.7	92.5	82	81	3 144	5 326	3
Thailand	61	0.766	73.4	65.2	90.5	94.9	72	74	5 284	8 644	1
Timor-Leste	..	..	..	..	..	..	..	..	..	..	..
Viet Nam	87	0.689	71.4	66.7	86.9	93.9	61	67	1 888	2 723	3

Source: UNDP, Human Development Report 2004.

Among the prominent cultural barriers preventing men, women and the youth from accessing RH services are those, which are gender-related. Many of the barriers are rooted in gender inequalities that restrict women's access to income, mobility, decision-making power, that together culminate in a general lack of empowerment.

At the same time, the 'culture of silence' and restrictions in social interaction between the sexes, pose additional constraints to health seeking by women. In some societies, women do not feel comfortable to be examined by a male doctor or health worker and, within certain groups, it is also against religious or cultural norms. In an Indonesian study, the main

Table 2. Gender empowerment measure

Country	Rank	Value	Seats in parliament held by women (% of total)	Female legislators, senior officials and managers (% of total)	Female professional and technical workers (% of total)	Ratio of estimated female to male earned income
Cambodia	69	0.364	10.9	14	33	0.77
China	..	..	20.2	..	..	0.66
DPR Korea	..	..	..	..	..	..
Indonesia	..	..	8.0	..	..	0.51
Lao PDR	..	..	22.9	..	..	0.65
Malaysia	44	0.519	16.3	20	45	0.40
Mongolia	62	0.429	10.5	30	66	0.67
Myanmar	..	..	..	..	..	..
Philippines	37	0.542	17.2	58	62	0.59
Thailand	57	0.461	9.6	27	55	0.61
Timor-Leste	..	..	26.1	..	..	..
Viet Nam	..	..	27.3	..	..	0.69

Source: UNDP, Human Development Report 2004.

suggestion for improvement of reproductive health services was to hire more female doctors as a significant number of women said they would refuse a variety of services from male providers.[4] In China too, village women became dissatisfied when men replaced women as birth planning cadres. The policy was said to have adversely affected women's access to support, as they were reluctant to talk to men about physical and contraceptive problems. This shift translated into reduced follow-up care after sterilization because of the perceived impropriety of a man visiting another man's wife.[24] In Indonesia, where use of the IUD was being promoted as part of the family planning programme, male service providers expressed concern regarding the insertion of IUDs. Negotiations resulted in the recommendation that preference should be given to the use of female providers or, in those cases where only male service providers were available, another woman or the husband of the client should be in the room[45].

Sexual double standards

As in many other societies around the world, countries in ESEA subscribe to a number of chauvinist cultural views on sexuality, including the perception of female sexuality as being passive, devoid of desire and subordinate to male needs; prescription of virginity and sexual monogamy for women while condoning multiple sexual partners for men before and during marriage; and to the norm of conjugal sexuality as being mainly oriented towards reproduction. Confucian tenets such as "respect the male, disregard the female," Buddhist advice regarding the restraint of personal passion for women, and the practice of couples

living in extended families and sleeping separately after having children, are some of the additional factors contributing to notions of sexual passivity in several of the countries in the region.

A consequence of cultural perceptions regarding the norms of male and female sexual behaviour is that legal systems are usually more punitive to women who are adulterous than to men. In the Philippines for example, definitions on what constitutes adultery are different for men and women. A married woman commits adultery simply by having sexual relations with a man who is not her husband, whilst a man does not commit adultery unless he keeps a mistress within the conjugal dwelling, cohabits with another woman, or has intercourse with another woman under scandalous circumstances. The Penal Code on extra-marital sexual relations provides that women should have a maximum penalty of six years imprisonment, and men four years – thereby reinforcing the double standards regarding sexual infidelity.[36]

Sexual double standards are part of the masculinity norm, resulting in negative reproductive health consequences for women, which are manifested in many forms. For example, in cultures where virginity is highly valued, unmarried young women may be persuaded to engage in anal sex or other practices that preserve their virginity, but place them at higher risk of infection. Virginity norms may also make young women reluctant or ashamed to seek treatment for reproductive tract infections (RTIs). On the other hand, masculinity norms as expressed in macho complexes lead men to engage in reckless behaviours such as having multiple sex partners, patronizing sex workers and perpetrating violence. In Thailand, it is reported that young men's infidelity is generally accepted such that if a young man does not patronize prostitutes he would be thought to be homosexual.[8]

Lack of decision-making power

Inter-spousal communication on reproductive health is hampered by women's subordination and other hierarchical gender relations. The absence of open, equitable discussion between men and women impacts on a wide range of RH issues including sexual relations between young people; STD/HIV/AIDS and condom use inside and outside of marital/partner relationships; preferred number of children, and whether or not to avail of temporary or permanent family planning methods; and gender violence.

In a survey in Indonesia, for example, most women reported that communication with their husbands was good, and that they could talk freely about almost anything. However, in-depth interviews[4] revealed that this communication was characterized by wives' needing to get their husbands' opinions on most matters, as well as their permission to participate in social activities. About one in seven of the respondents said that their reason for not using contraception was because of opposition from husbands. Additionally, the decision to stop childbearing was not one that a woman could usually make independently as her husband's opinion had much influence on the issue. The main reason cited for stopping childbearing, given by both women and men, was for economic reasons, whilst in fact women tended to also have other, more personal motives, such as concern for their health.

On the other hand, it has been shown that there is ready husband's approval on family planning methods which their own comfort. For example, a programme in Sulawesi, Indonesia, which aimed to increase spousal communication in relation to family planning, had the unforeseen consequence that male participants stopped relying on their wives to decide which method to use and began to take the decision themselves – often in terms of their own pleasure and convenience.[44] In the same vein, it was shown that in Viet Nam where until recently the IUD was the only contraceptive method offered through the health services, husbands' approval was high for the IUD because of their perception that this method does not interfere with male sexual pleasure and poses no threat to their health, whilst also being reversible and more effective than traditional methods.[26]

2.2 Cultural Vulnerability

Vulnerabilities refer to dangers, risks, disabilities or insecurities. Many forms and levels of vulnerability are experienced by groups of people on the basis of factors such as age, sex, religion, race, ethnicity, geographic location, physical and/or mental disability, sexual orientation and occupation. These characteristics can form the basis for discrimination, marginalization, stigma and inequitable and unequal access to social services, or participation in the development process and its benefits.

In the context of UNFPA cultural programming, the focus is on sub-cultural groups that are underserved in terms of reproductive health. The second type of group consists of people with beliefs and practices that expose them or their partners to risky sexual and reproductive health.

Ethnic minorities

Most countries in the ESEA region have minority population groups with different languages, religions, and other belief systems from the mainstream ethnic population. The term minority is here used in the sociological sense that is of lacking power and status rather than in the numerical sense. In this regard, there are instances of numerical minority groups which oppress the majority and many numerical majorities which are the oppressed or marginalized.

There is a variety of nomenclature applied to minority ethnic group: indigenous peoples, native people, tribal people, people in remote areas, isolated people, rotational forest farmers, nomadic people, cultural communities etc. These terms refer to their places of habitation and/or occupational lifestyle. A common factor is that ethnic minorities tend to have minimal access to health and other social services and are characterized by considerable gender gaps. Some governments are less inclusive towards ethnic minorities than others, which subsequently impacts negatively on ethnic peoples' rights, including rights to access education and health services. Some ethnic groups that are constrained by language, limited economic resources and geographic isolation, do face more overt and covert forms of discrimination.

In Viet Nam, there are 54 ethnic groups in the country of which the largest is the Kinh (Viet) comprising 86 percent of the population. The remaining 53 ethnic groups exhibit a high degree of diversity with regard to language, agricultural practices, kinship system and gender relations. It is notable that whilst these ethnic minorities constitute only 14 percent of the population, they account for 29 percent of the country's poor.[53]

In north and north-east Thailand, of the estimated one million highlanders, nearly half are classified as resident aliens and do not have citizenship. This restricts their access to government services and to employment, and makes them easy prey for traffickers and unscrupulous employers.

Lao PDR, as with neighbouring countries in the Mekong River Sub-Region, also has a diverse ethnic population. The Lao Loum (lowland settlers) comprise 68 groups which constituting 65 percent of the population. They are the dominant ethnic group politically, culturally and socio-economically. The Lao Theung live in the foothills and comprise 22 percent of the population, whilst the remainder are Lao Sung who are highland settlers.[11] The Lao ethnic minority populations are national citizens, but geographical isolation and different cultural practices and languages mean that they face immense difficulties in accessing services. Their reproductive health challenges include high fertility rates, poor uptake of health services including ante-natal care, attended deliveries, and contraception. The remote areas throughout the country where minority groups live have been designated as 'focal sites' by the Lao government to receive a wide range of development attention.

Recent economic developments have resulted in the 'opening up' of the country, through the building of roads linking countries in the region. Such infrastructural projects bring disadvantages as well as development. There is evidence of increasing involvement of young girls in the sex industry – either for the economic opportunities afforded, or because ethnic girls are easy prey for traffickers, as in northern Thailand. Ethnic girls in the north are reputed to be preferred as sexual partners by the Chinese as they are perceived to be free of HIV infection. As the country becomes land-linked, so HIV is likely to spread to areas of the country which were previously inaccessible. Similarly, in the Chinese city of Jinghong in Yunnan Province, China the Dai-Lue minority girls are exoticized and eroticized in entertainment venues and are exploited in the booming sex industry.[32]

Another aspect of ethnic minorities is that they also feature prominently among migrant workers, a large proportion of whom tend to be illegal or unregistered and as a result of which they are often excluded from social services including health, education and pensions. Migrant workers returning to Lao PDR from Thailand, for example, have been found to have higher rates of HIV infection than among the general population, even though the overall prevalence in Lao PDR is low. In China, according to UNFPA Country Office, two-thirds of maternal deaths in urban areas appear to be of migrant women, who account for only 10 percent of total pregnancies. Migrant workers often face specific reproductive health risks. Within the Burmese migrant community in Thailand, many young Burmese women are involved as informal commercial sex workers, servicing men from within their own

communities. Access to condoms and other contraceptive methods is difficult, not least because of language and financial constraints. Pregnant women are unable to access antenatal care or skilled assistance during labour, and their babies do not usually receive the full complement of vaccinations, if any.

Burmese migrant workers involved in the fishing industry are at risk of contacting HIV/AIDS, which has a high prevalence among fishermen. They are also involved in self-harming practices such as penile implants. It is difficult even for NGOs to access them through prevention and IEC programmes due to their 'invisibility' and reluctance to be identified by the authorities.[5] In the aftermath of the tsunami in Thailand the needs of Burmese illegal migrant women, often wives of fishermen, were neglected by the host government due to their illegal status. Their already perilous reproductive health status was further threatened by their reluctance to come forward for help, because of fear of being prosecuted.

With respect to reproductive health, there is a host of beliefs, myths and practices implicated in maternal morbidity, mortality and child survival among certain ethnic minority groups. For example, *yu kham*, wherein a recently delivered woman lies on a bed over a hot fire for a period of up to one month, is a post-partum practice found among most ethnic groups in South-East Asia. Various explanations are given as to why this practice is followed include a rite of passage, to protect against evil spirits, to 'dry up' the womb and to delay the next pregnancy. Among many ethnic minority groups there also exist beliefs about the power of animal sacrifice to cure various ailments and fevers by appeasing the spirits. Failure to follow prescribed practice can lead to further ill health or death, affecting not just an individual or a family, but sometimes even a whole community. For those whose belief-systems constitute such a reality, there is a natural reluctance to give up these practices and beliefs. The case of Katang forest people in Lao PDR that is presented in section 5.2 further illustrates risky birthing practices.

Infanticide is also occasionally practiced in accordance with strict criteria defined by spiritual leaders among the Akha people who live in the mountainous regions of China, Thailand, Lao PDR and Myanmar. Specifically, there exists a tradition of infanticide of twins or infants born with disabilities, in the belief that they are not truly human and are born as a sign of the spirits' displeasure. Ritual purification for the parents of such infants, and indeed for the whole community, has to take place to appease the offended spirits. Increased contact with majority population groups has resulted in these practices taking place less frequently however, and infants who would previously have been killed are now sometimes given up for adoption instead. Due to the highly sensitive nature of even using the taboo words to describe such practices, anthropologists have cautioned against outside intervention by those with limited or no understanding of the cultural context.[37]

Youth

Contemporary socio-economic and technological developments have tremendous potential to impact on the youth sexual and reproductive health culture. Formal education, globalization

and information technology have created a "global village" syndrome in which the youth culture is one of the most pronounced. Among the potential cultural changes for the youth are the increased heterosexual interaction in school, entertainment and occupational settings, increased age of marriage, increased availability and diversity of information on matters of love, sex, music, dress and entertainment due to exposure on the internet and in the popular culture media. The rate and magnitude of these changes vary across countries, rural and urban residence and religious and socio-economic groupings.

The cultural vulnerability of the youth is manifested in the sense that traditionally they are not expected to engage in pre-marital sexual activities and as such parents and other socializing agents often restrict their access to sexual and reproductive health information, education and services. Some of the barriers are backed up by conservative interpretations of religious texts and in some instances are also embodied in legislation. Yet, according to WHO review of literature and projects on sexual and reproductive health of adolescents and youth between 1992 and 2005 for at least five countries in ESEA, there is notable evidence of premarital sex activities, unwanted pregnancies, abortion and STI/HIV/AIDS.

Lack of access to proper reproductive health information and services is a factor affecting young people's knowledge and attitudes in relation to many sexual and reproductive health issues. In China, Indonesia and Malaysia, providing contraceptives to unmarried adolescents is illegal. In other countries it may, technically speaking, be legal although the access of young people to contraceptive services may be hindered by a number of external factors. One is a belief that adolescents and youth are not sexually active and that knowledge of contraception and access to commodities would promote immoral behaviour. This belief manifests itself in a lack of services targeted to young people and in negative attitudes on the part of service providers. Hence, at best, most interventions have been 'knowledge-based' and without the option of services for those who are sexually active.[30]

A study on correct knowledge of HIV transmission conducted in China found that young unmarried adolescents were the group least likely to know that condom use prevents HIV transmission. Information about contraceptives in China has until recently been mainly targeted at married couples.[10]

In Indonesia, a programme experimented with a 'family-centred' approach of providing sexuality and RH information to young people through their parents[31]. However, given the strict rules of propriety and filial respect that place the discussion of sexuality out of bounds of the nuclear family, parents felt embarrassed and reluctant to talk about sexual health matters such as masturbation and menstruation with their children. Another important finding was that age-group peers of the 15-19 year-olds generally lacked self-confidence to carry out effective ARSH counselling and education to their peers. Instead, the programme resorted to training the 22-35 year group as mentors or youth advocates who then successfully played the role of peer educators.

A study conducted in Viet Nam among single, sexually active women showed that they associated contraception with married life, especially when the desired family size had already been reached[7]. Secondly, keeping sexual relationships secret was extremely important. Respondents disclosed that their reputation and future chances would be destroyed should anyone find out that they were already sexually active. Buying contraceptives was considered very risky because if someone they knew saw them, their reputation would be ruined. Close living quarters in cities is another practical barrier to use of contraception among the unmarried: hiding contraceptives in the family home is practically impossible, and the risk of parents or other family members finding out about them is considered worse than the risk of pregnancy. Most of the interviewees considered it important that their new partners should believe that they were virgins and sexually inexperienced. They were reluctant to mention contraceptives or other information that would reveal that they knew more about sex and reproductive health than is common among virgins. Thus, at the beginning of a relationship, the power in negotiating safe sex seems to lie solely with the man. On the other hand, when the girls became pregnant, all reported that they made the choice of terminating the pregnancy on their own, and seemed quite confident about their decisions.

Sex workers (SW)

The ESEA region has become a target for sex tourism and trafficking of women, men, and children for many reasons, but chiefly for sexual purposes. These activities constitute thriving cross-border businesses especially in the Mekong River basin. The nature of and attitudes towards sex work in the region are varied. In Thailand, despite a large and visible sex work industry, sex work is nevertheless illegal. In Cambodia, prostitution itself is not illegal, although it *is* illegal to facilitate or profit by it and sex workers have no legal rights. In Viet Nam, Indonesia. Philippines, Myanmar and China, sex work is illegal, socially condemned and hidden, making it particularly difficult to address the RSH needs of such women and men.

Due to unequal gender relations, sex work tends to be a highly stigmatized profession, with female sex workers at risk of prosecution, whilst male clients are free to buy sexual services with impunity, and are often regarded as being quite 'normal' for doing so. Because of cultural definition of men's perceived physical needs, in most of the ESEA countries it is quite acceptable for men to visit prostitutes, or even to have second, 'minor' wives[33]. Whilst virginity is highly rated in a bride and monogamy within marital relationships, men are nevertheless perceived as needing an outlet for their sexual urges. Hence there is tacit approval for prostitution in most countries in the region. Sex workers themselves however are generally looked down on and are regarded as a necessary social evil, whilst the legal status of commercial sex work varies between countries.

Although illegal, in the Philippines sex work is divided into two categories, registered and freelance, as the authorities make some attempt to regulate prostitution. Registered sex workers are employed in various entertainment establishments and carry a 'health card' whilst they are working. They are supposed to undergo medical examinations at government-

sponsored Social Hygiene Clinics on a monthly basis which, in theory, is a positive initiative ensuring sex workers have access to essential services. Freelance sex workers are more vulnerable though and do not necessarily have the same access to health care.[3] In reality however, corrupt systems and limited law enforcement means that the health of women is rarely protected. Sex workers can request their clients to wear condoms but cannot insist on safe sexual practices.

Of increasing concern is the number of child sex workers in the region. In Thailand, girl children from the hill tribe areas, from Myanmar, China, Lao PDR, and Cambodia are sold into the sex industry. Although sex with children is illegal, the law has rarely been enforced and increased internal and external efforts to do so have resulted in the trade going 'underground'.[9] In Cambodia girls from rural areas and from Viet Nam are coerced or sold into prostitution.

In China, prostitution is seen as immoral, a symbol of corruption, and one of the so-called 'six evils', labelled as a crime against the state. It is therefore an illegal and un-regulated business. However, despite the presence of public security officers in urban China, brothels thrive and are a profitable business in the emerging market economy.[21] Due to its illegality however, there is no established system for providing sex workers with the necessary information and services to protect themselves and their clients from increasingly prevalent STDs and HIV/AIDS. In Viet Nam also, the selling of sex is considered to be a social evil – a practice strongly condemned by the state, which can result in severe punishments for those found to be involved.

In the small border town of Jinghong, known for sex tourism in China, a study found that whilst condoms were in plentiful supply in local shops in boxes promoting 'pregnancy prevention', sex workers used them only when clients did not object[32]. The sex workers emphasized that all they needed to do to avoid AIDS was to keep themselves clean by bathing after having sex with customers. They also said that they would never have sex with foreign men, particularly men from Thailand, who were perceived to be AIDS carriers. In the absence of RH information and services – despite the ready availability of condoms – sex workers health was frequently at risk. Such insights into the beliefs and practices of sex workers, as well as those of their clients, can provide useful information that can enable agencies involved in the provision of RH services to identify entry points for service delivery and strategies for addressing specific RH issues.

The perception of SW by clients is another issue, which is implicated in the perpetuation of risky sexual behaviours. A study carried out among 50 male clients of commercial sex workers in Bali found that the most common protection used by clients against HIV infection was careful selection of 'clean-looking' sex workers, followed by the practice of taking prophylactic antibiotics, vitamins or herbal potions *jamu* before or after having sex[19]. Only one client mentioned using condoms. When clients were asked about symptoms of sexually transmitted diseases, their responses included a wide variety of non-specific symptoms including lethargy, a pale face, bad breath, body odour or sunken eyes. Nearly all respondents considered STDs

to be prevalent among prostitutes in Bali and considered infection in a sex worker to be readily identifiable by 'screening' for the above-mentioned 'signs'.

Men who have sex with men (MSM)

Men who have sex with men constitute another group outside of mainstream society, which finds it particularly difficult to access reproductive health services because they are often looked down on or discriminated against by society at large. Interventions focusing on providing access to information and services rarely target MSM however, leaving them highly vulnerable to HIV/AIDS.

The cultural context, as well as the legal situation regarding MSM varies greatly between the ESEA countries. In most of the countries, homosexuality has been hidden within society for a long time and the HIV/AIDS epidemic and the gay movement from the West have influenced the need for its recognition as an existing sexual behaviour, as well as a legitimate lifestyle choice. Some MSM also have sexual relations with women, thereby creating a 'bridge' between homosexuals and heterosexuals.

In Cambodia there is not a homogenous group of MSM. The distinction locally is often made between *MSM short hair* and *MSM long hair*, with the understanding that the former are men who present and identify as men with normative masculine gender characteristics, and the latter are men who present with more feminine characteristics and whose identity may sometimes correspond to the 'transgender' category. Some MSM also have sex with women, indicating that they may constitute a 'bridge' in terms of HIV transmission. In Thailand, the homosexuality scene consists of *kathoey* (transgender and transsexual males called 'lady boys', lesbians or tomboys and male sex workers. So far homosexual sexual minorities face no legal sanctions or religious interdictions but they operate in a legal vacuum with respect to their rights. In none of the ESEA countries is there a gay movement carrying on a discourse about their rights. They instead face a lot of negative stereotypes as being of being social misfits and emotionally deviant and culturally violent.

The stigma and discrimination faced by MSM pose obstacles to effective sexual health promotion, especially in relation to prevention of HIV. *MSM long hair*, in particular, face discrimination because they are more easily identifiable as MSM. *MSM short hair*, on the other hand may conceal from health workers that they have sex with other men, therefore making it unlikely that they will receive appropriate clinical services. Access to information on HIV prevention specifically addressing the needs of MSM is limited and confusion exists as to whether prevention messages targeting heterosexual partners also apply to men. Discrimination against *MSM long hair* by the police is prevalent, with police forcing physical examinations to 'prove' sexual identity, and demanding money and, occasionally, sexual favours.[48]

Studies among MSM in Viet Nam have found that many men believe that sex with men is safer than sex with women – largely as a result of public education campaigns stressing the

risks of drug use and female prostitution as HIV transmission routes, as well as non-recognition of homosexuality. Lack of attention to MSM in campaigns has also resulted in misconceptions about risky sexual practices, in that several respondents considered oral sex to be riskier than anal sex. Accordingly, it was found that among MSM, condom use with female partners was consistently higher than with male partners, whether regular, non-regular or commercial sex workers.[13]

A study of MSM in China found many misconceptions regarding what constitutes safe sexual practice. Over a quarter of respondents believed that they would not get HIV if they withdrew before ejaculation, or if they did not ejaculate inside their partner. Almost a quarter of them believed that they could only get HIV from foreigners, whilst 18 percent believed it was not possible to get HIV if they only have sex with someone they trust. Almost two thirds of the respondents reported having sex with women in their lifetime, and almost a third within the last six months. MSM are therefore a potential bridge of HIV transmission to heterosexual women, and vice versa.[12]

Trafficked women

The UN Protocol to Prevent, Suppress and Punish Trafficking in Persons defines trafficking as: " the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other form of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payment or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation".

Trafficked women are likely to be amongst those with least access to reproductive health information and services. Many of them are highly vulnerable to sexual abuse and physical violence, unwanted pregnancy, STDs and HIV/AIDS due to the nature of the work they end up doing at their destination points. Due to their social and legal 'invisibility' they often have no way of accessing health care.

According to the United Nations Inter-Agency Project on Human Trafficking in the Greater Mekong Sub-region (UNIAP)[69] and other sources, in the Greater Mekong Sub-Region alone – comprising Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam – hundreds of thousands of women, children and even men are estimated to be trafficked between countries and, in some instances, further afield. Trafficking takes place amid high levels of internal and cross-border migration, much of which has been going on for generations, and occurs in a wide range of settings and for a variety of purposes.

In Viet Nam, Lao PDR and Myanmar, girls are trafficked to China where there is high demand for brides as a result of the sex imbalance. Girls are also trafficked from Viet Nam to Cambodia, and within Cambodia from rural to urban areas to cater for the vast domestic and international sex trade. Within China, trafficking of babies extra to the permitted quota per family takes place to cities by poor families. In villages in Yunnan Province, for example,

where a variety of factors, including extreme poverty, contribute to the powerlessness of women, trafficking of babies 'additional to the national quota' is not unusual, and is seen by village women as being 'a better option than leaving such babies to die'. The average price for male children is considerably higher than that for females – $250 as opposed to $60 per infant.[69]

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Main Trafficking Routes

Countries of Origin	**Transit Countries**	**Countries of Destination**
• Cambodia	• Cambodia	• Cambodia
• China	• Myanmar	• China
• Lao PDR	• Thailand	• Thailand
• Myanmar		• Singapore
• Thailand		• Taiwan
• Viet Nam		• Malaysia
		• Hong Kong
		• Japan

Source: UNIFEM. East and South-East Asia Regional Office and UNIAP. Trafficking in Persons: A Gender and Rights Perspective. Briefing Kit.

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The distinction between economic migrants and those who are trafficked for the purposes of employment or sexual exploitation is difficult to draw, and it is argued that increased promotion and protection of migrant workers' rights could reduce trafficking.

3 HARMFUL BELIEFS AND PRACTICES

Within the region there are a number of traditional and emerging cultural beliefs and practices, some religiously-based, which impact negatively on the sexual and reproductive health of women and men. The harm may be physical or psychological, and immediate and/or long-term. Commonly, the physical damage manifests in medical symptoms, whereas the psychological impact may be reflected in ways such as negative self-image and lack of coping skills in social interaction. Four broad categories of issues deemed to be of particular relevance to UNFPA programmes are presented here: son preference, gender-based violence, harmful sexual practices, family instigation of sex work and myths and misconceptions.

3.1 Son Preference

Son preference is a prevailing cultural norm in a number of countries around the world. It is most pronounced in China, India, Republic of Korea and Japan where for many years, it manifested in sex ratio imbalance approaching or even exceeding 120 baby boys born for every 100 girls, which is far beyond the natural ratio of 105 male infants born to every 100 female infants. In ESEA, the countries that exceeded the normal sex ratio at birth according to a 2005 source (http://www.nationmaster.com/graph-B/peo sex rat at bir) are: China 112, Myanmar 106, Republic of Korea 108, and Viet Nam 108.

Characteristics of Son Preference Societies:

- Patrilineal and patrilocal kinship relations including residence and inheritance
- Reliance on sons to carry on the family name through religious ceremonies for the spiritual nourishment of ancestors
- Confucian cultural traditions on the duty of children in providing security for aged parents, descent groups, repairing ancestral shrines and compiling genealogies
- Sons bestow strength and prestige on their families and descent groups by helping them to compete for economic and political resources
- Sons provide labour, economic security and continue the male line by performing ancestral worship, whereas after marriage daughters leave to become members of their in-laws' families.
- Labour intensity of male dominant tasks in some animal and cash crop production and trade which gives the impression that males are more skilled and able than women who are responsible for domestic chores, subsistence vegetable cultivation and raising pigs
- Coercive population policies such as China's one-child policy

Source: Murphy, Rachel. "Fertility and Distorted Sex Ratios in Rural Chinese County: Culture, State and Policy". *Population and Development Review 29(4)* Dec. 2003.

The sex imbalance in these countries is attributed to preference of sons over daughters, such that female babies are abandoned, under-reported, aborted or killed. Republic of Korea is reputed to have the strongest son preference in the world while in DPR Korea this does not appear to exist, due to legal, urbanization, and surveillance factors. Despite the criminalization of the use of ultrasound for pre-natal sex determination in China and India, the practice prevails with subsequent abortion of female foetuses.[23, 24]

3.2 Gender-Based Violence (GBV)

Gender-based violence is defined as physical, sexual, psychological or economic mistreatment of men, women or children, for whatever reason. It takes many forms including domestic violence, sexual violence, sexual abuse, sexual harassment, sexual assault, and trafficking and culture-driven gender violence. These forms of violence may include threats of such acts, coercion or arbitrary deprivation of liberty, and may occur in public or private contexts including the home, schools, places of employment and in entertainment, conflict and disaster situations. While all these forms occur in various degrees in ESEA, the most prevalent is domestic violence. Additionally, trafficking has become an issue of immense proportion both in supply and demand and it has been estimated that approximately one-third of the global trafficking trade in women and children takes place in this region. Table 3 summarizes the multi-faceted causes of GBV.

While acknowledging that there is a strong culture of stigma and silence around GBV and that it is rarely brought to the attention of family members, or other gate-keepers and law enforcers, the reported number of cases (mostly in metropolitan areas) is still high in those countries in the region which have such data available. In Thailand for example, a number of surveys referred to in the 2004 Thailand MDG report[52] testify to the magnitude of the problem. In 2003, the police department reported 4,037 rape cases. The number of women approaching crisis centres for help was also relatively high. Within the first six months of 2000, the Hotline Foundation provided counselling services to 891 women on domestic violence and 131 on rape. The following year, the Friends of Women Foundation provided services to 869 women on domestic and sexual violence.

At the same time as reports of physical abuse and rape have been rising alarmingly over the past decade, it has also been reported that the victims are younger than previously, ranging from 4-15 years of age. The involvement of young male youth in acts of violence is reported also in Cambodia. Some research revealed a disturbing picture of an increasing number of young men gang raping sex workers, garment workers or other "*srey kalip*" (modern women). Interviews revealed that a phenomenon known as *bank* – gang rape – was common among male university students. *Bank* involves taking a woman, often a commercial sex worker, sometimes by force, to a hotel where several men are waiting and proceed to rape her. The men justified *bank* by saying that the victim was "sexually available" – in other words, because she was not a virgin, she was "fallen" and therefore the rape was acceptable. Gang rape of commercial sex workers is also widely recognized and even accepted among young people. Only 13 percent of men and women interviewed recognized *bank* as rape if the woman did

Table 3. Causative Factors of Gender-Based Violence

Cultural	• Expectations of roles within relationships • Belief in the inherent superiority of males • Values that give men proprietary rights over women and girls • Notion of the family as the private sphere under male control • Customs of marriage, (bridge price/dowry) • Acceptability of violence as a means to resolve conflict
Economic	• Women's economic dependence on men • Limited access to cash and credit • Discriminatory laws regarding inheritance, property rights, use of communal lands, and maintenance after divorce or widowhood • Limited access to education and training for women
Legal	• Lesser legal status of women either by written law and/or by practice • Laws regarding divorce, child custody, maintenance and inheritance • Legal definitions of rape and domestic abuse • Low levels of legal literacy among women • Insensitive treatment of women and girls by police and judiciary
Political	• Under-representation of women in power, politics, the media and in the legal and medical professions • Domestic violence not taken seriously • Notions of family being private and beyond control of the state • Challenge of status quo-religious laws • Limited organization of women as a political force • Limited participation of women in organized political system

Source: Heise, Lori L. et al. "Violence Against Women: The Hidden Burden". *World Bank Discussion Paper* 255:3-13, 1994.

not give permission to have sex with many men. The most common concern was that the perpetrators might contract a sexually transmitted disease – but there was no expressed concern for the victim.[71]

Cultural perceptions of what constitutes acceptable or unacceptable behaviour, especially within marital relations, make it difficult to address gender-based violence. For example, a study in Viet Nam found that law enforcement officers in Viet Nam regarded a certain level of domestic violence as being quite acceptable. "*A couple quarrel, then several slaps… these are all normal, not violence*," commented a district judiciary officer. Many district and commune level officers believed that unless serious physical harm was incurred, physical or verbal abuse from a man towards his wife was normal. "*I thought, being a wife, women should accept many things and please her husband's feelings. This is the most important factor.*"[73]

Forms and Magnitude of Gender Violence in Viet Nam

Child prostitution

- The Ministry of Labour, Invalids and Social Affairs reported that in 1995, there were about 70,000 prostitutes of whom 13 percent were children. In big cities, such as Hanoi and Ho Chi Minh, children constituted an estimated 16 percent of prostitutes. Organizers of prostitutes entice poor rural girls to leave their homes by painting a bright future with city employment as maids, sales girls etc.

- The Vietnamese police estimated that 5,607 women were sold to China in 1996. In Cambodia, the Human Right Commission in 1996-97 counted 14,725 young women in brothels, bars, and massage parlours, private accommodations and hotels and of these 18 percent came from Viet Nam.

Child abuse

- In 1998-99 lowest level courts in provinces and cities sentenced 1,337 defendants for raping children. Of the offenders, 7 were put to death and 175 were given life imprisonment.

Marital disharmony and abuse

- During the 2002 9th National Congress of the Vietnamese Women, the Vietnamese Women's Union (VWU) reported on the number of GBV cases they had supported during the period 1997 – 2002: 3,078 cases at central level, 5,533 at provincial level, 21,558 at district level and 105,738 at grassroots level. Various issues were addressed including marriage and family problems, adult sexual abuse, child sexual abuse and other forms of violence. They also gave a figure of 2,488 trafficked women assisted by the Union in 5 years.

- Despite these high figures, the rate of intervention and assistance provided by the authorities in cases of family violence was low. According to research conducted by the WU in 2000, 62.7 percent of cases were resolved by neighbours; 36.3 percent by the Women's Union; 2.9 percent by the local authorities, and 4 percent by police. The main reason for limited support from the authorities was that victims had little trust in law and authority, whom they considered to be ineffective, slow and untimely. Additionally, women regarded violence as being a family issue unless they were physically injured.

- The majority of divorce cases was filed by women and were mainly due to family conflict, gender violence and maltreatment. Such cases accounted for 52 percent in 1998, 56 percent in 1999 and 62.62 percent in 2000.

- The Law on Marriage and Family 2000 stipulates that all divorce cases must pass through reconciliation procedures. There is concern that such 'reconciliation' might be more concerned with 'honour and dignity' of the family, rather than the human rights and health of the victims of violence.

Source: United Nations in Viet Nam. Gender Briefing Kit. 2002.

3.3 Harmful Sexual Practices

Female genital cutting/female circumcision

In the literature, the various forms of cutting of the female genitalia is variously referred to as Female Genital Cutting (FGC), Female Circumcision (FC) or Female Genital Mutilation (FGM). Studies have documented this practice in Indonesia although there is no official endorsement of the practice in the mainstream Islamic teaching in the country or for that matter in any other parts of the world[14, 30, 38]. According to these sources, FC, as it is known in Indonesia, is a practice, which has traditionally entailed either removal of part of the clitoral hood, or merely symbolic gestures such as "sticking" the clitoris with turmeric and then cutting the turmeric rather than the clitoris. The procedure of actually cutting the clitoris is sometimes practiced because of pressure from the family who feel guilty if this is not done, whereas traditionally the symbolic gesture usually sufficed. For those who practice FC, it is performed under their understanding that it is a part of Islamic teaching and therefore a form of devotion to Islam or rites of passage. FC service providers comprise modern health practitioners such as midwives, nurses, and physicians and *dukun,* traditional healers recognized particularly by those living in rural areas, who are deemed to have a supernatural ability to drive out evil spirits or to cure diseases.

It is reported that short-tem side effects of FC, such as infection or bleeding, can occur as a result of scratching the labia very deeply. Girls are circumcised at 7-40 days. In Indonesia, the practices of both FC and male circumcision have increasingly become commercialized and promoted with the advent of modern medical facilities and equipment. The availability of medical equipment and medication means that pain can be reduced and the risk of complications eradicated. Health staff are in a strong position to promote the service and are themselves gaining financial benefits due to the costs involved.[38] It is ironic however

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Female circumcision (FC) household survey findings among 1694 mothers of female children under nineteen years of age in Indonesia:

- 92 percent of families in Muslim communities support continuation of FC because they perceive it as both a societal custom or tradition and a religious duty.
- Many maternity clinic midwives have begun to market FC part of a birth delivery package.
- The danger of medicalization of FC lies in the fact that midwives tend to use scissors which result in cutting of the clitoris (incision accounting for 28 percent and excision accounting for 22 percent of all the cases in the study area), whereas traditional providers usually use penknives for a more symbolic act of scraping, rubbing, pricking or piercing the outer part of clitoris, accounting for 28 percent of cases in the study area.
- FC involves pain and is potentially harmful.
- FC violates the rights of the child as guaranteed under the Convention on the Rights of the Child, ratified by the Indonesia government in 1990.

Source: Meiwita Budiharsana, Lila Amaliah and Budi Utomo Erwinia. "Female Circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights". Population Council Research Report, Sept. 2003.

that a practice which, in Indonesia, has traditionally tended to be more of a symbolic gesture, has now been adopted in a more radical form due to advances in medical practice, which complement an increased adherence to orthodox Islamic practice in that country.

Dry sex

In parts of Indonesia, Malaysia and Thailand, research has shown that women consume a variety of herbal medications and also insert herbs, astringents, and alum to dry and tighten the vagina so as to increase friction, which is deemed to be more pleasurable for men during intercourse.[30] In an evaluation of a peer education project in Indonesia, two types of herbal preparations were widely used by young women: one to bring on menstruation in cases of unwanted pregnancy, and another to cause vaginal drying or tightening for having sex.[31]

This practice is potentially harmful to young women in particular, exposing them to increased risk of infection from STDs/HIV. Since the sensitive lining of the vagina is not fully developed, it is highly vulnerable to tears and scratches, which can become easily infected.

Penile implants

Penis implants, inserts and augmentation devices include ball bearings sewn under the skin, selected semi precious stones, gold bars (*palang*) or rings inserted through the glans, piece of horsehair or the strand of a stiff-leaved plant *bolitas* (small balls). These implants produce "humps" that men believe bestow them with sexual powers that will enhance the sexual pleasure of their partners. There is reported an increasing trend of the practice among young drug addicts, prisoners, sea-farers and gang members and certain other low-class occupations in Indonesia, Lao PDR, Myanmar, Philippines, Thailand, Timor-Leste and Viet Nam[6,14, 38].

In Thailand, an intervention supported by UNFPA through World Vision has been established to inform Burmese fishermen of the risks associated with penile implants using a peer outreach approach. Special IEC materials illustrating the implants, and describing the side effects and dangers are used by trained peer educators to promote safe behaviour and practices.

3.4 Family Instigation of Sex Work

In at least two countries in the region – and possibly more – it has been observed that cultural perceptions of sex work as a prospective employment opportunity are changing, particularly amongst the very poor. Whereas traditionally a girl's 'virtue' was seen as being of ultimate importance – both in terms of her future marriage prospects and also in terms of the family's 'honour' – in some places daughter's are increasingly being seen as a potential source of income and material possessions through their involvement in sex work, without the associated stigma.

Thailand has long been known for its sex industry, but the pattern of those becoming involved in sex work has changed over the past fifteen years. Some families, particularly poorer

families in the north, actually encourage their daughters to become sex workers in order to be able to access more income and material benefits. As daughters are usually responsible for caring for their parents in old age, it is difficult for girls from such families to refuse to enter the sex trade. In some areas prostitution has come to be seen as an acceptable occupation, with families who do not sell their daughters being regarded as foolish, especially as the income to be earned from commercial sex is considerably higher than that earned through unskilled labour. Although pre-marital sex is frowned upon, the 'sin' of being involved in commercial sex is offset by the merit gained by being able to provide financially for the family.[54]

While many children and young women in Thailand have been 'sold' into the sex trade, most available data suggest that the process is not always involuntary or forced. For many young women involvement in commercial sex is seen as an economic opportunity and men are seen as targets, a source of income. In one study, when asked how they entered commercial sex, 58 percent of women said it was their own decision, 37 percent said a friend or relative had advised them and only 3 percent said they were either sold by their parents or recruited by an agent.[72]

In Indonesia, a field survey[43] was conducted among 300 households in the places of origin of sex workers (West, Central and East Java), and of 400 sex workers operating in the same localities. Interviews were conducted with sex workers' parents, youth and community/religious leaders. Key findings from the survey are highlighted in the box. For parents with limited employment opportunities and unable to afford keeping their daughters in school, access to the sex work industry is relatively easy. The financial contribution such daughters bring to the household income was reportedly considered to be an expression of daughters' love for their parents. Attitudes towards entering the sex industry vary; in some areas it is viewed as being quite acceptable. Other socio-cultural factors also contribute to the likelihood of young women becoming sex workers. These include the perceived value of children, especially daughters, in relation to future family life, early marriage of women leading to divorce, perceptions about sex workers, and perceived life success and role model of sex workers.

Socio-Cultural Factors Contributing to Existence of Sex Workers in Indonesia

Perceived value of children especially young daughters

- access to sex work is relatively easy and less demanding than education and formal sector jobs
- sex work is seen as a promising route to support the family and is seen as an expression of love to parents

Marriage at early ages leads to a high divorce rate

- poor parents who could not keep children in school tended to marry off their daughters at age 16 or 17 to stop community gossip
- early marriage tends to end in divorce usually with delivery of a child
- such young daughters, with no job and in difficult living conditions, view sex work in major cities as being the most viable option for a better life

Perceived life success and role model of sex worker

- no social or other sanctions from the family and/or community against sex worker
- possession by sex workers or their contributions of jewelry, family conveniences and properties looked upon as symbols of life success within the larger community

Source: Sanie, Susy YT; Tampubolon Lamtiur H; Pardoen, Sutrisno, R; and Pramono, Herry. The Social and Economic Correlations of Women Entering into Sex Work and its Reproductive Health Implications. Centre for Societal Development Studies, Atmya Jaya Catholic University , Jakarta, Indonesia 2003.

4 CULTURAL BARRIERS IN PROVISION OF REPRODUCTIVE HEALTH SERVICES

This section presents cultural issues that pose constraints in delivery of reproductive health services. The constraints may be due to the cultural or religious values of the service providers themselves or determined by political and administrative decisions. Service providers may also be constrained by the mainstream culture, which may be opposed to delivery of certain messages and services on reproductive health issues. These issues are presented in some details below.

4.1 Health Providers as 'Moral Police'

Service providers sometimes reflect their own cultural or religious values, particularly when dealing with sensitive issues such as unwanted pregnancies and contraceptives.

Whilst in most countries in the region there are widespread family planning campaigns encouraging small family size and promoting increased use of modern contraceptives, access to services remains poor for some client groups, and many women continue to resort to abortion in an effort to deal with unexpected or unwanted pregnancies. Abortion remains illegal in countries including Myanmar, Indonesia, Thailand and the Philippines. Thus abortion remains politically sensitive in most countries and attracts widespread negative public opinion. Yet, even where family planning is available through regular service provision, there continues to be a demand for abortion among married women who experience contraceptive failure and among adolescents wishing to terminate unwanted pregnancies. In this case, service provider attitudes do not make it any easier for such women.

In Indonesia a study found that due to their own religious beliefs or for fear of reprisals, some health providers were unwilling even to treat complications of illegal abortions. Others adopted a more pragmatic approach, some expressing a wish that abortions could be performed in safe medical facilities, hoping that this would lead to fewer severe complications from unsafe abortions. Service providers seemed to be more tolerant towards clients wishing to terminate unwanted pregnancies due to contraceptive failure, rather than for other reasons. In all cases, however, continuation of the pregnancy was usually recommended.[15]

In Myanmar many health providers felt they should scold the clients who came in for post-abortion complications, and that this scolding was in the interest of the clients in order to keep them from seeking abortions in the future. Many village women delayed seeking help for even severe complications due to fear of being reprimanded, as well as fear of neighbours finding out about the abortion.[29]

In a survey carried out among formal and informal sector health providers in Lao PDR, 18 percent of the providers considered it their duty to inform the parents of their children's sexual activity. They hoped that the parents could exert influence on their children to refrain from sexual relationships.[50]

In some cases, health service providers subscribe to myths, which inadvertently contribute to people's reluctance to seek treatment. In Viet Nam, for example, service providers perpetuate several myths about STDs. Rather than raise the possibility that the patient's husband or partner might be having extramarital sex, service providers have been known to accuse women presenting with STD symptoms of having poor personal hygiene. Such an attitude has resulted in women being reluctant to discuss the situation with their partners, or to seek health care. Another commonly held misconception in Viet Nam is that reproductive tract infections are 'women's diseases,' caused by working in dirty water in rice fields[22].

4.2 Political Sensitivities

Political contexts shape the institutions which impact on individual and community level responses to health interventions. The political agenda may be geared to achievements of certain family planning targets or projection of a harmonious or equalitarian society or an environment devoid of violence or certain diseases. In those countries where policies have been centrally-controlled for many years, the role of some state institutions and mass organizations is to implement at community level health interventions determined at national level, even when such a stance may be counter-productive to developing positive relations with clients. Thus some countries, including Thailand, first hesitated in responding to the HIV/AIDS epidemic for fear of slowing their tourist industry. Altogether, these political considerations can compromise quality of reproductive health services or the rights of individuals or couples to choose methods they want or access other reproductive health services.

For example, in rural China, where male dominated village committees are commonplace, research has shown that family planning institutions and Women's Federation-run community education activities promote and reinforce local gender and family norms which uphold women's subservient status and character: virtue, submission to authority, industriousness and aptitude for meticulous work. Although these officially sanctioned pedagogic activities may well have empowered women by providing them with knowledge and resources, researchers found that the over-riding objective was to moderate women's behaviour in ways compatible with their role as mothers of the next generation of Chinese citizens.[41]

A study in China revealed that management staff and health workers in hospitals and medical centres denied coming across cases of domestic violence such as wife-beating in their practices, with some even denying its existence over the past 10-15 or even 30 years. Staff even went so far as to prevent researchers from accessing medical records.[25]

A review conducted in 2000 of Viet Nam's laws on family violence showed that within the local authorities, including the Women's Union, the preferred solution for addressing family violence was reconciliation – even where elements of crime were involved and the cases should have been directed to properly constituted legal authorities.[35] Similarly, Women's Unions and mediation teams in many places believe that an important part of their role was to ensure that couples remain together, irrespective of circumstances. They considered that they had failed in their work if they had been unsuccessful in preventing a couple from going to court to seek divorce.[25]

Through the one-child policy in China, control over contraceptive use is obligatory for concerned officials. Women's Leaders are expected to know which women in their areas are using contraceptives, which methods they use, and who has become pregnant.[16] IUDs, pills and sterilization are methods currently sanctioned by the state, with IUDs and sterilization being the most popular methods of birth control. For a long time, condoms have been viewed as both sexually improper and a medically inferior method of birth control. Sterilization is mandatory for all couples with two children and monitoring is done by birth planning cadres who, in most cases, are women although they have been increasingly replaced by men who it was believed would be more effective in achieving quotas for sterilization.[24]

One of the areas most affected by political decisions in Viet Nam is reproductive rights with respect to choice of timing pregnancy, determining the number of children and whether or not to have children. There are cultural values attached to these decisions, which in the long run are affected by, among other things, political decisions. Viet Nam formally introduced its one-to-two child policy in late 1988 and, though not enforced, it was widely promoted by family planning cadres, mass media campaigns and outreach work. There were penalties in the form of higher fees for health services or the payment of a certain amount of rice or money to the commune for giving birth to more than two children.

In the Philippines, where abortion is illegal and public attitudes are very negative, abortion complications constitute a significant public health problem and are a major cause of maternal morbidity and mortality, accounting for 400,000 cases annually, among whom one-quarter is hospitalized. One of the causes of opposition among some health providers to shifting from using dilation and curettage to manual vacuum extraction is the perceived risk of its being used for induced abortion.[17]

According to the Philippines MDG report, following the process of decentralization local government units are now entirely responsible for decision-making on contraception purchase. This is likely to impact negatively on women's access to family planning in more conservative regions and to be further exacerbated by current retrogressive attitudes of the Philippines' government towards funding of modern methods, combined with aggressive promotion of natural family planning.

4.3 Cultural Sensitivity and Accuracy in Messages

One of the main means of empowerment is knowledge. Many UNFPA projects focus on provision of RH information and education and, in this regard, the challenge has been delivering scientifically accurate information on culturally sensitive issues of sexuality, gender violence and reproductive rights.

A number of studies have highlighted this issue. For instance, it has been found that the need to have older generations to approve materials targeted at young people can result in materials that, while being culturally sensitive, are not explicit enough in delivering accurate information to enable youth to judge risks involved in different sexual activities. Thus, emphasis on prevention of unwanted pregnancy, can lead young people into modifying their behaviour in ways they think will help to avoid pregnancy, but can result in high risks of STIs. A focus group discussion conducted among young people in Indonesia found that the chief means used by young boys to avoid pregnancy included coitus interruptus and anal sex.[28] In the same study, comparison of IEC materials on youth sexuality with popular magazines targeted at young people in Indonesia showed that the two sources gave a markedly different portrayal of sexuality. While the image of sexuality conveyed in the IEC materials was very negative and destructive, with emphasis on the terrible consequences of sexuality, the popular magazines and discussions among the young people gave a more balanced and positive image of sexuality. One article notes that the huge amount of different RH manuals published in Indonesia can consist a problem in itself. Often the manuals have small print runs, and occasionally there is contradictory information. For instance, several of the manuals claim that masturbation is harmful, and can have serious implications for the future of young people's health.

> ### Communicating Effectively on Cultural Issues
>
> "While respecting each culture, and understanding the need to see issues from the audience's perspective, attention may also be drawn to the fact that there are universal principles and rights of individuals that must also be respected and taken fully into account in UNFPA programmes. This is particularly important when considering topics such as sexual violence, violence against women, and traditional harmful practices".
>
> *Source:* UNFPA. Policies and Procedures Manual, 1998.

Again in Indonesia, a survey on family planning revealed that most women interviewed expressed a very strong desire for more information, especially practical explanations of contraceptive methods. The writers of the article suggest that this might be due to the fact that the Indonesian family planning programmes have concentrated more on 'motivational' rather than 'educational' messages.[4]

In some instances, the "culture of silence" or tabooed discussion on issues identified as culturally sensitive, has turned into misinformation even by service providers including doctors. For example, in a recent television Talk Show in Viet Nam, in response to a question about whether or not masturbation was harmful, a doctor replied that masturbation causes infertility, is dangerous for young people's health and is a social evil. He also said that pills are only

for use by married couples. In other circumstances influential pressure groups or authorities perpetuate myths that support their own particular ethical stance, such as the notion that provision of sexual health information to young people encourages them to experiment with sex. In fact, research has shown that the opposite is correct: informed young people are more likely to delay their sexual debut and to use protection at first intercourse, than those who have not had access to sexual health education.[54]

Certainly, there is a lot of myths and misconceptions held by people themselves and which influence their sexual behaviour and related choices: inaccurate information about ways in which STDs/HIV is transmitted can result in people engaging in risky behaviour; misconceptions about contraceptive methods can limit women's choice; male myths about sterilisation has resulted in this being an under-utilized method of fertility control in many countries in the region. Hence, without having prior knowledge or understanding of existing myths and linked risk behaviour, project interventions can be ineffective. By understanding the context and source of the myth it is easier to develop strategies that bring about behaviour change. This is particularly successful when IEC materials that counter the myths and alternative narratives are presented.

5 STRATEGIES IN CULTURAL PROGRAMMING IN REPRODUCTIVE HEALTH

The experiences presented in this section illustrate interventions that have addressed both the needs of health service providers and other gatekeepers in coming to terms with their own beliefs or perspectives as well as that of target groups such as clients or other culturally vulnerable groups like ethnic minorities and sexual workers. At the same time, there is coverage of a variety of approaches and partnerships that have proved successful in addressing culturally sensitive issues in reproductive and sexual health.

5.1 Engaging in Value Clarification

Service providers need to be trained to explore and change their own values and attitudes in order to become competent in delivery of required services.

A programme developing mental health services in Cambodia trained health service providers to respect cultural beliefs and explanations in order to enhance patient compliance and satisfaction with the treatment. The programme found that some of the people trained initially resisted this approach, even though they were quite familiar with the traditional beliefs and approaches. Those from an urban background who had had a western style education tended to view traditional processes in a negative way, at least whilst working in the context of a 'western' programme.[47]

In the Philippines, service providers were encouraged to be self-reflective as part of a strategy to improve post-abortion care.[17] In 2001-2002, EngenderHealth adopted an innovative strategy to spearhead a programme called Prevention and Management of Abortion Complications (PMAC), with the ultimate intention of upgrading health provider skills in post-abortion care. The strategy was two-pronged, consisting on the one hand of a forum of service providers who were encouraged to examine their own values and attitudes towards post-abortion clients and, on the other hand, a technical working group consisting of representatives from Departments of Health, academia, physicians, nursing and midwifery associations, NGOs and tertiary hospitals who were responsible for developing a country-level work-plan for post-abortion care.

A pre-training situation analysis identified that post-abortion care clients did not receive routine counselling or referrals to family planning and other reproductive health services. In addition, providers showed bias in their attitude towards clients, and punitive treatment was the rule rather than the exception. Health staff were then provided with training in

post-abortion care (PAC) counselling and family planning counselling, as well as in infection prevention and clinical post-abortion skills. Subsequently a significant change in service provider attitudes was observed, as providers sought to improve their behaviour and practice. Staff became more aware and supportive of the need to treat clients with dignity and compassion, and were highly sensitized to preserving confidentiality and privacy during procedures and counselling. The intervention proved the value of using participatory, self-reflective approaches to encourage providers to examine their own attitudes and values towards clients and this resulted in improved attitudes and service provision.[17]

5.2 Incorporating Cultural Factors in Health Services

In Lao PDR an intervention was initiated within a local community, in an attempt to encourage women with high risk birthing practice to modify their customs.[11] Among the Katang forest dwelling ethnic group it is taboo to allow blood in the house because of the perceived belief that evil spirits may eat the blood and subsequently cause the death of mother and baby during childbirth. Traditionally childbirth therefore takes place in the forest, with a woman either alone or accompanied by older women and/or her husband. The mother and baby then stay in a small shelter or hut for three days until the bleeding stops. This practice, compounded by endemic malnutrition and high fertility rates, contributes to a high level of maternal mortality.

An innovative approach was developed to alleviate women's fear of delivery in the forest, whilst at the same time accommodating cultural prohibitions regarding blood. Village men decided that, when the time came, a husband would construct a birthing hut for his wife just outside the village, close to the forest or rice fields. In the hut, the woman would have access to skilled attendance in the form of a traditional birth attendant trained by an NGO, and the availability of referral in cases of complications to a district level clinic. The men also decided that, provided the mother and baby were clean, they could return to the home after one day, rather than waiting for three days in the forest.

A combination of factors contributed to the successful outcome of this intervention. Participatory rural appraisal (PRA) conducted by the NGO Concern Worldwide brought discussion to the fore about the traditional birthing practice and women's fears of delivery in the forest. Village men decided to make the necessary cultural adaptations to address the situation, and enabled significant moderations to take place regarding traditional practice. They also took on the responsibility of building birthing huts for their wives. Technical inputs from Concern helped develop local health service capacity through the training of TBAs and by building a small clinic in the locality, thereby enabling referral networks to be established. Women were subsequently more confident than previously and, at the same time, awareness was raised within the community about the importance of being able to access referral services and the link with the possibility of reducing maternal deaths.

Another example describes health service providers in southern Thailand adapting their approach to accommodate a cultural practice specific to local Muslim communities. The

number of hospital deliveries, or deliveries assisted by trained health staff, is significantly lower in three provinces in the south than elsewhere in the country, and maternal mortality rates slightly higher. In general, Muslim women living in this region prefer to deliver their babies at home with the support of untrained female assistants. A rapid base-line assessment, conducted with UNFPA support, found that one of the reasons given for preferring home births was because of the ease of conducting traditional rituals associated with the naming ceremony for the baby, which it was not possible to do in hospital. Subsequently, health service staff were willing to accommodate this post-delivery practice in hospitals, in an attempt to encourage hospital deliveries. Another expressed reason for non-attendance at hospital was because staff did not speak the local language common to the Muslim community, and women wished to be able to communicate in their own language with health staff. Commitment was also made to provide language training for selected service providers who would be interacting most with the Muslim communities.[5]

5.3 Building Collaboration and Group Solidarity

As one of the causes of stigma against sex workers (SW) is their role in transmitting STD/HIV/AIDS, some notable strategies have been developed to address the issue. Two of the strategies incorporate cultural factors, namely partnership with government agencies and building a sense of group solidarity among SW.

Government Commitment

The 100 percent condom programme introduced in Thailand during the 1990s, is credited with lowering HIV/AIDS prevalence rate from 10-15 percent down to 1-2 percent.[33] The programme was based on a public health model requiring the regulation and registration of sex workers, and based on the premise that a positive impact could be made by engaging local health and police authorities in negotiated relations with brothel owners. The Government played a prominent role in policy and planning, and health authorities demanded a guarantee of 100 percent condom use from brothel managers under the threat of legal sanctions. STD services were linked to the programme and free condoms made available. The 100 percent programming included hourly one-minute messages on TV, a government-led promotion of condom use, distribution of free condoms, and required free STD treatment among brothel workers and increased allocation of funds to NGOs.

According to researchers however,[46] the strategy, whilst successful in lowering HIV prevalence, did not empower sex workers, as police and brothel owners played a major role and gained additional power over them, usually through government health service intervention. The 100 percent condom programme in Thailand is still in operation, but with the advent of more 'indirect' sex work taking place in or from entertainment establishments such as bars, clubs and restaurants, there are doubts whether a programme focusing on promoting condom use among 'direct' commercial sex workers is adequate any longer. Reaching 'indirect' sex workers with effective preventive programmes is a challenge, not least because the owners of the establishments where they work are unwilling to admit that sex is traded on their

premises. A study found that 44 percent of such owners denied sex was being sold, 50 percent of them had not introduced any measures for condom promotion, and approximately 30 percent did not facilitate STD check-ups and treatment for the sex workers.

Although this approach was apparently very successful in Thailand during the 1990s, with national HIV levels dropping from 11.9 percent in 1991 to 2.4 percent in 1998, there has since been an increase in the prevalence of HIV among sex workers from 10 percent in 2000 to 16.6 percent in 2002. Another consequence was that Thai sex workers stopped working in brothels and moved to less visible establishments, such as massage parlours and karaoke bars where they tended to be replaced by non-Thai women, illegal migrant workers and hill tribe women, whose health is at greater risk due to language and legal barriers which severely limit their access to services.

Altogether, despite the fact that the 100 percent condom programming was not directly empowering to SW, it illustrates the potential of the government and national level orchestrated programmes in reversing the level of HIV/AIDS epidemic.

Building a sense of community among sex workers (SW)

An alternative approach has been devised in Cambodia, focusing on health promotion and awareness-raising aimed at generating a sense of community and solidarity among SW. This approach is based on the assumption that improved self-esteem among sex workers enables them to have greater control over their working conditions and hence their practice of safer sex. Sex workers themselves are central to the design, implementation and even monitoring of the interventions. Women are encouraged to determine their own priority needs, and resources are sought to address these needs. Peer education plays an important role in this approach.[76]

Targeting indirect sex workers

In Myanmar, UNFPA supports the NGO Population Services International to conduct outreach work, focusing on the provision of information on HIV/AIDS and safe sex, and promoting male and female condoms, among young girls working in entertainment venues, such as karaoke bars. This is an attempt to target the need of 'indirect' sex workers, who are not willing or able to acknowledge the work they are doing.

Similarly, projects supported by the EC/UNFPA RHIYA Programme in Lao PDR and Cambodia target 'beer bar girls' – who engage in casual commercial sex, but do not necessarily identify themselves as sex workers – with prevention strategies and negotiation skills. Peer education has also been used as a tool to promote messages between the beer girls themselves, as well as with their clients.

Building alliances with the owners of entertainment establishments – without necessarily openly discussing the nature of the work that takes place 'behind the scenes' – can have

positive outcomes. As with *mamasan* and brothel owners, it is in the interests of the proprietors of such entertainment venues to ensure that the girls who work for them are healthy and free from disease. Once positive relations have been established there is usually willingness for the girls to participate in activities.

5.4 Working Through Networks

Efforts to include community level actors in the process of designing and monitoring health care provision are essential, although care has to be taken in determining which actors participate in which consultations, so as to ensure that the sensitivities of all parties are taken into consideration.

In Indonesia, a project aiming to promote an inter-sectoral problem-solving approach to safe motherhood, and to enhance involvement of local level actors in issues that were not solely the domain of the health sector, incorporated village leaders, religious officials and other policy-makers in the audit discussions on maternal deaths in South Kalimantan.[49] It was found however that this approach limited self-criticism among medical providers, who felt rather threatened when weaknesses in clinical management were discussed in the presence of those with no direct expertise in medical matters. This finding demonstrated that such medical audits are only of value when the professionals involved are confident that the findings will not be used for legal or other actions. A lack of confidentiality in the existing system might have been a contributory factor resulting in resistance to report cases for audit.

The study also found that by using the village midwife as the central conduit for reporting, the audit tended to focus on factors contributing to maternal deaths in the community, rather than on those, which occurred in health facilities. Hence the research concluded that whilst such an 'open' approach to audit among health staff encouraged communication and collaboration between the village midwife and higher levels of the health care system, it did not necessarily foster accountability by doctors and midwives in health facilities.

The following case illustrates a successful attempt in the same region in Indonesia to address nutritional anaemia, one of the most prevalent malnutrition problems, utilizing wider networks than usual. The Ministry of Health and Mother Care project incorporated an anaemia control programme into an existing intervention offering pre-marriage counselling to engaged couples. The objective was to ensure that all participants were immunized against tetanus toxoid before obtaining a marriage certificate. The approach involved asking the parents of the engaged couples to register the forthcoming marriages at the sub-district Ministry of Religion office, instead of the young people themselves. As part of this process they were then responsible for collecting and passing on to the young couples IEC materials on the immunization programme.

Through enlisting the support of family members with a vested interest in the young women being immunized, it was found that there was a clear link with lowering of anaemia prevalence in the subsequent period. Almost 70 percent of the women in the programme received IEC

materials delivered to them by their parents, and there was a subsequent 40 percent decrease in anaemia prevalence between the baseline and first monitoring (one month after the baseline). The conclusion of the study was that the positive results were attributable to the use of respected family members for counselling of young women on important health matters before marriage.[34]

Information originating from a community itself can have a significant effect on major decisions such as contraceptive choice. A census carried out in Thailand in 1984 found that the 51 villages in Nang Rong, a relatively small geographical area, had very different patterns of contraceptive choice, with one method predominant in each village, but significant differences between the villages. An in-depth study carried out to find out the reasons for these differences stressed the importance of social networks in contraceptive choice, noting that conversational networks helped direct and control the flow of information about contraceptive methods in these villages, and thus influence the contraceptive choices to a great degree.[18]

5.5 Forging Partnerships

Religious institutions and leaders

The religious and/or spiritual frameworks within which most communities operate can be an important entry point for reproductive health programming. Through mutual respect and collaboration, results can be achieved which might otherwise be hindered because of pre-conceived ideas about 'entrenched' beliefs or practices. Religious and animistic beliefs often provide the framework within which individuals operate and, by ignoring the existence of these cultural reference points, opportunities may be lost for advancing reproductive health rights and improving people's reproductive health.

Issues relating to sexual and reproductive health are often highly sensitive or even taboo to discuss openly, but when positively engaged and provided with evidence-based information, religious and spiritual leaders are often willing to collaborate and to interpret their teachings progressively. This happens especially when it can be seen that both parties are working towards a common goal, or when a health intervention is either not contradictory to religious teachings or traditional practice, or can clearly be seen to be complementary.

In Indonesia, an early decision was made by the government not to promote sterilization or abortion as part of the family planning programme. There was also initial resistance from religious leaders towards use of the IUD, due to fears that it might cause abortion. Negotiations were carried out with Islamic leaders on how IUDs could be introduced in ways acceptable to the Islamic faith. Strong support by key politicians at all levels of the country's administrative structure was instrumental in facilitating the smooth operation of this programme.[45]

Similarly, in the Autonomous Region of Muslim Mindanao in the Philippines, a special project was designed to target a community with higher MMR and IMR rates than the national averages.[67] A core group of *ulama* (Muslim scholars) were invited to help provincial health officers explain the advantages of family planning to Muslim couples. Subsequently they became involved in advocacy and IEC campaigns as key partners of UNFPA and implementing agency POPCOM. Subsequently the *ulama* went on study tours to Indonesia and Egypt, to discuss issues relating to family planning in the context of the Qur'an with other religious leaders. Their findings were used as the basis on which subsequent advocacy materials were developed. By 1999 increased numbers of Muslims in Mindanao were using contraception.

Later, to ensure the support and involvement of all key Islamic scholars in the Philippines, a Special Committee on RH and Family Management, headed by the House of Islamic Opinion of Central Mindanao, was established, with technical inputs from Muslim doctors. Following several reviews, a religious edict *or fatwah* was drafted, stating that contraceptive methods were acceptable as long as they were safe, legal, in accordance with the Islamic Sharia, and approved by a credible physician (preferably Muslim) for the benefit of both the mother and the child. The *fatwah* was endorsed by the Grand Mufti of Egypt and publicly pronounced in the Philippines in March 2004 with two hundred Muslim religious leaders from all over the country in attendance.

Buddhist values of moderation, self-discipline and compassion have been tapped into in the fight against HIV/AIDS in a number of South-East Asian countries. The temple has always been the heart of the community – the place where people go to seek spiritual guidance and support. Aware of the role performed by Buddhist and lay clergy within local communities, many organizations, including UNFPA and their partners, have taken the opportunity to use the revered status of the Buddhist clergy to help promote and demonstrate messages of compassion and care, and to raise awareness on sensitive issues relating to sexual health. In Cambodia, supported by the EC/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA), monks are trained to promote messages on safe sex to adolescents at risk of STDs/HIV and unwanted pregnancies. In addition, they are contributing to the elimination of the stigma associated with HIV/AIDS by providing accurate information on HIV/AIDS transmission and prevention, and emphasising compassion for those already affected.[59]

Politicians and law-makers

Dialogue and interventions on cultural issues can be greatly facilitated or hampered by political leaders. Political statements and support can give credibility to issues that are otherwise stigmatized and steeped in silence and hidden in the family or domestic fronts. Political leadership may come from a charismatic leader either at the level of the head of state, or at any other level, by visibly supporting or opposing an issue or programme.

For example, the success of the Indonesia Family Planning Programme during the Suharto era from the 1970s through the 1990s has been attributed not only to the effective technical management of the contraceptive delivery systems, but equally to political management by

the officials of the National Family Planning Coordinating Board (BKKBN), which was the national coordinating body.[45] In an autocratic political set up, BKKBN officials were able to ingratiate themselves with the politicians, bureaucrats and fieldworkers across national, provincial, district and village levels. The political management involved securing alliances with the Islamic leaders to diffuse religious opposition, broadening the role of field workers to include a national network of village-level family planning groups including women NGOs and thereby surmounting human resource deficiencies and, lastly, putting FP on the political agenda. To this end a series of decrees were passed which institutionalized high priority for FP inside the Ministry of Home Affairs including criteria for assessing performance were nine numerical FP targets including the crude birth rate, the number of active users of contraceptive methods and the number of village FP groups created. The strong political orientation of the BKKBN chairman, Haryono Suyono, also played an indispensable role in successfully orchestrating the programme.

Another example at the political level is partnership with an organized group of lawmakers. In this regard, the Asian Forum of Parliamentarians on Population and Development (AFPPD) constitutes an advocacy group on population matters. In particular the Forum's Standing Committee on Women Parliamentarians has highlighted the plight of women survivors of GBV among educated women and men parliamentarians through national and regional workshops to motivate them to take legislative and monitoring role.[2]

As a result of such advocacy, many countries in ESEA have taken steps to address the absence of legislation in this area. Indonesia, Malaysia, Mongolia, the Philippines have passed Domestic Violence legislation in 2004, whilst Cambodia, China, the Lao PDR, Thailand are in the process of drafting and reviewing proposed bills.[1] It is noteworthy that parliamentarian advocacy together with activism of NGOs and professional groups have led also to passing laws or regulations to control other forms of VAW such as the anti-sexual harassment and an anti-rape law in the Philippines, the Code of Practice on the Prevention of Sexual Harassment at the Workplace, and anti-trafficking law and a national plan of action to control trafficking in Thailand, the Zero Tolerance Policy against VAW and the National Plan of Action on VAW in Indonesia, and the Act to Institute Policies to Eliminate Trafficking in Persons in the Philippines.

Promoting male participation

Empowerment of women and challenging gender biased cultural practices require multi-pronged approaches. Among the effective strategies are those directed to changing traditional masculinities through a number of channels including school curricula, media coverage and male participation in social reproduction and reproductive health.

In the area of RH it is acknowledged that men as spouses or partners are normally the ones who take decisions in the home and who therefore need to be more involved in RH interventions. In this regard, it is imperative for boys and men to be socialized or re-socialized to take responsibility for the effects of their own sexual behaviour on their partners' and children's health and well-being.

An example of this is male participation in ending gender-based violence. A number of countries including Cambodia, China, and Malaysia have formed men's networks to play an important role in the elimination of GBV, rather than to relegate it solely to women's groups. In ESEA, since 2000 UNIFEM has implemented a regional programme on the elimination of violence against women (EVAW), which operated through men's networks. In Malaysia for example, the Man Action Network against violence (MAN.V) was initiated as the first men's group in the country. It received a wide spectrum of male support, including radio deejays, sports personalities, film actors and policy makers. MAN.V conducts training, talks and seminars in schools, colleges and holds dialogues with policy makers on GBV.

A number of RH programmes in Indonesia which aimed at empowering women on a personal level, showed that whilst women had gained significantly in knowledge and confidence, they still remained powerless within the social sphere, lacking the confidence to question or challenge their husbands. Recognizing that existing gender imbalances in sexual and reproductive relationships had not been challenged through the programme, women participants asked the programme managers to develop strategies to target men. Subsequently, a more holistic approach was adopted, wherein reproductive health activities were introduced to male and female groups at the same time. As a result of this modification, many cultural taboos were challenged and some significant behaviour changes took place in relationships between men and women. A first year evaluation, based on interviews with both men and women, showed that men had reduced their violent behaviour against women and no longer compelled their wives to have sexual intercourse against their wishes. The overall conclusion of the study was to encourage exploration of multi-faceted approaches, aimed at empowering women, whilst also challenging established gender norms with men, in order to affect change in both the private and public spheres.[44]

A study in China assessed the effectiveness of a family planning intervention with and without husband's participation in reducing pregnancy and abortion rates in Shanghai. Among non-IUD users, the researchers found that pregnancy and abortion rates among women receiving family planning education with their husbands were significantly lower than rates among those receiving the educational intervention by themselves, or those receiving usual care. The

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Involving Men in Promoting Gender Equality and Women's Reproductive Health

"Women cannot achieve gender equality and sexual and reproductive health without the cooperation and participation of men. It is men who usually decide on the number and variety of sexual relationships, timing and frequency of sexual activity and use of contraceptives, sometimes through coercion or violence.

Men – as community, political or religious leaders – often control access to reproductive health information and services, finances, transportation and other resources. As heads of state and government ministers, as leaders of religious and faith-based institutions, as judges, as heads of armies and other agencies of force, as village heads, or indeed as husbands and fathers, men often wield enormous power over many aspects of women's lives."

Source: UNFPA. It Takes 2: Partnering with Men in Reproductive and Sexual Health. *Programme Advisory Note.*

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findings confirm the importance of men's participation in prevention of HIV and other STDs, and argue for the principle of equitable allocation of the benefits and burdens of reproductive health decisions.[12]

A final example of male involvement in RH is a Philippines initiative that promotes the role of men as potential partners and staunch advocates, while at the same time addressing their health concerns.[68] The initiative began in 2000 and was implemented in the provinces of Nueva Vizcaya, Sultan Kudarat, North Cotabato and Davao del Norte. It started with seminars and short training courses to different sectors, followed by dissemination of information down to the *purok* level. The intervention evolved into the formation of a male reproductive health association, with male community health workers on tricycles delivering advocacy and IEC/BCC messages, as well as male clinics being set up in rural health units and at district hospitals. Overall the programme focuses on the following:

- Improving available medical services especially for male adolescents
- Enhancing communication between spouses on the use of contraceptives
- Prevention of sexually transmitted diseases
- Screening for prostatic and testicular cancer
- Referrals for cases of urological problems

Tangible results of the programme have been an increase in number of men accompanying their wives to the clinics for prenatal check up, bringing their children for immunization, and discussion among themselves on family planning methods and on the ways by which they could protect themselves from STDs.

Interventions for Youth Gatekeepers

Successful strategies for addressing the problem of transmission of misinformation on sexual health matters from adults to young people have been developed through some of the projects funded through the EC/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA). Although inaccurate information has sometimes been provided for 'political' reasons – in the interests of preserving 'traditional values' and 'cultural mores', it has been found that adult 'gatekeepers' are not always aware that the information they are providing is incorrect. On many occasions they themselves do not have knowledge of, or access to, correct information on sexual and reproductive health matters.

By designing activities that educate and inform 'gatekeepers' about reproductive health issues and adolescent needs, community acceptance of interventions with youth is usually much stronger. Youth Union and Women's Union personnel, community leaders, teachers and parents have welcomed access to information they did not receive when they were young. Parents, in particular, welcome the opportunity to learn about subjects that they themselves would choose to teach their children, if they had accurate information. In Myanmar, peer education activities for young people, supported by UNFPA and the NGO JOICFP, proved so successful

that young people took on the role of sharing reproductive health information with their parents and other community members, as well as with their peers.[65]

Health service 'gatekeepers' tend to pose more of a challenge in terms of trying to create different attitudes towards service provision for unmarried youth. This is often because they fear the responses of colleagues, senior staff and parents, as well as the possibility of breaking written or unwritten laws, should they provide services for youth. Within the RHIYA programme, successful strategies have included advocacy campaigns targeting key decision makers and politicians; support for research which produces 'evidence' of unsafe sexual practices among young people, which can then be used for advocacy purposes; and workshops focusing on youth-friendly service provision.

Role plays and other participatory exercises designed to encourage health service providers to imagine how it feels to be a young person unable to access services when faced with a reproductive health 'problem', such as an unexpected and unwanted pregnancy, a STD, or fear of having contracted HIV/AIDS, tend to become much more sympathetic in their attitudes. Participants take it in turns to play the role of the young person, an 'unfriendly' service provider, and a 'friendly' service provider, and then explore their feelings through group discussions. By enabling them to explore alternative approaches and design criteria for youth friendly services, attitudes can be changed over time. Health staff are often very familiar with the issues facing young people and, once they are convinced of the importance of providing services for unmarried youth, they themselves can become excellent advocates from within the system.

6 CONCLUSION

6.1 Cultural Programming Challenges

The paper has covered a number of issues that pose challenges in cultural programming, and which are fundamental to achievement of the shared vision of a much-improved world by 2015, as articulated in the Millennium Development Goals. It has stressed that many challenges on the global social development agenda are shaped and influenced by culture and are anchored in gender inequality and cultural vulnerability. Unequal division of labour and subordination of women, including lack of autonomy and restrictions in decision-making in the public and private domains are manifestations of this. These hierarchical gender norms result in beliefs and practices that are inherently harmful to women's sense of self-worth, as well as to their reproductive health and that of their families. Such practices often violate principles of human rights and gender equality and include GBV, son preference, female circumcision, penile implants, dry sex and gender and cultural constraints to RH health seeking and service delivery.

Another challenging set of issues relates to the specific needs of vulnerable groups whose socio-economic characteristics, behaviour or life-style are often the object of stigma and marginalization within the wider society. Youth, sex workers, men-who-have sex with men, and ethnic minorities are among the vulnerable groups whose reproductive health needs tend to be neglected. It is also often the case that members of these groups hold misconceptions relating to sexual and reproductive health, and engage in risky sexual behaviour, whilst at the same time having less than adequate access to RH services. The reviewed interventions concerning these groups have reflected a diverse cultural discourse, ranging from moralizing attitudes and victimization, to concern about their human and reproductive health rights needs.

The paper has referred to the challenges in RH service delivery that can both emanate from and impact on the socio-cultural context. Among these are deeply held cultural and religious values of the service providers and community development workers which may, for example, impel them to breach confidentiality by revealing youth sexual activities to parents, reproach post-abortion care clients, or fail to report criminal cases of GBV. At the same time, the ramifications of political decisions, and technological and economic developments brought about by globalization, have brought their own challenges to cultural programming. In some cases, they have created or exacerbated cultural practices such as son preference and sex work.

Sometimes scepticism is expressed regarding the value of paying attention to those cultural practices that may not be prevalent but, rather, are restricted to marginal groups. The justification for this is that the criteria for intervention should not be the prevalence, but rather the gravity or degree of harmfulness the practice has on the health and psychosocial well-being of the practitioners and/or their partners. It is often among these marginalized cultural groups that harmful and practices such as penile implants, dry sex and son preference occur, and a rights-based approach demands that such practices should be researched and strategies developed to address them.

The implications for cultural programming with respect to all these issues is that a wide range of factors have to be taken into consideration when delivering reproductive health services: the socio-cultural orientation of service providers, local ethno-medical systems, local knowledge and relationship to western medical knowledge, health seeking behaviour, cultural perceptions of disease causality, gender issues, and existing community structures and hierarchies. The cultural diversity of the ESEA countries and the rapid globalization impact on sexuality cultures has pointed to an urgent need for a shift from preoccupation with reproductive and conjugal sexuality or "reposexuality", to a concern with sexuality issues of diverse groups including youth, sex workers, the aged, and MSM.

6.2 Cultural Programming Strategies

In terms of strategies, the paper has described a number of interventions where cultural factors have been successfully incorporated into reproductive health service delivery as, for example, the case where the traditional birthing practice of the Katang in Lao PDR was modified. Another example of cultural sensitivity was the training in value clarification for healthcare workers, resulting in staff that were better able to empathise with and understand the circumstances of their clients, leading to less judgmental attitudes regarding the provision of family planning and counselling for post-abortion clients. Likewise, the example of partnering with Islamic religious leaders to overcome opposition to fears among men that the Indonesian family planning programme promoted abortion and IUD insertion, which subsequently had a successful outcome.

Another strategy featured is that of promoting collaboration between cultural, professional and civil society groups, which in most instances, has contributed to positive results. However, there have been instances where the strategy has resulted in an unanticipated dilemma, as happened when village leaders and traditional midwives were included in joint maternal audit discussions with hospital medical personnel in Indonesia. The experience had the undesired effect of discouraging transparency and accountability because medical providers felt threatened, particularly when deficiencies in clinical management were discussed in the presence of those with no expertise in medical matters. The important lesson learned there was that there is need for minimal requirements of understanding on the legal and medical dimensions of issues, in order for a meaningful dialogue to ensue with non-professionals.

Forging partnerships with religious leaders, men and law-makers' networks is another strategy that has proved effective in cultural programming. These categories of people are revered and recognized leaders in their respective communities or constituencies, and wield considerable power and influence on moral issues, and on reproductive health, community development and political matters. Advocacy efforts on a range of issues were described, including Muslim scholars (*ulama*) support for FP in the Philippines and Indonesia, and Buddhist monks' promotion on safe sex to adolescents and de-stigmatization for HIV/AIDS sufferers in Cambodia. In the same vein, the Asian Forum of Parliamentarians on Population and Development (AFPPD) is actively involved in advocacy for legislation several cultural issues particularly GBV.

Some strategies aiming to promote cultural sensitivity have had ambiguous results however. An example from Indonesia is cited where providing sexuality information to unmarried youth through parents failed, due to reluctance to overstep cultural boundaries in communication on such a sensitive topic. Conversely, parents willingly complied with passing on health messages in IEC materials to their engaged children. Likewise, with respect to sexuality education, it has been shown in Indonesia and Philippines that delivering culturally acceptable information is sometimes done at the expense of scientific accuracy, which can lead to adoption of high-risk sexual behaviours.

6.3 Way Forward

Culturally-sensitive programming constitutes a cross-cutting strategy in UNFPA. One of the challenges in this regard, is the lack of data, which are disaggregated by cultural variables such as ethnicity, religion and language. Regrettably, these background variables are sometimes considered politically sensitive in some countries so as not to routinely be specified in various data collection exercises. The fear is that they graphically depict the inequalities in social development which politicians and other entrenched power structures may not be ready or willing to address. However, the human rights perspective necessitates such levels of disaggregation in order to rectify inequalities and inequities in social development.

A related area of emphasis is the need for more quantitative investigation so as to clearly discern the prevalence and patterns of distribution of the cultural issues, both positive and negative so that relevant interventions can be made.

Lastly, it should be emphasized that, as noted in the introduction section of this paper, development workers and institutions are increasingly mainstreaming and focusing on culture in their programmes. In order to gain and strengthen expertise in cultural programming, partnerships and experience-sharing need to be fostered within and between agencies. In this way, UNFPA strategic goals linked closely to the ICPD, CEDAW and the MDGs can be realized.

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