MATERNITY AND REPRODUCTIVE HEALTH *in Asian Societies*

Edited by

PRANEE LIAMPUTTONG RICE
AND LENORE MANDERSON

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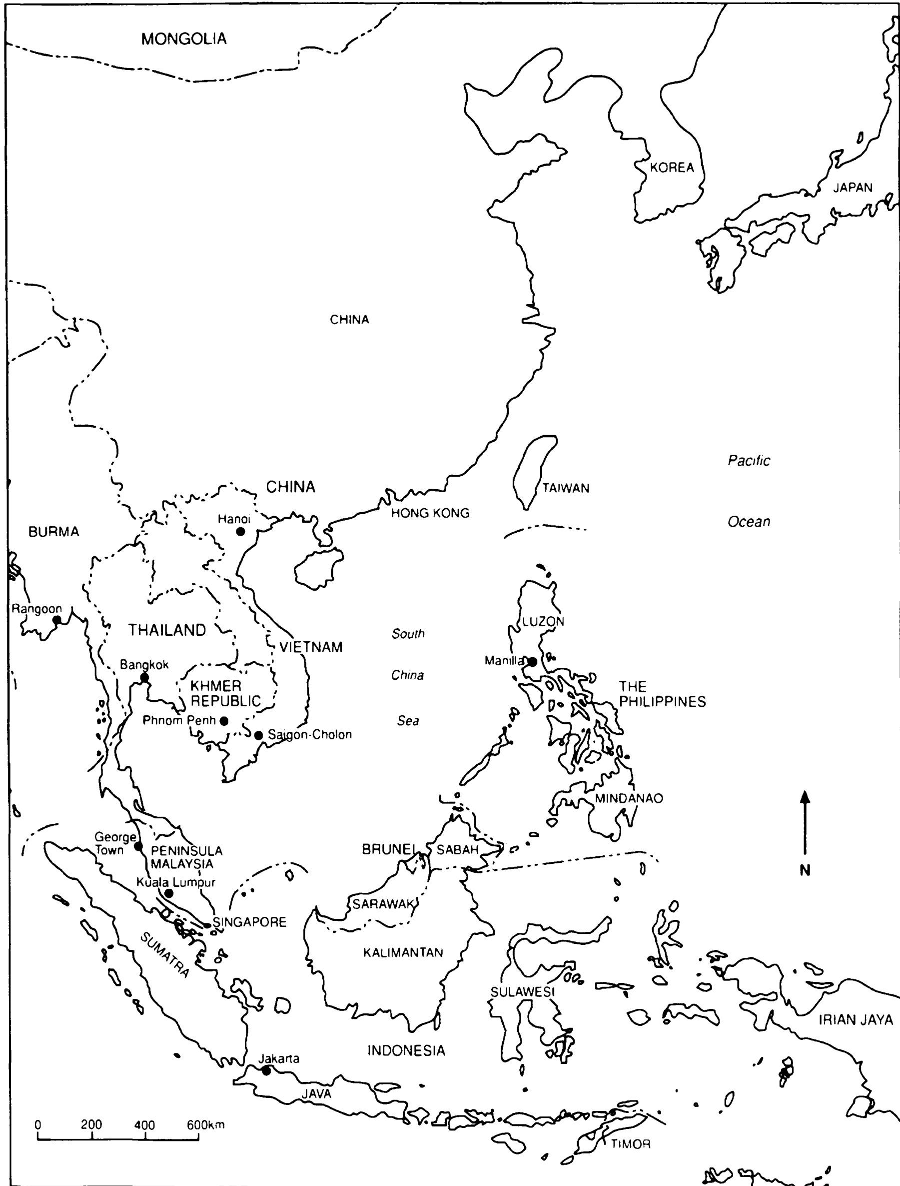

FRONTISPIECE: Map of East and Southeast Asia

MATERNITY AND REPRODUCTIVE HEALTH *in Asian Societies*

edited by

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Pranee Liamputtong Rice
Lenore Manderson

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Introduction

Pranee Liamputtong Rice and Lenore Manderson

In the past decade or so, a number of publications have brought together ethnographic accounts of birth and reproduction. Brigitte Jordan's work (1978) is one of the first comprehensive comparative studies, written relatively recently, that draws attention to the diverse ways of managing birth and nurturing the new mother in different social and cultural settings — Yucatan, Sweden, the United States and the Netherlands. Subsequent anthologies by Kay (1982), MacCormack (1982) and Michaelson (1988), among others, highlight women's experiences of pregnancy, childbirth, the postpartum and the days of early mothering, and draw attention to the degree to which these events of reproduction are cultural and social as much as they are biological. They highlight too the extraordinary variability across cultures of the roles played by others — kinswomen, husbands, children, traditional birth attendants — in the management and care of the new mother and the unborn/newborn child.

Works such as these highlight the importance of reproduction to women with respect to their personal identity and social status, and in terms of the ways in which their lives have centred around events of biology. For women in pre-industrial societies, early marriage and lack of means of birth control has meant that the cycles of conception, pregnancy, birth, and lactation have dominated their adult lives. Women's work has therefore been structured around the home, their labour spent in activities which allowed them to combine infant and child care, food production, and income generation.

Everywhere, the accessibility and use of effective contraceptive technology has had major impact on women's lives, shifting women's roles away from those primarily associated with mothering, and enabling them to play a greater role as productive workers in a working environment separate from domestic life. Pregnancy and birth have been transformed from recurrent events that absorb much of women's adult lives, to rarer but no less important occasions. Significantly, the frequency of reproduction does not appear to correlate with its positive cultural evaluation, and birth remains a critical life event in the lives of women everywhere, regardless of social formation, family structure, or their other activities and roles.

Concern with ensuring the health (and survival) of the mother and child are evident in the various rituals that are observed throughout pregnancy and following delivery in all cultures. In nation states, this concern has parallel expression in the medicalisation of reproduction. Over the past century, women and children have been increasingly subject to health programs designed to reduce maternal and infant mortality, which emphasise ante-natal care, supervision of birth and the regulation of

midwifery, and the monitoring of early infant care and feeding (Davin, 1978; Lewis, 1980; Manderson, 1992, 1996). These programs focus on women's role as mother and the presumed links between different ways of mothering and the health of infants. The maternal and child health programs that exist today, including those described in this volume, share this long history: in former colonial states such as Indonesia, the Philippines and Malaya, colonial governments established antenatal clinics and home visiting to monitor indigenous women and to encourage the management of birth and infancy along the lines of contemporary medical views.

Pregnancy and birth are emphasised — culturally, in health programs, and in the scholarly literature — at the expense of other aspects of reproductive and sexual health, and by bringing them together we hope to widen our understanding of the workings of women's bodies. A relatively small literature exists on non-reproductive aspects of women's bodies and women's health. There are, for example, a few anthropology and history collections concerned with infant care and breastfeeding (e.g. Hull and Simpson, 1985; Fildes, Marks and Marland, 1992), and a number of articles on menstruation and menopause (Skultan, 1972; Flint, 1974; Snow and Johnson, 1977, 1978; Chu, 1980) which explore this particularity of women's experience. In Emily Martin's book (1992), menstruation, reproduction and menopause are treated together, as logical contrasting surfaces of the one phenomenon. Yet surprisingly, this approach is rare, and more commonly, menstruation, menopause, lactation, and particularly sexual health problems and functions, ordinary discharges, reproductive tract infections, and women's care of their own bodies, are unspoken. The silence which maintains discretion and privacy is one which also controls, and the dominance of medical understandings of women's bodies reinforces this control, creating an illusion of discharges as abnormal; sexual dysfunction as aberrant; blood and other exudations as dirty and polluting; fertility, infertility, and the end of fertility mysterious and frightening. In this process, women's health is jeopardised. Women resist from reporting and seeking care for sexual health problems, for example, out of embarrassment and for fear that any abnormality will be interpreted as social aberrance, physical symptoms of disease as evidence of breaches in propriety. Frequently, women themselves assume that changes in bleeding, discharge, and so on, are evidence of immorality, perversion or sin; negative constructions of women's bodies are always internalised. Lack of education about reproductive and sexual health maintains the silence and hence the discomforts that women experience. Concern with these silences, and the confinement of understandings and interest in women's bodies to reproduction, has lead Jacobsen (1991:5) to write of a "widespread and deepening — but largely neglected — crisis", and to draw attention to what continues to be the limited improvement of women's health globally, despite the focus on reproductive health issues within primary health care programs.

We have noted above that women's reproductive success determines their social status, the roles they play in a given society, and indirectly, the control they can exercise over their own lives and those of their children, and their continued well-being. Women's status — a broad term which we use here to include their economic standing and the power they are able to exert domestically and publically

— affects their access to property and resources, but also their access to health care, their access to information that influences treatment seeking behaviour in the event of illness, choices about whether and when to have a child or children, and their ability to control their own bodies.

Women's reproductive and sexual health is of particular interest in terms of preventive health, not just because of the cost to individual women of poor health, but because of its wider social costs. Women's health has an economic value, since ill health affects women's ability to work and so their productivity; although the nature of their work too may cause ill health. Similarly reproduction may both compromise and be compromised by women's health status: that is, women's ability to conceive and carry to term is impaired by ill health (e.g. anaemia), and conversely, women's lack of control of reproduction (e.g. frequent pregnancies) may result in ill health. Women's health is also important because of their position as custodians of family health. Women are carers and nurturers within the household, responsible for the everyday health and care of other members of the family, by producing food, cooking, and so on, and by ministering to the ill (see Koblinsky, Timyan and Gay, 1993; Leslie, 1992a; Rathgeber and Vlassoff, 1993).

The focus on reproductive health has reinforced a supposition that reproductive health and women's health are synonymous, and typically, "women's health" has been understood to refer to pregnancy, childbirth and contraception, leading to interventions such as safe motherhood and family planning programs. But as a consequence of this, there has been continued neglect of other aspects of women's health, including the way in which gender influences the risk of most if not all infections. All health problems are affected by gender, since morbidity and mortality rates reflect not so much sex differences in the biology of disease, but the mediation of disease through cultural and social circumstances. Being female or male affects the risk of infection, the social experience of illness, and care and outcome, resulting in what Ojanuga and Gilbert refer to as the "significant disparities" that exist between women and men (1992:613; see also MacCormack, 1988, 1992; Fitzpatrick and Manderson, 1989; Leslie, 1992b; Rathgeber and Vlassoff, 1993; Vlassoff and Bonilla, 1994).

The conflation of women's health and reproductive health restricts and ignores the complexity of gender. Still gender issues constellate around issues of reproduction and sexual health, as the papers in this volume illustrate. Hence the focus in this volume on the most conventional aspects of being female — aspects which, because of their cultural and personal significance, are also profoundly meaningful to women.

THE MANAGEMENT OF PREGNANCY AND BIRTH

Reproduction is not a solely biological affair, but rather "is socially constructed and formed by political and economic processes" (Browner and Sargent, 1990:228). Pregnancy and birth are culturally patterned, and women's knowledge, beliefs and behaviours are shaped in this context (Cosminsky, 1982). But pregnancy is also a "natural" state, normal rather than pathological, one which needs supervision but

usually not medical care. This may explain why women are often reluctant to attend antenatal care and have a poor comprehension of its purposes, and why campaigns for regular prenatal attendance in order to reduce infant and maternal mortality have not been entirely successful (MacCormack, 1982; see also papers by Cabigon, Grace, and Hunter, this volume). As Jirojwong (this volume) demonstrates with respect to southern Thailand, women seek prenatal care primarily if they believe that their health and/or that of the foetus is compromised, although their decision to attend is further confounded by problems of access to care (transport, finances, childcare) and other circumstances. Further, even in industrialized countries where literacy is high and information concerning pregnancy and birth is readily available, women seek antenatal care for reassurance in the majority of cases, rather than medical care (e.g. in Britain, see Homans, 1982; in Australia see Crouch and Manderson, 1993a; Brown, Small, Lumley and Atsbury, 1994), and attendance at antenatal clinics has ritual rather than clinical significance for such women (Crouch and Manderson, 1993b).

Women are typically encouraged by family members to observe various rules to ensure their health and safety, successful conception and viability of the pregnancy, an easy delivery, and a healthy child. Local understandings of the nature of conception and the development of a child underpin these rules. In Japan, conception and birth were influenced in the past by belief in the cyclical nature of birth/death/rebirth, and belief in the arbitrariness of conception. This contrasts with modern beliefs in the intentionality of the individual, which emphasise the role of the individual in deciding to become pregnant, to carry to term, and to deliver successfully (see Nakayama, this volume). This latter belief system is clearly more in sympathy with practices of contraception, reproductive technology, and the medical management of pregnancy and birth. Jirojwong (this volume) also describes various traditional beliefs relating to pregnancy and delivery, in Thai communities influenced in part by Buddhist beliefs concerning the cyclic nature of birth/rebirth and the importance of *karma* in influencing birth outcome. To the extent that karma influences pregnancy outcome, medical intervention is considered to have little effect. Again, Symonds (this volume) argues that issues of birth, death, and the social system are inextricably linked to Hmong views of the cosmos, whereby the world is divided into that of the living and that of the spirits, with the "souls" of the dead re-entering the world of the living through appropriation of the body of a newborn infant.

Women traditionally have given birth at home where they have had control over their own bodies, and where childbirth and delivery have been an affair of women — the parturient woman, her female kin, and midwives. In her study of childbirth among peasant women in the Yucatan Peninsula of Mexico, for example, Jordan (1978) argues that home birth provides women with support in a time of crisis because of the extensive assistance of female relatives, neighbours and the traditional midwife. The process of home birth also fits with cultural understandings of female modesty, and minimises medical procedures which may often be regarded as unnecessary and frightening. Townsend and Rice, Symonds, Grace, Hunter, and others (this volume) describe contexts where home births are still usual. Home birth remains a preferred

option for most women because of their dislike and fear of hospitals, the importance of the traditions that might only be followed in the home, and the continuity of care offered by a midwife (Jordan, 1978; Manderson, 1981; Kay, 1982; MacCormack, 1982; Rice, 1993, 1994a).

Birth has increasingly moved from a familial and social domain to that of hospital-based medicine, for many an alien institutional setting and knowledge base. Oakley (1975) for the UK, Shorter (1984) for the USA, and others, have documented the transition of the control of birth from midwife to doctor, and the increasing medicalisation of birth that has been part of this process in industrialised countries from the late 19th century. In most industrialised countries, pregnancy and childbirth are seen as a diseased state, a physical bodily disturbance (Cosminsky, 1982:225); the woman's body is the subject of control by medical professionals and technology (Davis-Floyd, 1987; Michaelson, 1988; Martin, 1992). A woman is required not only to give birth in hospital where she may have little or no control, but she is also given the message, as Davis-Floyd (1987:479) points out, about her powerlessness, "defectiveness", and her dependence on science and technology. This shift in understanding of birth, and the care of the pregnant and parturient woman, is arguably even more alien in non-Western states, where obstetric definitions of pregnancy and birth as "unnatural events of illness" are diametrically opposed to indigenous understandings of birth as natural and normal.

The appropriation of childbirth by medicine ignores women's own beliefs and the social and cultural meanings of childbirth, or rather, medicine declares such beliefs ill-informed, ignorant or irrelevant. Contemporary health systems emphasise instead the importance of machines and institutions over the woman's body, reflected within the labour ward where the midwife's hands are replaced by foetal monitors and forceps. However, government policy in many countries has supported traditional birthing to some degree, since hospital systems would be unable to meet the demand if all women were to seek hospital deliveries. Hence the emphasis in current policy on antenatal care as a mechanism of surveillance, by which to identify women at risk of complication and to encourage those women, primarily, to give birth in hospitals (Clark, Ketteritzsch and Mills, 1993; Begum, Seguerra and Hasan, 1994; Grace, Hunter, this volume). The various policies relating to antenatal care and monitoring suggest the ways in which this has been translated in contemporary Asian societies.

TRADITIONAL MIDWIVES

A report of the World Health Organization in 1978 (cited in Helman, 1990) indicated that worldwide, two-thirds of babies are delivered by traditional midwives, and as we already note, still the majority of woman give birth with the assistance of traditional birth attendants or other, non-specialist, older women and female kin. Serving as a medical and ritual specialist, the traditional midwife plays a vital role in managing the woman's body during childbirth, and in many cases, providing continued care from early pregnancy through the early months of the newborn's life. In Guatemalan society, as described by Cosminsky (1982), the midwife is responsible for ensuring

conception, maintaining the pregnancy, caring for the pregnant woman and preparing her body for birth, and supervising labour and delivery. Postpartum, the midwife's role is even greater in ensuring the woman's recovery and future health. In India, the *dai's* work in supervising childbirth involves not only the "polluting" work of cutting the umbilical cord, disposing of the placenta, and cleaning up the birth blood and clothes (McGilvray, 1982; McConville, 1988; Islam, 1989), but she also massages the woman, cooks for her family, cleans and washes the house, and takes part in "bathing" and "stepping out" ceremonies (Jeffery, Jeffery and Lyon, 1989). Laderman's (1983) description of Trengganu midwifery and Paton's (1988) work in Central Java provide further examples from Asia of the important role that older women play in providing health care and social support for the pregnant, parturient and newly delivered mother. These findings echo the representation of the traditional midwife's role as "an expanded role, part of a support system that includes social, ritual and psychological components" in the care of childbearing women (Cosminsky, 1982).

The midwife's status varies in different cultures, and is closely linked with general attitudes towards women, their bodies, and bodily functions. Where menstrual and childbirth blood are seen as polluting, the midwife's status may be rather low. In the Indian sub-continent, for example, the *dai* has low status — as the above reference to pollution suggests. In contrast, Malay *bidan* do not have particularly low status, but rather, are reverred as professionals who enjoy especial skills and knowledge. As Laderman (1983:150–1) describes, the *bidan* nurtures the woman throughout pregnancy and takes charge of various ritual and ceremonial activities, supervises labour and helps the mother to deliver; if labour is prolonged, she might intervene by offering "hot" medicine to drink, or massaging the abdomen, and will massage again to help expel the placenta. While the *bidan* is a key player, control remains with the labouring woman. Her role is neither predetermined nor usurped by the midwife even in the event of a difficult labour or a problematic delivery (Laderman, 1983:172). Balinese women healers also enjoy considerable status, although they are denied access to some of the more prestigious ritual roles (Connor, 1983); and in Cambodia, the *chmop* (traditional midwife) also has high status (Townsend and Rice, this volume).

The discussions of conception, pregnancy, birth and the postpartum in many of the chapters in this volume further illustrate the important roles played by the traditional birth attendant, and the very different functions — and relationships between individuals — of antenatal clinics, labour wards, and infant health centres. As some of the chapters illustrate (e.g. Jirojwong, Cabigon, and Townsend and Rice), women use government services primarily because of perceived practical advantages. Lack of fully trained staff and services mean, however, that the traditional birth attendant remains a key person in village births throughout much of Asia, and today as in the past many women receive antenatal care from them and deliver with their assistance in preference to government medical services. It is in recognition of this, as well as the lack of alternatives, that the World Health Organization has supported their further training and aimed to integrate them into health programs in developing countries. Townsend and Rice (this volume) describe the role of traditional midwives

working at the Maternal and Child Health Centres in Site 2 Refugee Camp in Thailand, all of whom have basic training in modern obstetric care. Grace (this volume) also portrays the work of traditional midwives, provided with additional biomedical training by the Indonesian Government in recognition of their social and ritual importance as well as their established community role in the maintenance of women's health.

BODILY SUBSTANCES: MENSTRUATION AND MENOPAUSE

In many societies, parts of the woman's body, as well as bodily products, are regarded as "ritually polluting and unclean" (Ahern, 1975:193), and these body parts have the power to inflict harm. Women's sexual organs and their emissions are regarded as particularly powerful and dangerous. Hence the rules that pertain in various Asian countries regarding the separation of women's and men's garments, as well as the importance of the positioning of the bodies of women and of men, and women's ability to exploit these fears of pollution at times to their own advantage (e.g. Spiro, 1977).

Beliefs about menstrual blood provide a good example of this. Snow and Johnson (1977, 1978) point out that menstruation in some cultures is seen to function to cleanse the "impurities" of the body, in which context the retention or cessation of the flow of blood is a sign of pathology, leading, for example, to the blood rotting in the uterus and eventually turning into cancer. This belief in the cleansing function of menstruation is by no means confined culturally; Chu (1980) documents the same belief among Chinese women in Taiwan, as do Chirawatkul and Manderson (1994) for northeast Thailand. There are of course variations in these beliefs, and in the way in which menstruation is managed. Blood may be polluting, strength-giving, strength-depleting, sexually enhancing, purifying, health-giving or -taking. Chirawatkul (this volume), for example, argues that cultural beliefs of blood influence women's interpretation of health and illness, and also influence women's practices with regard to menstruation, childbirth, and menopause. In menstruation, the beliefs affect women's choice of self-care and ways to absorb and dispose of menstrual blood; in childbirth and menopause too, beliefs of blood influence women's practices to maintain "good health" (Chirawatkul and Manderson, 1994; see also Jennaway and Whittaker, this volume).

Blood from menstruation and childbirth is often regarded as immensely powerful (Douglas, 1966; Ahern, 1975). Due to the perceived potential of women to cause harm through pollution which might be effected by contact with blood, women may be banned from certain activities when they are in an "unclean" and "dangerous" state. A menstruating woman or a woman who has just given birth in Taiwan, for example, is not allowed to worship the gods (Ahern, 1975). While menstrual blood may be regarded as dirty and polluting, it is also commonly considered powerful because of its association with procreation: it "creates flesh and bones" of the foetus. Lochia (childbirth blood) is the "residue of the creation process", hence it is also

powerful and endangers others. In this context, Kang-Wang (1980) recalls that when she was pregnant and a midwife in a birth station in Taiwan, older women rejected her not only as a midwife responsible for delivering the babies of their daughters-in-law, but were also displeased that she was present in the birthing room.

Attitudes towards menopause need to be understood in the context of understandings of reproduction. In most societies, procreation is a woman's greatest achievement and the means by which she gains some power; at times, it may be the only means by which she has any authority. The birth of a first child is critical since it alters a woman's status within the family, ensuring the continuity of the lineage. Women gain status when they bear children, or secure their personal status within their husband's lineage because of their success in producing a child from their own body (Kang-Wang, 1980; Rice, 1995; Jennaway, this volume).

Yet in precisely these societies where importance is placed on reproduction, so women gain authority and autonomy with ageing. Menopause is a universal event in the lives of all women. But Lock's (1982, 1986, 1991) research on menopause highlights the social meanings attached to this event. Menopause, like other reproductive health events, is also a social and cultural event, in which the physiological changes associated with the climacteric are only part of the experience and ascribed meaning. Woman's social status, sex roles, personal circumstances, life history and state of health influence their experiences of the menopause and their position in society post-menopausally.

Kaufert (1976) argues that these factors in turn affect the symptomatology of menopause. A number of studies indicate differences cross-culturally in the perception and reports of signs and symptoms of menopause. An example is hot flushes, which is very commonly regarded as a sign of menopause in western cultures. Yet in some cultures, there are no reports of hot flushes; elsewhere, hot flushes are reported but not as commonly as other physiological changes (Flint, 1974, 1975; Beyene, 1986; Lock, 1986; Chaiphibalsaridhi, 1990; Chirawatkul and Manderson, 1994). This difference may relate to biological differences among women, but may also relate to differences in the significance accorded to various bodily signs and symptoms.

Hence menopause is constituted both by biological changes and events, and by beliefs, attitudes and values that inform a woman's life cycle and her roles over its course. While factors such as diet, general health, and use of contraceptives may affect the production and equilibrium of hormones in a woman's body (Beyene, 1986), cultural factors such as status acquisition and the removal of taboos, or alternatively, loss of status and cultural devaluation, play an important role in how women perceive menopause (Flint, 1974, 1975; Brown, 1982, 1985). Cross-cultural data are limited but suggest that in general the experience of menopause is conditioned by the cultural context that shapes the pattern of a woman's role, and this in turn is subject to the effects of industrialisation and urbanisation. Menopause offers to many women a range of economic, political, social, and personal opportunities denied to them during their reproductive years, and is therefore a welcomed event. Rice's paper (this volume), for example, illustrates that for Hmong women, menopause is regarded unproblematically as part of growing old. Although having many children is highly

valued, women do not see menopause negatively since they have already borne many children and ensured the continuity of their lineage. Chirawatkul, however, indicates that widespread changes in farming and patterns of everyday life have led villagers to perceive illness and diseases rather differently than in the past, and an increasing acceptance of health care, while resulting in clear improvements in maternal, infant and child health, has also had the effect of medicalising other health states. In this context, menopause is increasingly shifting from being regarded as a natural condition of older women, to one of a deficiency illness.

SEXUAL HEALTH

Increasing attention has been given to reproductive and sexual health in recent years (Jacobson, 1991; Gray and Underwood, 1991; Cook, 1993; Abernethy, 1994) as a consequence of a number of political, economic and public health concerns: high population growth and continued high fertility, women's continuing poor health — particularly maternal mortality despite several decades of maternal and child health programs, and increased concern about reproductive tract infections (RTIs), cancer of the reproductive system, and HIV infection. Reproductive tract infections (RTIs) and sexually-transmitted diseases are increasingly being recognised as a widespread health problem. These infections cause not only pain and discomfort, but may result in marital disruption, social stigma, and a range of serious and potentially fatal health consequences including infertility, ectopic pregnancy, miscarriage and stillbirth, increased risk of HIV infection, and cervical cancer. Despite their prevalence and consequences, they remain largely invisible due, Dixon-Mueller and Wasserheit (1991) argue, to taboos associated with such infections, and a belief among many that such symptoms are part of the price of being female. It is widely held that women should endure symptoms such as vaginal discharge, discomfort during intercourse and chronic abdominal pain, along with other reproductive health problems such as menstrual difficulties, side effects of contraception, miscarriages, and stillbirths (Dixon-Mueller and Wasserheit, 1991:11). The intense focus on AIDS has arguably obscured reproductive tract infections (Jacobson, 1991), and in Southeast and East Asia, as elsewhere, the development of approaches to the prevention, diagnosis and treatment of reproductive tract infections remains at an early stage. Traditional herbal remedies exist for these illnesses, attesting to their prevalence, but women often do not seek clinical treatment because of fear or embarrassment, and because such infections are often regarded as something women should bear as a natural part of "being a woman". Hence "a culture of silence" pertains in many parts of the world.

Our knowledge of the distribution of reproductive tract infections is limited because of women's reluctance to present for diagnosis or treatment health problems that include genital or urinary involvement. Women will often disguise symptoms such as swollen labia, swelling in the groin, and pain for fear that these are signs of sexually transmitted diseases, or because of fear of disapproval of others, including health workers as well as kin. Strong taboos also prevent many women from gaining familiarity with their bodies, to detect signs of disease and to differentiate the source

of blood, and not all women notice minor bleeding. Further, many women suffering from reproductive and urinary health problems are reluctant to report possible infections to others — such as mothers-in-law — who hold both power and the economic resources that might enable treatment to occur. Studies including ones conducted in rural India (Bang, Bang, Baitule, Choudhary, Sarmukaddam, *et al.*, 1989) and Indonesia (Hull, Widyantoro and Fetters, this volume) draw attention to this. Poor care or lack of appropriate care, as documented by Whittaker (this volume), also influence women's decisions to seek help even where they perceive irregularity or signs of disease.

Improved understanding of ethnogynaecology and the cultural construction of sexual health will provide an important step in developing programs to encourage women to recognise and seek treatment. In her study of local understandings of common gynaecological conditions in a remote rural village community in northeastern Thailand, Whittaker (this volume) indicates that there is a rich indigenous understanding of women's health. Women's descriptions and narratives are invested with complex meanings concerning their fertility, and reveal the links between women's health and the changing socio-economic context of their lives. A number of gynaecological complaints are identified by the women. Vaginal discharges are of great concern and are viewed negatively as signs of lack of uterine cleanliness and ill-health. They are treated with both traditional humoral medicine and cosmopolitan medicine. Older women also commonly suffer from uterine prolapse, a health problem that has been virtually ignored outside of the gynecological literature.

A contemporary growing interest in reproductive tract infections and sexually transmitted diseases relates to the association between STD and risk of HIV infection. As of mid-1994, 2.5 million people in Asia were estimated to be infected with HIV, and proportionately more women and more poor people are among those with HIV infection and AIDS (Over and Piot, 1990). At the time of writing, the largest numbers of people known to be affected in Asia are in India, Burma and Thailand. Of these countries, knowledge of the epidemiology and social risk factors of infection, and experience of intervention programs, is best in Thailand. The government of Thailand estimates that by 2000, between two and four million Thais will be infected with HIV, and surveys in the early 1990s indicated that around 50–60 percent of commercial sex workers and injecting drug users were already infected (Weniger, Khanchit Limpakarnjanarate, Kumnuan Ungchusak *et al.*, 1991; Thailand, Ministry of Public Health, 1992). The rapid spread of HIV infection in Thailand has resulted, in the space of a few years, in dramatic changes, including the rise of indigenous NGOs to develop and deliver preventive health education and care interventions (Cohen, 1988).

Limited testing indicates that HIV already also has a foothold in the Lao People's Democratic Republic, an impoverished, land-locked country in the hub of Southeast Asia. Prevention programs are undermined by poverty and lack of infrastructure, and are compounded for Lao women by social and cultural factors which limit their capacity to protect themselves from infection. These are elaborated in Savage's chapter (this volume), which examines the risks of HIV infection to

urban, ethnic Lao women in the Lao PDR, and the implications for planning and implementing AIDS prevention strategies. HIV transmission is linked with women and their culturally unacceptable, "uncharacteristic" or "immoral" behaviour. Obstacles to preventive behaviour are compounded by other factors, including financial considerations. Such factors pertain elsewhere in the region where there are similar changes effected through the opening of borders, expanding economic opportunities, improved transport, and the increased circular migration of people (e.g. in Northeast Thailand, see Lyttleton, 1994; in Burma, see Porter, forthcoming).

HEALTH SERVICES, CHOICES AND CONSTRAINTS

In many parts of the developing world, family planning programs were initiated to improve health and reduce population growth. However, these programs have failed to improve reproductive health. At one level, this is largely due to the fact that the programs have been too limited to meet women's varied needs. However, at a political level, it is, as Jacobson (1991:39) argues, due to "the limited mandate under which programs operate and the equally limited criteria by which they gauge success. In practice, deepening concerns about population growth and its potential to undermine development efforts result in a heavier emphasis on fertility control than health". In Bangladesh, for example, the government has only recently introduced "more secure" contraceptive methods to the women. These methods include mainly intra-uterine devices (IUDs) and tubal ligation (sterilisation) to reduce birth rates, with little regard for women's reproductive health or personal desires. It remains true that broader contraceptive choice, management of contraceptive side effects, and continuity and effectiveness of contraceptive practice have received little emphasis (Germain, 1987:20).

Despite government attempts, programs face a number of resource constraints. Many women have difficulties attending clinics due to the traditions of "seclusion" which limit their movement outside the home, or because of difficulties in taking time off from work, childcare and household responsibilities. At the national level, countries face limitations of "infrastructure, transport, logistical systems and personnel" (Germain, 1987:20).

A prime goal of government programs is to reduce the birth rate. State health policy in Indonesia identifies women as primary recipients of national health services only insofar as they have reproductive potential; and family planning and the concept of "family" are part of a state ideology in relation to population control rather than women's reproductive health. Hunter (this volume) describes the links between the state, women's voluntary organisations, and village practices, as these exist in an East Lombok rural mountain village. Here, services are provided through the *posyandu* (the integrated village health service post).

In North Bali, women's reproductive health is again closely monitored (Jennaway, this volume). Mass contraception, particularly the IUD, has been vigorously promoted through nationwide education campaigns conducted through

the mass media as well as by community health clinics. Indigenous political structures have been enlisted to achieve initial contraceptive compliance and encourage birth spacing aimed at limiting ultimate family size. However, as Jennaway describes, individual women are not entirely compliant, and may use maternal health services instrumentally to achieve sexual and reproductive goals of their own.

Above, we have referred at a number of points to women's variable use of health services, whether for pregnancy care, the treatment of reproductive tract infections, or the provision of family planning advice. While the major problem in much of the developing world remains a lack of services, it is also apparent that where services for reproduction and sexual health are available, women are often reluctant to use them. What can account for this?

Grace (this volume) describes the use made by Indonesian women in many rural communities of both traditional and modern practitioners and treatment. However an examination of their preferences for contraception, pre-natal care and assistance during birthing indicate a relatively low level of acceptance of government (modern) health services. Grace argues that a kind of pluralism has evolved, which, rather than being planned, is the result of uneven access to government health services. The health department is in fact antagonistic toward traditional practitioners, and aims eventually to convert villagers from seeking their services to using only those offered by the government. But poverty, lack of formal education, and inadequate dissemination of information about health matters and the formal services available, and the value that women place on traditional midwifery practice, means that many women continue to seek treatment only from those practitioners they know, trust, can afford, and to whom they have easy access.

Antenatal care is not utilised if women do not see its relevance or if it is too far from home, as Jirojwong (this volume) found in Southern Thailand. Long distances to health services, sometimes made worse by poor roads, lack of public transport, and its costs, prevent women from receiving prenatal care.

Quality of care is another important factor for women's decision to or not to seek care. The lack of emotional support and privacy, and differences in languages, social class, and cultural expectations between women clients and health professionals, explain women's lack of use of services in many places (see Clark, Ketteritzsch and Mills, 1993; Begum, Seguerra and Hasan, 1994), and use of services would appear to be higher where there is little social or cultural difference between clients and providers. In Site 2 Refugee Camp, traditional birth attendants were the main care givers for Cambodian women in Maternal and Child Health (MCH) Centres (Townsend and Rice, this volume). These midwives share social and cultural norms with their clients and provide emotional and physical support throughout pregnancy and childbirth, resulting in their greater use by women. But in addition to women's appreciation of the value of antenatal care to ensure safe pregnancy and delivery, in this case the women also sought care to secure a "pass" to ensure that they would receive a food portion for the infant after she/he is born; without this legitimate "pass", they would not be able to get food for their child. Symonds provides a similar example of the pragmatic benefits of the use of health services in her chapter.

In addition, health services are used where they are perceived to be relevant to women's needs, although women's needs may not be consistent with medical understandings of birth and delivery. Further, traditional and modern practices of childbearing are not always in opposition to each other; rather, new technologies and approaches are incorporated into traditional understandings and practices. For example, Muecke (1976) illustrates the use of a heat lamp by women in Northern Thailand to replace traditional means of "roasting" and heating (Manderson, 1981), and Rice (1994b) similarly describes Hmong and Vietnamese women who have settled in Australia, who use electric heaters to regain heat lost in childbirth, as they are no longer be able to practice "mother-roasting" (see also Sargent, Marcucci and Elliston, 1983). Chu (this volume) points to the popular use of "sitting the month" centres among Taiwanese women. Due to rapid social changes in Taiwan, including the decrease of extended families and increase of nuclear households, the traditional "sitting the month" ritual, as described by Pillsbury (1978), has become difficult for women to observe. The emerging of "sitting the month" centres enables women to continue to do so. As McClain (1982:25) argues, women have attempted to "preserve valued traditional beliefs and practices even as they accept innovations in birth location and management" in response to social and cultural changes.

CONCLUSION

The chapters in this volume represent some of the research currently being conducted in the areas of reproduction and sexual health in East and Southeast Asia. The cover they offer is only partial, of course, but it reflects the interest in placing women's health in a social context, and in linking aspects of women's physical health with cultural understandings of gender, sexuality and the feminine body. We have argued that women's health has largely centred around pregnancy and birth, both in discussion and programmatically. This derives, at least in part, from the tremendous social and personal importance given to reproduction, as much as to any state interest in maternal or infant mortality. Beyond pregnancy and birth, with the exception of family planning programs, women's reproductive and sexual health has received little serious attention, and women's health consequently remains poor (Jacobson 1991:57).

In general, "women's health" has been conflated with issues of maternal and infant mortality, foetal outcome, and fertility control, and these associations are maintained in various government health programs. Other health problems which women experience are self-treated or ignored, since they are considered as minor irritants only, not sufficient to prevent them from undertaking their usual tasks. Health care provided at the primary level (at rural health posts, midwifery centres, and so on), which includes a means to elicit information about women's general health when providing treatment for specific reported problems, may help address difficulties relating to reluctance to report. But the ability of a health worker to undertake this task, as well as other duties, is problematic where the health worker

is already inundated with a variety of clinical and administrative duties, and where improved services for women may require additional training and support. Means need to be found to streamline primary health worker duties to maximise their effectiveness without simply adding new tasks.

In most Asian countries, social and cultural changes have occurred rapidly. These changes have, in turn, affected women's reproduction and sexual health, and childbirth in most developing countries is increasingly under the control of western trained health professionals (McClain, 1982). The chapters in this volume explore the tensions that exist as states in Asia modernise and industrialise, in which context women's bodies are often situated between tradition and modern medicine, the midwife and the doctor, and home therapist and government health service.

This book is organised in the following manner. The first four chapters, grouped together as "Birth and its inflections", explore folk and medical understandings of reproduction, ideational and institutional settings of birth, and the changes that have occurred with the evolution of health care systems. Nakayama's paper focuses on the significance of a linguistic shift in speaking of conception and pregnancy — from *sazu-kara* (conception through the volition of the gods) to *tsuku-ru* (human acts of intentionality) — that has occurred with changes in economy and technology across Japanese society. Jennaway's paper explores understandings of fertility and reproductive health in a North Balinese village, and she provides a rich ethnographic description of reproduction and sexuality in Bali. Jirojwong (for southern Thailand) and Cabigon (for the Philippines) examine women's health beliefs and understandings of pregnancy and birth, and the way in which these influence their use of antenatal services set up to monitor reproduction and to improve pregnancy "outcome", in ways that are not always consistent with women's own needs and desires.

In Part II, "From her womb ...", we focus specifically on pregnancy and birth, and offer a number of different accounts of reproduction: Symonds on Hmong women, Townsend and Rice on Cambodian women in a refugee camp in Thailand, Grace on antenatal, birthing and postpartum care in rural East Lombok, Chu on provisions for the postpartum in contemporary Taiwan, and Hunter on maternal and child health in a Sasak village, also in Lombok, Indonesia. In Part III, we turn our attention to other aspects of women's reproductive and sexual health, and include chapters on ethnogynaecology in northeast Thailand (Whittaker), reproductive tract infections in Indonesia (Hull, Widyantoro and Fetters), menopause among Isan (northern Thai) and Hmong women (chapters by Chirawatkul and Rice), and finally and importantly, a paper addressing HIV and AIDS (Savage). This final chapter implicitly, we hope, underlines the value of the volume. We will not be able to develop or introduce interventions that will effectively prevent the transmission of HIV, or provide women with safe means of controlling their fertility, or address other health problems, until we are able to discuss reproductive and sexual health in ways that extend beyond pregnancy and birth and that appreciate the social and cultural significance of these events.

The chapters in this volume share several common themes. First, most chapters are based on ethnographic inquiries which utilise participant observation

and interviews, and all authors describe societies in which we have lived for extended periods of time. As a result, the chapters offer insights into women's points of view, in ways that are not possible through the objective distancing of survey-based research. At the same time, all authors are women and we write our chapters from this particular subject status (Roberts, 1981). Many of us also write of our own cultures, and these are very much chapters from "insider" perspectives. They are not the only ways to speak of women's experiences. But they open a window into those experiences even so, inviting the reader to learn more about women in Asia, the role of reproduction in their lives, the rhythms of the life cycle, the rituals of pregnancy, birth and confinement, and the changes and disorders of the body.

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PART I:

BIRTH AND ITS INFLECTIONS

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