HMONG AND KHMU MEN'S PERCEPTION OF
Family Planning, Sexual and Reproductive Health Services in Rural Lao PDR

Research report – 2023

BACKGROUND

Lao PDR, despite health sector improvements in recent years, continues to face significant family planning as well as sexual and reproductive health (SRH) challenges. This is evidenced by the country having the highest adolescent birth rate, at 89/1,000 live births[1], in the Association of Southeast Asian Nations region (ASEAN). This rate is even higher in rural areas of the country, adolescents and in lower income and education groups. Early marriage by girls aged 15–19 is common (26.5 per cent)[2] and the norm in many areas, especially rural ones. With a Modern Contraceptive Prevalence Rate (mCPR) for married women remaining low, annual average increases of just 1 per cent during 2011–2021 amount to 53 per cent, in contrast to the unmet need for contraceptive methods at 14.3 per cent LSIS III. As a result, Lao PDR faces a significant challenge to achieve an mCPR of 65 per cent by 2025, as per the National Strategy and Action Plan for Integrated Service on Reproductive, Maternal, Newborn, Child andAdolescent Health 2021–2025.

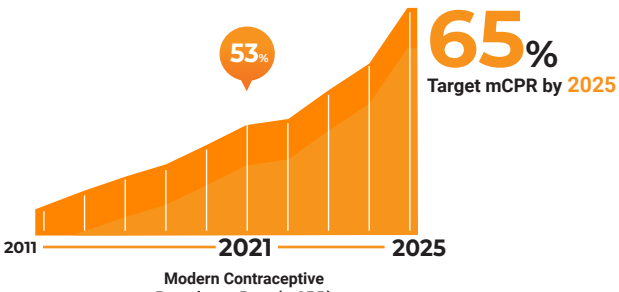
Critically, health inequities are commonly defined by ethnic groups, especially access to reproductive, maternal, newborn, child and adolescent health (RMNCAH) services.

This brings a layer of complexity to addressing unmet family planning as well as SRH needs in a country such as Lao PDR, comprised of 49 different ethnic groups, each characterized by diverse cultural beliefs and practices. Such diversity is categorized into four main ethno-linguistic groups: Lao-Tai, Mon-Khmer, Hmong-Iu Mien and Chinese-Tibetan. Every woman and girl, no matter their ethnic grouping, has the right to accessible, affordable and quality SRH support, including voluntary family planning and maternal health. This is not only a human right, it is critical to saving lives, advancing development and promoting gender equality.

That is why the United Nations Population Fund (UNFPA), the lead United Nations sexual and reproductive health agency, works in Lao PDR with the Ministry of Health and stakeholders to promote universal access to sexual and reproductive health information and services, promote comprehensive sexuality education to empower women and girls to exercise their rights, choices and autonomy over their SRH.

ADOLESCENT BIRTH RATE:
89/1000 live births

15-19 years old
Early marriage by girls
26.5%



1 Lao PDR (2023). Lao Social Indicator Survey III (LSIS III).

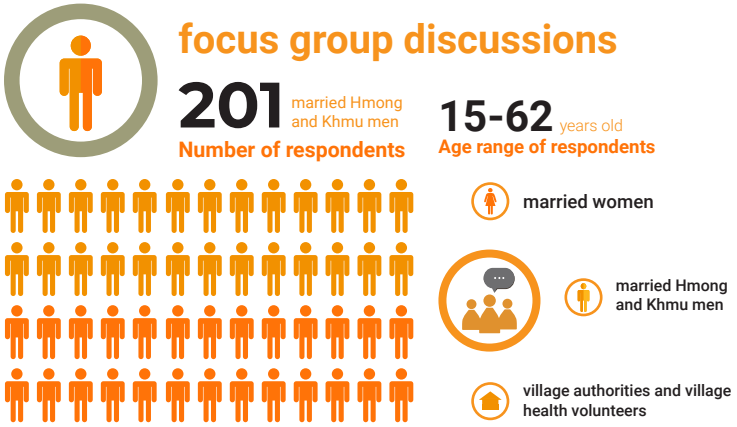
2 Ibid.

MEN'S ROLE IN FAMILY PLANNING AND SRH IN THE SPOTLIGHT

A key focus of UNFPA's work in the country is strengthening access to gender sensitive data and information to help orient government policy and programme implementation for impactful responses to national family planning and SRH challenges.

To further realize this goal, UNFPA commissioned research to better understand men's perceptions, attitudes and practices in terms of supporting or preventing their wives from accessing family planning and SRH services. The resulting report 2023 "Hmong and Khmu Men's Perception of Family Planning, Sexual and Reproductive Health Services in Rural Lao PDR", from which this research brief is based, sheds light on these factors. Importantly, it will help inform national health stakeholders' approaches to engage men to address the current status quo, whereby women have less power to access family planning and SRH services, and fewer development opportunities due to early marriage and pregnancy.

This small-scale formative study with a quantitative and qualitative mixed methods approach focussed on married Hmong and Khmu men, aged from under 15 to 62 years, in five villages (Donngern, Huayhia, Kiwdokkhae, Thongtai and Thongsy) in Phonthong district, Luang Prabang province. From previous research these sites were found to have a high early marriage and pregnancy rates as well as low essential healthcare services uptake. Aside from individual in-depth interviews with 201 respondents, focus group discussions were held with: 1) male champions identified in each village, 2) village authorities and village health volunteers, and 3) married women.



STUDY FINDINGS IN FOCUS

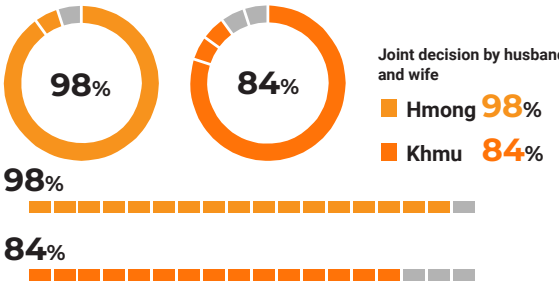
- Men as FP champions
- Negative perceptions on FP
- Women's dependence on husbands
- Cultural beliefs & practices
- Limited capacity and trust in health providers

The study findings provide unique insights into the role and perceptions of husbands in decision-making within households and women's access to family planning and SRH services in ethnic minority-dominated rural areas of Lao PDR.

Importantly, the research indicates that *some men are already family planning champions* who understood its benefits, trusted healthcare providers and therefore supported their wives to access essential healthcare. However, while encouraging, this is tempered by findings that women's access to family planning and SRH services is still limited by multiple factors, including underlying negative perceptions of modern contraceptives, women's dependence on husbands, cultural beliefs and practices as well as the perceived limited capacity and trust in healthcare providers.

A Modern contraceptives: agency and access

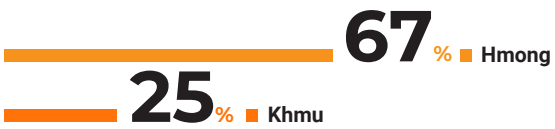
In the key area of agency in decision-making and use of modern contraceptive methods, this study found that high percentages of married Hmong (98) and Khmu (84) men claimed that both husband and wife made joint decisions on use of any modern contraceptive method.



Just 2 per cent of married Hmong men and 14 per cent of Khmu peers said this decision was made by husbands only.

Decision made by husband only

Strikingly, no wives were reported to independently decide whether to use modern contraceptives. This is significant in terms of women's agency, as all seven modern contraceptive methods available in Lao PDR must go into the female body, while only two contraceptive methods—male condom and vasectomy—are for men, but rarely used. This was underlined by the percentages of men and their wives found to not use modern contraceptive methods (67 per cent of Hmong and 25 per cent of Khmou). This reluctance to use modern contraceptive methods was also reported in focus group discussions, with participants claiming they impacted users' health, such as causing headaches, dizziness, "bo kheng heng" (feeling weak), causing spotting or no menstruation and reducing sex drive.



percentages of men and their wives found to not use modern contraceptive

> "In the community, it is difficult to limit the number of children since we see our parents have a lot of children, and we rather follow that until women can no longer be pregnant."- a village chief and study participant.

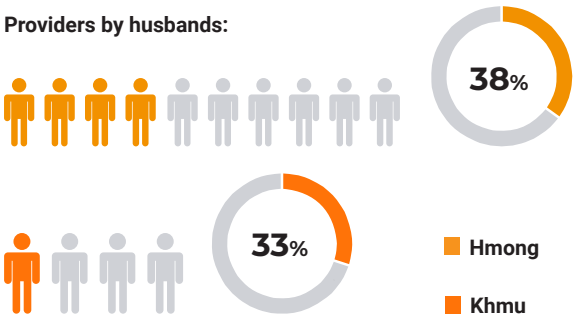
Factors behind the underlying unmet need for contraceptive methods were also spotlighted from married Khmu and Hmong women's perspectives. In the Hmong community, women participants claimed they wanted to use combined oral contraceptive pills, but such pills were commonly out of stock at health centres, sometimes for up to six months. Women's access to family planning and essential SRH services *depended on their husbands' support in terms of decision-making and transport,* as the majority of women could not drive motorcycles nor was public transport available. Also, Hmong women needed their husbands to act as translators to speak Lao with healthcare providers. Some participants also reportedly wanted to use contraceptives, but they received *inaccurate family planning information from health centre staff.*

A 38-year-old Khmu woman, who had experienced 11 pregnancies, was reportedly told by a health provider that she could not take oral contraceptive pills ("kin ya khum") less than three months after giving birth. Hence, this resulted in further pregnancies.

B Opening the door to essential healthcare services

Trust in health providers was revealed by this research as be the most influential factor for husbands (Hmong, 38 per cent and Khmu, 33 per cent) to support wives in accessing essential healthcare services, such as family planning, antenatal care, delivery and other support as needed at Phonthong district hospital and health centres.

Providers by husbands:



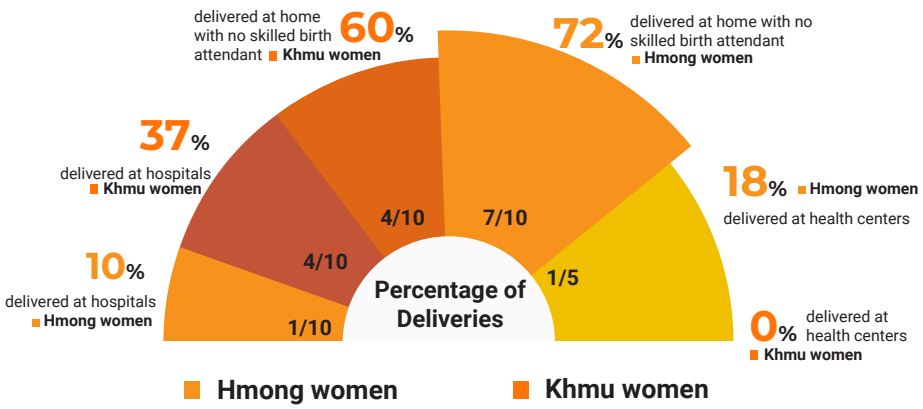
This need to build trust is further underlined by a 2023 case study in rural Lao PDR, that suggested a significant increase in COVID-19 vaccine uptake by six-fold from the first dose among unreached populations was triggered by positive approaches to building trust, improving communication, engaging local governance and enhancing community ownership and motivation.[3] However, the Hmong and Khmu-focussed research revealed that *women participants had encountered inappropriate comments, inattentiveness and a lack of stocks of modern contraceptives at the hospital and health centres, which had deterred them from repeat visits.*

> *"I trusted that healthcare staff would help my wife and children to be safe." – a husband family planning and SRH champion*

> *"My wife is pregnant for six months now, and I take her for antenatal care every month because of love and care." – a husband family planning and SRH champion*

C Births: at home versus health facilities

The study found *a high percentage of deliveries at home with no skilled birth attendant* (72 per cent for Hmong and 60 per cent for Khmu), compared to health facilities (18 and 0 per cent at health centres – 10 and 37 per cent at hospitals for Hmong and Khmu women, respectively). The main reasons cited for not delivering at health facilities include self-determined easy births, cultural beliefs, fear of being cut (episiotomy), body shyness around male healthcare providers, transport difficulties and previous poor service at health facilities.



According to three-quarters of Khmu husbands, their wives always wished to deliver at hospitals, which indicates *a large gap between the proportions of women who wished and actually delivered at hospital.* Focus groups discussions also suggested that many pregnant women get antenatal care at least once to obtain the mother and child health "pink book[4]", which would save them from admonition from health providers in the event they sought treatment from health centres and hospitals when having complications with the pregnancy.

3 Reaching the unreached through building trust under CONNECT: a case study on COVID-19 vaccination in rural Lao PDR. Phrasisommbath, et al., 2023.

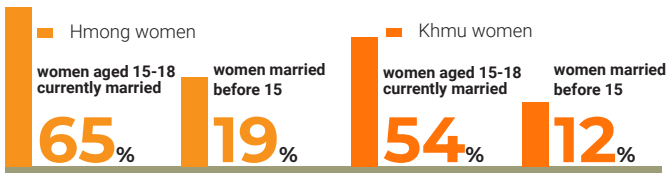
4 The pink book is a tool used nationwide to monitor and record a mother's health.

D Child marriage remains entrenched

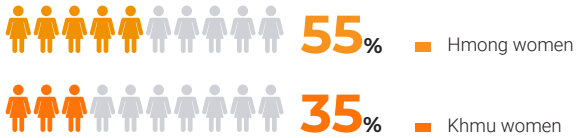
Early marriage, aged from 15–18 years, was found to be ingrained in studied communities among Hmong (65 per cent) and Khmu (54 per cent) women, with nearly one-in-five (19 per cent) of Hmong women and 12 per cent of Khmu women marrying even younger than 15, in contravention of Lao PDR family law. International evidence shows that child marriage puts girls at risk, including early pregnancy, social isolation, stopped schooling, limited possibilities for career advancement, and increased risk of domestic violence. Equal to or greater than four pregnancies per woman accounted for 55 per cent of Hmong women (maximum of 16 pregnancies) and 35 per cent of Khmu women (maximum of 11 pregnancies). *More than half of Hmong women each had four or more children.* "Forced sex in marriage" was reported by around one-in-five of Khmou wives and 10 per cent of Hmong wives.

"We know that getting married before 18 years is risky. We don't want children under 18 to marry, but if we did not allow them, they would commit suicide for love. Then, who would be responsible for their deaths?"
– a village chief and study participant

Early Marriage Rates



percentages of equal to or greater than four pregnancies per woman



RECOMMENDATIONS AND WAY FORWARD

Based on the research findings and key insights, a series of recommendations have been developed to inform and support decision-makers in taking steps:
1) to raise awareness and boost access to family planning and SRH support services within rural communities,
2) to ensure equitable health outcomes,
3) to ensure no one is left behind and
4) to define key areas of support by partners and donors.

A AT HEALTH CENTRES AND VILLAGE LEVEL

01 Addressing clients' claims of inaccurate health information delivered at health centres, "health education" could shift from traditional one-way communication to interactive engagement and communication for behavior change at health facilities and through mobile outreach.

02 Put in place a Bahvior Change Program to address the prevalence of child marriage and child pregnancy.

03 Establish a community-driven mechanism to ensure even the most marginalized and people with disabilities at reproductive age in villages can access essential family planning and SRH information and services.

04 Engage with champions, parents, village authorities and community members to further build trust and increase family planning and SRH service uptake.

05 Build inclusive participatory strategies involving all actors—men, women, boys, girls, parents, and village authorities and engage them in community dialogue and outreach.

06 Link the SRH and gender Social Behavior Change to broader areas such as combating drug consumption, creation of education, employment and empowerment opportunities including life and vocational skills.

B AT DISTRICT LEVEL

01 Establish a community-driven mechanism to ensure even the most marginalized and people with disabilities at reproductive age in villages can access essential family planning and SRH information and services.

02 Link the SRH and gender Social Behavior Change to broader areas such as combating drug consumption, creation of education, employment and empowerment opportunities including life and vocational skills.

C AT PROVINCIAL AND NATIONAL LEVELS

01 Policies on national health insurance coverage, management, and governance should take into consideration the availability and use of adequate commodities.

02 Strengthen the contraceptive supply chain and distribution to the local health facilities to address the stock-out and provide women and couples with the possibility to exercise their right in choosing the desired contraception method.

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