# CULTURAL BELIEFS AND PRACTICES AFFECTING ANTENATAL CARE (ANC) UTILIZATION AMONG ADOLESCENT PREGNANT WOMEN IN RURAL AREAS OF LAO PDR

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ABSTRACT

Accessing a health care facility is a common issue in Lao PDR. The aim of this study is to understand the cultural beliefs and practices affecting antenatal care (ANC) utilization among adolescent pregnant women in Hatpang village, Pak Ou district, Luang Prabang province, Lao PDR. The research design applies qualitative methodology. Data collection methods were ethnographic interview and participation observations from August to October 2013.

The findings showed that women's overall cultural perception regarding ANC services was poor. The quality of care was due to lack of health staff technical competence, lack of culturally sensitive health care service, language barrier, and lack of convenience in terms of time and travelling. Cultural beliefs related to pregnancy and child birth of individuals are the natural state of pregnancy; risk during pregnancy is determined by the sized of the fetus which can be managed by food restriction. Regarding gender practices, women carry on with traditional double responsibility of working hard in the rice field, and working in the home. Women also rely on the husband's decision for family or financial matters, and childbirth is handled by the family of the husband. Women do not participate in community activities. As a result these factors influenced adolescent pregnancies because of incomplete or non-use of ANC in their community.

The researcher recommendations are that the government provide health care information related to the risk and the signs of early pregnancy among young women through the media. Additionally, health care insurance is needed for all pregnant women, particularly in remote areas, in Lao PDR.

KEY WORDS: CULTURAL BELIEFS/ PRACTICES/ ADOLESCENT PPREGNNAT WOMEN/ ANTENATAL CARE UTILZATION (ANC)

111 pages

# CONTENTS

# CONTENTS (cont.)

# CONTENTS (cont.)

# LIST OF TABLES

# LIST OF FIGURES

# LIST OF ABBREVIATIONS

| | |
|---|---|
| ANC | Antenatal Care |
| CMR | Child Mortality Rate |
| LFNC | Lao Front for National Construction |
| LRHS | Lao Reproductive Health Survey |
| MDG | Millennium Development Goals |
| MoH | Ministry of Health |
| MMR | Maternal Mortality Rate |
| PDR | People’s Democratic Republic |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations International Children's Emergency Fund |
| WHO | World Health Organization |
| WREA | Water Resources and Environment Administration |
| UNDP | United Nations Development Programme |

# CHAPTER I
# INTRODUCTION

## 1.1 Personal background

I myself got pregnant when I was 26 years old. At first, when I found out that I was pregnant, I felt very happy at the idea of having a child for my family. But at the same time I was a bit worried about whether my baby would be born healthy because I had been told by some elderly people, including my mother, that I should follow our customs. I realized that I could not do certain things during my pregnancy. I was also concerned about two other things: firstly, I could not see how the baby was developing inside me, and, secondly, I was afraid something might happen to my baby because sometimes I did not follow the advice given to me by the elderly in my community, such as not eating twin bananas or passing by a funeral, and so on. However, through my previous job at the World Health Organization (WHO) in Lao PDR (WHO-Lao) in 2007, before I came to study at Mahidol University, I gained some Western knowledge about pregnancy and I was advised by some doctors who worked at the WHO-Lao office that I should register for antenatal care (ANC) at my local hospital. I completed my four ANC visits and never missed my appointments with the doctor at the clinic, where the development of my baby was checked and monitored. Every time I attended the clinic, I noticed that there were a lot of pregnant women who did not pay much attention to the ANC service, especially young pregnant women. Many of these women came late or missed some or all of their follow up appointments, even though these services were free of charge. I thought that these young women might not be aware of the crucial benefits offered by the ANC services, such as tetanus vaccinations, blood tests, and examinations of the abdomen. It is also possible that these women may not have had decision-making power because they were still very young. However, this was just speculation on my part.

**Rational of Study: Why study antenatal care utilization by adolescent pregnant women in rural areas of Lao PDR?**

## 1.2. Low utilization of antenatal care among young women in rural areas of Lao PDR

Antenatal care (ANC) literally means care before birth (WHO, 2005). It is provided to help women identify potential risks and to plan for a safe delivery (MoH, 2009). In particular, the focus is on preventing the main factors of maternal mortality, such as severe bleeding and infections after childbirth, high blood pressure, threatened abortions during pregnancy, and factors associated with conditions like malaria and AIDS during pregnancy (WHO, 2012). In general, women should receive ANC at least four times during pregnancy as follows: the first visit at 8-12 weeks, the second visit at 24-26 weeks, the third visit at 32 weeks, and the fourth visit at 36-38 weeks of pregnancy (Lincetto, Mothebesoane-Anoh, Gomez, & Munjanja, 2006).

In Lao PDR, according to the Lao Reproductive Health Survey of 2005, ANC services are more accessible in urban areas than rural areas (National Statistics Centre, 2007); and ANC utilization among pregnant Lao women is generally quite low. Only 15.7% of mothers received ANC from a doctor, 8.7% from a nurse, 4.3% from a midwife, and 1.6% from a health worker, while 0.8% received traditional and "other" kinds of birth attendance (National Statistics Centre). The LRHS indicated that utilization of ANC services was low among younger women and that there was a low level of attendance among young women for the first visit of their pregnancy (National Statistics Centre).This trend has also been demonstrated by other studies. For example, Manithip, Sihavong, Edin, Wahlstrom and Wessel (2011) found that mothers under 18 years of age were less inclined to seek ANC services than older mothers. Many studies have demonstrated that a proportion of Lao women never utilize ANC services, or make only one ANC visit during their pregnancy (Manithip, Sihavong, Edin, Wahlstrom, & Wessel, 2011; Phathammavong, Ali, Souksavat, Chounramany, & Kuroiwa, 2010; Phoxay, Okumura, Nakamura, & Wakai, 2001; Sychareun et al., 2009; Ye, Yoshida, Rashid-Or, & Akamoto, 2010).

## 1.3 High maternal and child mortality rates in Lao PDR

Lao PDR is a developing country in Southeast Asia that has chronically high neonatal and maternal mortality rates (MMR). The fifth United Nations (UN) Millennium Development Goal (MDG) focuses on improving maternal health. The Lao government is attempting to reduce MMR and neonatal mortality in the country, and responsibility for this lies with the Ministry of Health (MoH), which implements reduction targets through providing health care services and other health resources throughout the country's 17 provinces and the capital city, Vientiane. Thanks to the government's resolute efforts, Lao PDR has seen continuous improvement over the last decade in this area.

Considerable progress has been made in reducing the Child Mortality Rate (CMR) from 145 deaths per 1000 live births in 1990to 54 deaths per 1000 live births in 2010. The CMR dropped by an average annual rate of 4.9% in 1990-2010. However, the CMR in Laos is high when compared with other countries in the region. For example, the average annual CMR in Cambodia is 4.3%, 2.6% in Myanmar, and 4.0% in Vietnam (WHO & UNICEF, 2012). The MMR has also dropped from 1,600 deaths per 100,000 live births in 1990 to 470 deaths per 100,000 live births in 2010, with an average annual reduction of 5.9 % (WHO & UNICEF, 2012). Considerable progress has been made and the government considers it will be feasible to achieve the 260 target indicators of the Millennium Development Goals by 2015(MoH/WHO, 2012). However, the progress being made may nevertheless not be fast enough to achieve the goals. Two or three women still die every day due to maternal health issues (MoH, 2009; Santatiwat, 2009). Moreover, the MMR is still very high compared with other countries in the region; and the figures for maternal deaths per 100,000 live births in China, Thailand and Vietnam are 38, 48,and 56 respectively(WHO & UNICEF, 2012). The MMR in Laos is undoubtedly still the highest of all the countries in the region.

## 1.4 High prevalence of young mothers in Lao PDR

In the Lao context, particularly in rural areas, it is common for women to get married at a very young age. According to the Lao Front for National Construction (LFNC), men and women begin to seek partners at14-15 years of age (LFNC, 2008). The LRHS showed that among all women aged 15-19, 13.5% already had children, and of married 15-19-year-olds, 54.7% had at least one child (National Statistics Centre, 2007). Therefore, there is no doubt that there is a high fertility rate among young pregnant women in Lao PDR.

## 1.5 Adolescent pregnant women at greater risk of complications than adult pregnant women

Several studies in developing countries have found increased incidences of sexually transmitted diseases among young mothers (Lao, 1997); preterm delivery (Agustin Conde-Agudelo, Jose´ M. Beliza´n, & Lammers, 2005; Candan İltemir DUVAN & Hilal YUVACI, 2010; Ekachai Kovavisarach, 2010; Jolly, 2000; Lao, 1997; PP Kafle, 2010); abortion (PP Kafle, 2010); and infants with a low birth weight (<2500 g) (Agustin Conde-Agudelo et al., 2005; Lao, 1997; Monjurul Hoque, 2010). Young mothers under the age of 18 are more likely to develop anemia (Jolly, 2000; PP Kafle, 2010), preeclampsia(Jolly, 2000; Monjurul Hoque, 2010), chest infections (Jolly, 2000), urinary tract infections (Jolly, 2000), pyrexia of unknown origin, and are less likely to breastfeed the baby(Jolly, 2000). A high incidence of cesarean delivery has also been found (Ekachai Kovavisarach, 2010), and a high level of complications among neonates of teenage mothers (Ekachai Kovavisarach, 2010; Kayastha S, 2012). Adolescent pregnant women also suffered postpartum hemorrhages (Agustin Conde-Agudelo et al., 2005; Kayastha S, 2012), and intrauterine growth restrictions contributing to neonatal health problems (Kayastha S, 2012). Among pregnant adolescents (aged 15 or younger) studies have shown other problems including higher risk of maternal death (Agustin Conde-Agudelo et al., 2005), early neonatal death (Agustin Conde-Agudelo et al., 2005), anemia (Agustin Conde-Agudelo et al., 2005), puerperal endometritis (Agustin Conde-Agudelo et al., 2005), operative vaginal

delivery (Agustin Conde-Agudelo et al., 2005), episiotomy(Agustin Conde-Agudelo et al., 2005), and small-for-gestational-age infants (Agustin Conde-Agudelo et al., 2005).

## 1.6 Rural adolescent pregnant women versus urban pregnant women

The Lao population is a young population, and of the estimated population of 6.2 million, only 32% live in urban areas. The rest live in inaccessible areas among scattered settlements in mountainous areas far from towns and thus have difficulty in reaching health care facilities (WHO, 2011). Several studies conducted in Laos have found that rural pregnant women mostly come from ethnic groups (Phathammavong et al., 2010; Sychareun et al., 2009), and work as farmers (Phathammavong et al., 2010; Ye et al., 2010). Rural women practice food restriction (LFNC, 2008; Phoxay et al., 2001; Sirivong et al., 2003), respect or worship various spirits (LFNC, 2008; Phoxay et al., 2001), and do not have time to access health facilities (Manithip et al., 2011). Pregnant women work hard and do not rest during pregnancy (LFNC, 2008; Phoxay et al., 2001), and in addition have little authority to make decisions in the household (LFNC, 2008; Phoxay et al., 2001). Pregnant women in rural areas either give birth alone or at home (LFNC, 2008; Sirivong et al., 2003; Sychareun et al., 2009). Rural pregnant women have a poor level of education (Manithip et al., 2011; Phathammavong et al., 2010; Phoxay et al., 2001; Sirivong et al., 2003; Ye et al., 2010), and most have husbands who work as famers (Manithip et al., 2011), and have poor household income (Phathammavong et al., 2010). In addition, some studies conducted in Laos have found that there is a high fertility rate as well as high child death rate among rural pregnant women (Sirivong et al., 2003). Further trends highlighted by studies show rural women, especially adolescent girls, have shorter intervals between births, marry younger, bear children at a younger age and have a higher fertility rate compared to those who live in urban areas (LRHS, 2005). Women get married at a very young age, which means they become pregnant earlier and are able to bear children for longer than adult women. This extended reproductive health time line means there are greater risks among adolescents.

## 1.7 Cultural beliefs and gendered structural factors influencing ANC utilization

In Lao PDR there are 49 officially recognized ethnic groups living in the country, many of which have different languages and customs (WHO, 2011). Cultural belief systems in Laos constitute a barrier to women's ANC visits. Studies have found that many pregnant women seek help from local healers or traditional birth attendants, or receive advice from their husbands if they experience problems during their pregnancy and delivery (Sychareun et al., 2009, LFNC, 2008). Phoxay et al. (2001) found that some women chose not to deliver at health care centers because they believe that if blood lost during delivery comes into contact with other people, it would be inauspicious for them. Within the social structural context of Lao society, i.e. social class, religion, social customs, gender system etc., gender structural factors form one of the key factors influencing ANC utilization. Women in rural areas of Laos are not only responsible for their reproductive health but also for their share of the work in the fields and in the house(Asian Development Bank & The World Bank, 2012). Pregnant women in some ethnic groups are not allowed to rest, or eat certain foods and fruit, for instance among the Phouthay, Makong, and Lamet ethnic groups. Moreover, some women bear responsibility for taking care of their parents and grandparents until their death in order to be able to claim their inheritance; they therefore have to obey their parents or elderly relatives (LFNC, 2008). Therefore, these traditional gender practices, beliefs and lifestyles may prevent women from accessing health care services. These factors have been suggested as playing a role in the low ANC attendance among Lao women (Manithip et al., 2011; Phathammavong et al., 2010).

Due to the abovementioned reasons, many Lao women prefer to give birth at home (Sychareun et al., 2009). Many unmarried young women also get pregnant. In many cases the relationship is not a steady one, and the partner does not want any involvement with the child. A lack of support from fathers and a tradition within the community of blaming women for premarital sex, together with a fear that health workers will not help, make it difficult for young women to take care of themselves during pregnancy and for example attend ANC clinics (Souksavanh, 2007; Sulistyaningsih, 2005).

In conclusion, a number of cultural beliefs about pregnancy and childbirth may constitute barriers for adolescent women and their ability to attend ANC services. Various gender practices in rural Laos may also make ANC visits difficult for young women. Therefore, this study aims to examine cultural beliefs and gender practices that may constitute barriers for ANC visits among adolescent pregnant women in remote areas of Lao PDR.

## 1.8 Research question

### 1.8.1 General question

What cultural beliefs and practices affect antenatal care visits at government health services among adolescent pregnant women in rural Laos?

### 1.8.2 Specific questions

What type of cultural beliefs about ANC services are held by adolescent pregnant women in rural Lao PDR?

What type of cultural beliefs on pregnancy and childbirth are held by adolescent pregnant women in rural Lao PDR?

What type of gender practices exist in the everyday lives of adolescent pregnant women in rural Lao PDR?

How do cultural perceptions of ANC services, cultural beliefs about pregnancy and childbirth, as well as gender practices influence visits to ANC services among adolescent pregnant women in rural areas?

## 1.9 Research objectives

### 1.9.1 General objective

To study how cultural beliefs and gender practices affect antenatal care visits at government health services among adolescent pregnant women in rural Laos.

### 1.9.2. Specific objectives

To describe cultural perceptions of ANC services among adolescent pregnant women in rural Lao PDR.

To describe cultural beliefs about pregnancy and childbirth among adolescent pregnant women in rural Lao PDR.

To describe gender practices in the everyday lives of adolescent pregnant women in rural Lao PDR.

To describe how cultural perceptions relating to ANC, pregnancy and childbirth, as well as gender practices influence ANC visits of adolescent pregnant women in rural Lao PDR.

# CHAPTER II
# LITERATURE REVIEW AND THEORETICAL CONCEPTS

## 2.1 Introduction

This study aims to explore cultural beliefs and practices that affect ANC visits among adolescent pregnant women in rural northern Laos.

The contents of this chapter are divided into three parts: theoretical concepts, the literature review and conceptual framework.

## 2.2 Review of theoretical concepts used in the study

### 2.2.1 Culture

To study culture means to study what people believe and practice in their everyday lives. A culture is a system of shared beliefs, values, customs, behaviors, and artifacts that members of a given society use to cope with their world and with one another.

Tylor (1871, p. 1), an early English anthropologist, whose work is representative of the concept of cultural evolutionism, defined culture as “a complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.” He also considered that the condition of culture among the various societies in the world could be used as a basis for studying the laws of human thought and action.

Boas (1930, cited in Arbuckle, 2010, p. 3) stated that a culture “embraces all the manifestations of social habits of a community, the reactions of the individual as affected by the habits of the group in which he lives, and the product of human activities as determined by these habits.”

In conclusion, a culture is a holistic system comprising beliefs, attitudes, values, meanings, knowledge, behaviors, social relationships, norms, customs and habits that are transmitted from generation to generation through learning.

### 2.2.2 Interpretive anthropology

Interpretive anthropology aims to understand how people give meaning to various things in their lives through symbols. Clifford Geertz (1973) put forward the idea that a culture is a complex assemblage of texts that constitute a web of meanings and symbols. These meanings are understood by individuals through their experience. In Geertz's view, the study of such webs of culture should not be "an experimental science in search of law but an interpretive one in search of meaning" (Geertz, 1973).

Ortner (1984, p. 129) also explained that people in societies use symbolic meanings to express their "worldview, value-orientation, ethos, and other aspects of their culture," meaning that symbols should not be studied in and of themselves, but for what they can reveal about culture. In summary, human beings create meanings through symbols and use them to communicate in daily life.

In inclusion, interpretive anthropology means to interpret the meaning through symbols. Moreover, people have to understand the social context of that society in term of its social norms, customs, beliefs, religion, as well as understand the daily life of the community in question by examining it from the perspective this entire context.

### 2.2.3 Adolescence

The WHO defines adolescence as the age between 10 and 19 years (WHO, 2013). It is a period of transition from childhood to adulthood (WHO, 2013) and is related to psychological and physical changes. Adolescents tend to perceive that they are not children, but that they are not adults either (Dehne & Riedner, 2001). According to Dehne and Riedner, adolescence is a dynamic concept involving biological, legal, socio-historical, demographic and behavioral aspects. The dynamic concept not only involves the transition from childhood to adulthood, but is also related to social, economic, cultural, legal, and health issues that affect adolescents (Dehne & Riedner, 2001).

In conclusion, adolescence marks a sensitive transition from childhood to adulthood that can be easily influenced by several factors in terms of social, economic, cultural, legal, and health issues.

### 2.2.4 Concept of motherhood

There are many perspectives from different writers in the field of anthropology on the different definitions of “mother or motherhood”. One book written by Erma Bombeck states that “Mother” is a broad term that has something mystical and reverent associated with it. However, the term was always used in association with love, devotion, and sacrifice (Erma Bombeck). She added that “motherhood is a one size-fits-all, a mold that is all-encompassing and means the same thing to all people.”

Ussher and Antonis (Ussher 1990; Antonis 1981;cited in Ann Phoenix and Anne Woollett, 1991, p 13) stated that “motherhood is romanticized and idealized as the supreme physical and emotional achievement in women’s lives, but when women become mothers; mostly they find that the everyday tasks of mothering are socially devalued and relegated to individual household”. They also added that the task of mothering is learned in everyday life, and it is extremely difficult to be a good mother.

From a feminist perspective it has been argued that motherhood is not biology and ideology but is organized by social structures that determine that women have to respond to the task.

In conclusion, motherhood is considered to be a concept associated with love, devotion and sacrifice. Moreover, women consider motherhood as a responsibility and a task in everyday life that involves a need to present themselves to society as being a good mother.

### 2.2.5 Gender and gender practices

Helman (1990) considers that being a woman or a man is socially and culturally constructed in addition to being biologically determined. Helman explained that human societies have divided their populations into two social categories, which they call ‘men ‘and ‘women’. Both of these categories are mainly based on a series of assumptions drawn from the culture in question. ‘Male’ and ‘female’ comprise

different attributes, beliefs and behaviors characteristic of the individual. Helman (1990, p. 129) has argued that gender comprises four aspects: genetic, somatic, psychological, and social:

- *Genetic gender, based on genotype, and the combinations of the two sex chromosomes, X and Y (XX=female and XY=male)*
- *Somatic gender, based on phenotype, especially physical appearance, and the development of secondary sex characteristics (external genitalia, breasts, voice and distribution of body fat and hair)*
- *Psychological gender, based on the person's own self-perception and behavior.*
- *Social gender, based on the wider cultural categories of male and female, which define how that individual is perceived by society, how he or she must look, think, feel, dress, act, and perceive the world that they live in.*

However, Helman emphasized that social gender is the component which is most flexible and most influenced by the social and cultural environment (Helman, 1990).

Ireson-Doolittle and Moreno-Black (2004) explained that gender practices in Lao have changed throughout historical periods. They were of the opinion that in the social structure during the pre-colonial period, there was gender equality between males and females. This changed during the colonial period when the status of women was considered to be lower but men's activities were valued less than women's activities. However, in the post-colonial period, Lao society has changed and the status of women has improved. However, the Lao government still conforms to the construct of Lao women and their gender practices by emphasizing the term "three goods and two duties" for Lao women. The term "three goods" refers to being a good citizen, a good mother, and a good wife, while the term "two duties" refers to work in service of the country and enhancing women's empowerment. As a result, gender practices of Lao women are still constructed and regulated by formal state institutions.

### 2.2.6 Nature and culture

The concept of nature and culture has been a matter of important debate in anthropology. MacCormack and Strathern (1980) explained that anthropologists seek

theoretical insight from perceived tensions between culture, a social entity, and nature, a bio-physical entity. They added that the argument became framed as to whether the two entities function separately from one another, or whether they have a continuous biotic relationship with each other. Strathem and MacCormack put forward the idea that one category can transform into another, for example nature can become culture.

Helman (1990, p. 128) elaborated further, as feminists have pointed out, that women have historically been viewed as less cultural than men and subject to the controlling forces of “nature,” which is understood to mean uncontrolled, dangerous, and polluting as opposed to “culture”, which is understood to be controlled, creative, ordered and masculine (Helman,1990).

In conclusion, women were viewed as being less cultural than men, and for example women were viewed as being uncontrolled, polluted, and dangerous. In contrast, most men were viewed as being creative, controlled, ordered and masculine in society.

### 2.2.7 Gender culture

According to Helman (1990, p. 130), gender culture refers to the differential treatment of (and expectations for) men and women: “boys and girls are socialized in very different ways, both are educated to have different expectations of life and to develop emotionally and intellectually in particular ways, and are subject in their daily lives to different norms of dress and behavior.” In most societies, the patterns of women’s work and men’s work are clearly designated both in the household and in the wider community; the cultures of these societies offer explanations about why it should be so. The patterns and the explanations differ among societies and change over time.

## 2.3 Literature review

### 2.3.1 Adolescent pregnancy

There is a considerable amount of literature on adolescent pregnancy around the world. The literature review below highlights some of the key materials and findings from writers and studies in the field. Several studies from developed countries have highlighted a number of findings including the fact that some teenagers had had a boyfriend and had engaged in sexual intercourse for the first time at a very young age (Rachel Jewkesa, 2001). Other findings included unplanned pregnancies and consideration given to terminating the pregnancy (Rachel Jewkesa, 2001); the first sexual experience was either rape, incest or with someone other than a boyfriend (Rachel Jewkesa, 2001). Pregnant teenagers often come from large households (Rachel Jewkesa, 2001), and have older partners, and are less likely to be in school and less likely to have other girlfriends (Rachel Jewkesa, 2001). The more experienced partner would force the woman to have sex and some women were beaten by their partner (Rachel Jewkesa, 2001). Adolescent pregnant women have poor knowledge of (Okonofua, 1995), and a negative attitude toward contraception, as well as a lack of knowledge of reproductive health (Okonofua, 1995).Other findings found a low birth weight of infants born to young women who give birth before marriage (L.A.Sawchuk, 1997). Some adolescent pregnant women did not feel ready to be a mother, which is a role demanding responsibility, respect, and preparation (Janna Lesser, Nancy L.R. Anderson, & Koniak-Griffin, 1998). They felt a sense of anxiety and a loss of self-esteem on discovering they were pregnant (Kaye, 2008). Some girls also find it difficult to access financial and emotional support from their parents (Kaye, 2008), and feel stigmatized by health worker (James.S., Rall.N., & Strümpher.J, 2012; Kaye, 2008), as well as experience serious health and social problems (PP Kafle, 2010).

### 2.3.2 Cultural perception affecting ANC utilization

On a global scale, many studies have found that adolescents do not utilize ANC services because of their perceived poor quality (Butawa, Tukur, Idris, Adiri, & Taylor, 2010; Gross, Alba, Glass, Schellenberg, & Obrist, 2012; Iyaniwura & Yussuf,

2009), and because of a perceived lack of equipment (Josephine & Christine, 2000). Pregnant women in general may have concerns about the lack of privacy (Campanelia, Korbin, & Acheso, 1993) or long waiting times (Campanelia et al., 1993; Zeidan, Idris, & Bhairy, 2011). Women may also perceive that using ANC services is not necessary (Manithip et al., 2011; Phoxay et al., 2001), especially if they think they are currently healthy (Campanelia et al., 1993; Ye et al., 2010). Other factors that play a role in the utilization of ANC services include poor attitudes toward health care personnel (Josephine & Christine, 2000; Ye et al., 2010; Zeidan et al., 2011), misconceptions about what happens during ANC visits (Josephine & Christine, 2000), feelings of alienation, too young age of the client and health staff, discomfort**,** too few staff members and too many patients (James.S. et al., 2012). Additional factors include a lack of awareness of the health benefits of ANC visits (Gross et al., 2012; Manithip et al., 2011; Pell et al., 2013 ), and fears of unpredictable and unexpected costs at health facilities (Campanelia et al., 1993; UNFPA, 2008; Ye et al., 2010). Barriers are likewise created when health care providers do not speak ethnic languages (Chavez, Mcmullin, Mishra, & Allan Hubbell, 2001; UNFPA, 2008), or if health staff ignore poor and ethnic patients (UNFPA, 2008). Other factors that have been identified as creating obstacles to ANC visits include transportation costs (Campanelia et al., 1993; Pell et al., 2013 ; Ye et al., 2010), a perceived lack of safety on the way to receive services (Campanelia et al., 1993), and lack of health insurance (Chavez, Mchullin, Mishra, & Allan Hubbell, 2001).

### 2.3.3 Gender practices influencing ANC utilization

The low status of women and lack of independent decision-making power on health issues have a negative impact on ANC visits even when the woman in question has money and is aware of the advantages of early ANC attendance. The woman’s husband and mother-in-law also play an important role in the household’s decision- making (Butawa et al., 2010; Siharath 2009; Phoxay et al., 2001). Heavy workloads and childcare duties may also make early visits impossible (Bank & ADB, 2012; Josephine & Christine, 2000; Phoxay et al., 2001; Sychareun et al., 2009);(Campanelia et al., 1993). The abovementioned factors can play a role in

preventing pregnant women from accessing ANC services in the early stages of a woman's pregnancy.

### 2.3.4 Cultural beliefs influencing ANC utilization

Some studies conducted in Lao PDR found that pregnant women do not attend ANC services because they view being pregnant as a natural state of life (Sychareun et al., 2009). Women from some ethnic groups in the southern part of Laos believe that if blood emitted during delivery comes into contact with others, it will be bad for them and their baby, so the women from this group deliver their babies in the jungle by themselves, and consequently these women see no value in ANC visits (Phoxay et al., 2001). Women who practice Animism were least likely to attend ANC services compared with Buddhists (Phoxay et al., 2001), and similarly ethnic pregnant women from highland areas attended ANC services less frequently than ethnic women from lowland areas (Phathammavong et al., 2010). Some Lao women prefer to give birth at home (Sirivong et al., 2003; Sychareun et al., 2009) because they feel it is more comfortable and the chance for a "natural birth" is higher (Campanelia et al., 1993). Some ethnic Lao women practice food taboos (Phoxay et al., 2001), and herbal self-care for minor problems during pregnancy has been documented in other contexts (Sychareun et al., 2009).

Some studies in developing countries found that there were numerous cultural beliefs that women practice during pregnancy and childbirth, and those beliefs influenced their decision as to whether to attend ANC services or not. One study by Jody Rae Lori (2009) found that there was a kind of pattern of communication between elder women and pregnant women on the subject of childbearing. For example, elderly women often provided guidance or information on pregnancy and childbirth in order to make pregnant women undertake certain actions or behaviors. Her findings pointed out that the elders had high expectations that traditional pregnancy and childbirth practices should be maintained (Lori, 2009). Traditional childbirth practices were one of the areas of cultural and belief practices that continue from one generation to the next and which influence women's behavior and actions. Supernatural forces are also associated with pregnant women and influence the way they behave and act during pregnancy and childbirth (Lori, 2009). There is a distrust

of health care systems and an acceptance of the traditional healer (Lori, 2009), and some women give birth behind their house because they have no power and authority and because of a distrust of the health care system (Lori, 2009). Another study by Pranee Liamputtong et al. (2005) found that pregnancy and birth are considered to be embodied knowledge by women and that they perceive pregnancy as a natural process. Women use their embodied knowledge to diagnose their own pregnancy and, for example, observed changes to their body, such as enlargement or soreness of the breasts. In addition, embodied knowledge was used to predict childbirth, as well as dietary and behavioral precautions with food cravings, for example, a way to let them know they are pregnant. Some cultural knowledge is more symbolic and, for example, in some traditions pregnant women are not allowed to attend funerals during pregnancy and childbirth. Thus, these kinds of beliefs lead pregnant women to not seek health care during their pregnancy (Pranee Liamputtong, Susanha Yimyam, Sukanya Parisunyakul, Chavee Baosoung, & Nantaporn Sansiriphun, 2005).

## 2.4 Conceptual framework

Gender practices that adhere to the gender roles and norms among young women in Lao society, such as the necessity to work, a lack of decision-making power and low status in the family, may influence the utilization of ANC services. Secondly, local cultural beliefs and practices related to pregnancy and childbirth, such as the notion that since pregnancy and childbirth are natural elements of a woman’s life cycle that involve no risk, may also influence young pregnant women to not make use of ANC services. Thirdly, perceptions among young mothers-to-be about health care (e.g. lack of staff, poor quality, lack of equipment, etc.) may also discourage the use of ANC facilities.

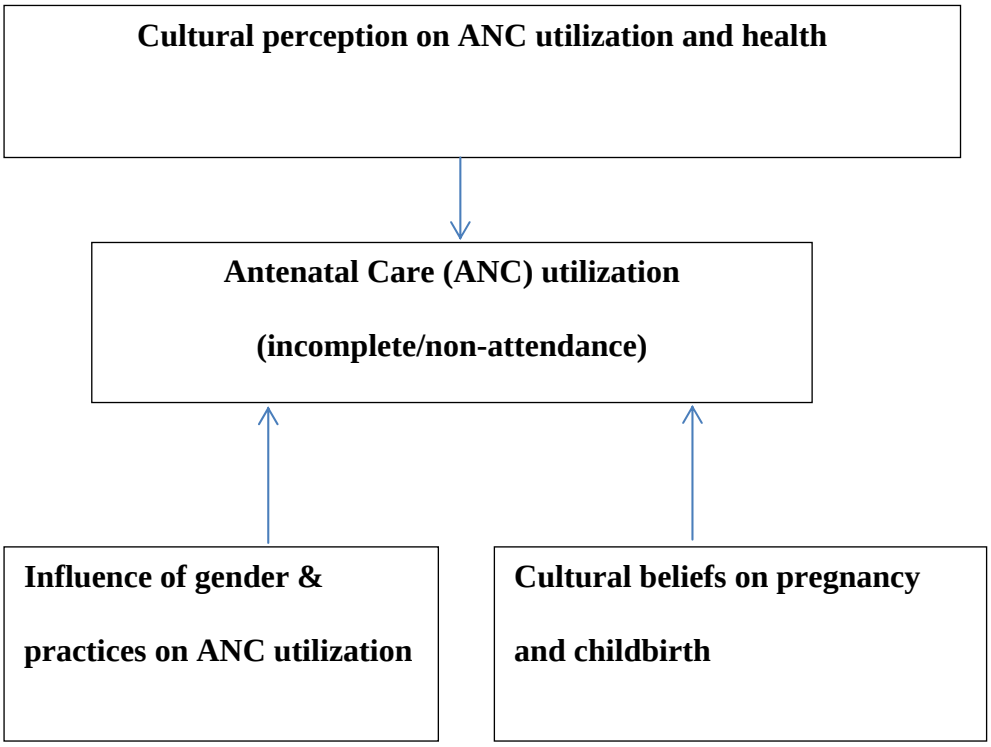


**Figure 2.1** Conceptual framework

# CHAPTER III
# RESEARCH METHODOLOGY

## 3.1 Research design

In this study I used a qualitative research design to explore cultural, experiential and behavioral aspects of adolescent pregnant women's lives, in particular their cultural beliefs, gender practices and use of antenatal care (ANC) services. The field study was conducted using an ethnographic approach consisting of participant observation, ethnographic and in-depth interviews together with semi-structured interviews as methods of data collection. Moreover, the ethnographic approach in this study allows me to understand the meaning of human actions and thought as demonstrated in the meanings given and practices related to pregnancy, and in particular to women's decisions regarding ANC utilization during pregnancy. Furthermore, the ethnographic approach allows me to understand in-depth studies, gain an insider's point of view, and to understand the social structural context of how cultural beliefs and gender practices influence the decision as to whether or not to attend ANC services. By examining the topics above through anthropological lenses, it also provides me with information on the significance of being a pregnant adolescent woman, and on the role of parents, husbands as well as other factors.

## 3.2 Research Site

**Luang Prabang province**

Luang Prabang was selected as the study site from among seven other provinces in the northern part of Lao PDR. The reason for this was because Luang Prabang has the highest number of pregnant women who give birth at home based on the assessment of skilled birth attendance in Lao PDR in 2008 by the Ministry of

Health and UNFPA (MoH/UNFPA, 2008). In Luang Prabang there were 324 births at home in contrast to 79 in Xayabouly province. Thus Luang Prabang made an appropriate study site as it has a high number of home deliveries. Therefore, the assumption was that Luang Prabang would also have a low rate of ANC attendance among pregnant women.

**Pak Ou district**

Pak Ou is one of 11 districts in Luang Prabang province. There were two reasons for choosing Pak Ou district. Firstly, a study done in Pak Ou in 2003 (Sirivong et al., 2003) found that there was a high rate of deliveries at home that were only attended by an untrained individual. Secondly, the author of this paper was personally acquainted with one of the health care providers in the district. The person in question is a medical doctor who works as a deputy at Pak Ou district hospital, and in the opinion of the author it would be possible to get help and support for the data collection part of the field study from her. Thus, Pak Ou was selected as the site for this study.

**Hatpang village**

Hatpang village is one of 50 villages in Pak Ou district. The reason for choosing Hatpang village was because according to a data report and advice from the health care provider at Pak Ou district hospital, the health care center at Hatpang had a low level of ANC utilization among pregnant women in the community despite the fact that the community has a health care center in the village. Therefore, Hatpang village is one of the research sites for this study.

## 3.3 Informants

### 3.3.1 Key informant selection criteria

**Pregnant women**

It proved possible to find only two young pregnant women (15-19-years-old) who were in their third trimester of pregnancy in the research village, so four additional young mothers who had a child under the age of one and who had not attended any ANC visits during their pregnancy were recruited. All of the women were willing to participate in the study after the purpose of the study was explained to them.

**Mother and father-in-law and husband**

Two elderly women aged between 50-64 and one old man aged 70 were recruited in order to gain a deeper understanding of reproductive health experiences and related cultural beliefs, as well as gender practices among young women. Those people were willing to participate in the study.

**Husband**

Two husbands of young pregnant women were recruited in order to gain a deeper understanding of what men believe and their practices while their wives are pregnant, since some young pregnant women did not reveal many details about their beliefs and practices relating to pregnancy and childbirth. Both of the men were willing to participate in the study.

**Health care provider**

Two health care providers, one female and one male, were recruited in order to understand how people utilize the health care center in the village and how health care systems work in the community.

**Trained traditional midwife**

Two midwives (aged between 50-61) were recruited to understand how the midwives provide support in the community and how people come to them for help and to make use of ANC services. Both of the midwives were willing to participate in the study.

**Village headman**

One village headman was recruited in order to gain greater knowledge and information about the history of the community, as well as information on gender practices and health utilization among young people in the community.

## 3.4 Entering the field

The first step in conducting the study was to get permission from Mahidol University Institutional Review Board (MU-IRB) and after permission was granted a letter together with a request form was submitted to the Ministry of Health, National Ethnics Committee for Health Research (NECHR) in Vientiane. After the Committee gave their approval, I immediately went to Luang Prabang province and the research areas. After reaching Luang Prabang during the first week of August 2013, it was necessary to prepare and submit a letter to the provincial health department and get their approval before commencing the field study. On receiving approval from the provincial health department, I travelled to Pak Ou district and informed the director of Pak Ou hospital about my objectives and showed him all the official documentation for the study. As part of the study, I stayed in Pak Ou district hospital for five days in order to observe and understand the pregnant women coming to receive ANC services at the hospital. The second aim was to observe and understand the perspective of professional health care providers who give services to pregnant women and other patients in the hospital. One important consideration was to work out which village to choose as the subject of the research, since Pak Ou comprises 50 villages. After spending almost a week at the district level, I finally chose a village called Hatpang after meeting one of the health care providers who works in Hatpang health care

center. In addition, I met a couple at the health center who lived in the village and they agreed to help with the data collection in the village. They introduced me to other people in the village whom I was able to ask about pregnant women and whether they had attended their ANC visits or not. After meeting one family in the village I conducted a snowball sampling method to help me find other pregnant women in the community.

## 3.5 Research methods

I conducted a snowball method as mentioned above to help me find other key informants in the community. The research methods undertaken included: field notes, participation observation, ethnographic interviews, as well as semi-structured interviews and in-depth interview (IDIs). In addition, after identifying the informants suitable for an in-depth interview (IDIs), their permission was obtained with respect to the time of the interview and privacy as well as, for example, the use of recording tools such as a voice recorder during the in-depth interviews. In-depth interviews were conducted with two pregnant women, four young mothers, three husbands, two mothers-in-law, one father-in-law, two health care providers, two midwives, and one village headman. The total number of key informants who participated in the study was 17, of which 12 were from the Hmong ethnic group and four were from the Lue ethnic group.

### 3.5.1 Note taking in the field

Field notes constituted a useful tool for helping to obtain a clear understanding during conversations, and for making observations with the informants and on other research sites in and around the village. Field notes were taken concerning any information relating to adolescent pregnant women on the basis of what the researcher saw, heard, smelt or felt during visits to the informants' homes. The notes cover every aspect of the community including the villagers' lifestyle, work relationships as well as pain during pregnancy.

### 3.5.2 Participant observations

Participant observation plays a very important role in ethnographic data collection. Observations were made of adolescent pregnant women as well as mothers and their interactions at work and activities at home, such as what they did and where they went in the community, which provided an understanding of what happens in the community. In this study, participant observations were used to observe cultural practices and beliefs relating to ANC attendance, and the relationship between young pregnant women and mothers and other members of their families.

### 3.5.3 Ethnographic interviews

Ethnographic interviews were undertaken with community members, including community members, and local healers. Ethnographic interviews in this research had two aims. The first aim was to gain information on the community's background, together with cultural beliefs and practices relating to pregnancy and childbirth, as well as the community's perceptions of ANC services and ANC service utilization among adolescent pregnant women. The second aim was to guide the researcher in choosing key informants for in-depth interviews and participant observations. Fifteen locals were chosen for ethnographic interviews, which took the form of conversations about daily life. The ethnographic interviews were conducted at several locations around the village such as in homes, kitchens, community gatherings, and streets, etc.

### 3.5.4 Semi-structured interviews

Semi-structured interviews were used to explore ideas from participants, especially elderly people, and to learn about their experiences as well as the meaning of cultural practices and beliefs influencing women's decisions on whether or not to utilize ANC services during their pregnancy. Semi- structured interviews took the form of conversations about daily life and the community, and were undertaken at various locations and times in and around the village, such as in homes, kitchens, community gatherings, on the street, in rice fields, and village shops, etc. For example, the researcher was introduced to a family by a couple the researcher had met at the health care center. The researcher visited the family at their house and explained the

purpose of the study on cultural beliefs and practices influencing ANC utilization during pregnancy and childbirth, and asked for their permission to conduct an informal interview with them as a semi-structured interview. The interview always started with very simple questions such as what activities the women do every day while or when they were pregnant. Did they observe any dietary restrictions, and what do other pregnant women do? Did they attend any ANC services? If they did attend ANC services, what do they think about ANC services in the community? Other questions related to cultural beliefs on pregnancy and childbirth and the perception in the community of using ANC services.

### 3.5.5 In-depth interviews

In-depth interviews (IDI) were used to explore the meaning of being a young mother, as well as the meaning of cultural practices and beliefs influencing women's decisions on whether or not to utilize ANC services. The aim of the interviews was to capture the interviewees' feelings about being a young mother, and their norms, beliefs, and perceptions about ANC visits and any health consequences. It was anticipated that a great amount of knowledge would be gathered on the research topic through this method.

Before conducting an interview, the purpose of the study was explained to the potential informants and they were told that they could withdraw from the study at any time they like, or did not have to answer particular questions if they did not want to. Each interview lasted at least 40-60 minutes and each informant was interviewed two or three times. A voice recorder was used during each interview if the informant consented to it. Notes were also taken on the informants' actions and feelings during the interview, as well as on the contextual aspects of each interview.

### 3.5.6 Review of secondary data

Secondary data was reviewed to ascertain additional information, and the sources used for secondary data included websites, books, and a literature review to support the data collected in this study.

### 3.5.7 Research tools

The research tools for collecting the data for the study were the following:

- Observation/in-depth/ethnographic/semi-structured interviews (adolescent pregnant women)
- Semi-structured interviews (husbands/mothers-in-law)
- Observation/in-depth/semi-structured interviews (midwives)
- Observation/ethnographic/semi-structured interviews (health care providers)

Community level: semi-structured interviews and participation observation (village headman)(see appendix)

Additional tools used during the study included a voice recorder, a camera and equipment for note taking. In order to secure the privacy and confidentiality of the participants, all the information obtained is kept in a personal file on a computer and will be destroyed when the study is finished.

## 3.6 Data processing and analysis

### 3.6.1 Data processing

All the information obtained and interviews were conducted in Hatpang village, Pak Ou district, Luang Prabang province. All the interviews, observation notes, voice recordings, and field notes were described and translated from Lao into English after the interview was finished.

### 3.6.2 Data analysis

In qualitative research, data collection and analysis form an ongoing process that starts from the first day in the field and ends when the study is completed. Ongoing case-by-case analysis moves conversations forward and creates new themes for discussion and analysis. During the period in the field, the researcher followed the key steps of data analysis as outlined below: firstly, the audio data and other information, such as information recorded from in-depth interviews, ethnographic

interviews, and observations, was expanded, presented, classified and interpreted and transcribed into a text format. All field notes were originally written in the Lao language and this was later translated into English. Secondly, as soon as any data became available for analysis, it was coded, noted, and dated in order to be able to make comparisons within and between cases. The data had to be arranged according to themes; and a hypothesis developed to extract meanings from the data, as well as to indicate any contradictions that may exist between the hypothesis and what is encountered in the field. In addition, any missing or incomplete information needs to be identified and followed up. The third step involved organizing the data so it can be mapped and interpreted to establish relationships between the data and codes with the help of diagrams. After this, all the raw data documents were entered into word processing software and the qualitative data analysis program ATLAS was used to complete the data analysis process. Finally, the data was double checked to see if there was any data not linked to the specific objective, conceptual framework, research question, and theoretical concepts in order to ensure the accuracy of the data sources and that the data is presented in the best way.

## 3.7 Validity of data

### 3.7.1 Data and methodological triangulation

Triangulation of data means collecting data through more than one method in order to improve the validity of the data. In this study, examples include observation, ethnographic interviews and in-depth interviews. Data from multiple sources are also more trustworthy than data from a single source. Therefore, in this study, data is not only included from adolescent pregnant women and mothers, but also from traditional midwives, ANC providers, and family members of adolescent pregnant women as well as mothers.

### 3.7.2 Building trust

Working with young women is a very difficult task, especially gaining their trust to be able to approach them and get them to participate in this study, and this is particularly so for young women from ethnic groups. The challenges faced included communication problems from young people who cannot speak the Lao language well and shyness in being open about their feelings towards pregnancy and childbirth. To deal with these challenges it was necessary to build trust before collecting data and to reinforce it during the process of data collection. In this study, trust was built up by visiting the participants every day at home and by joining in and helping them with some activities during the visit, such as helping with the cooking, or looking after their child. Another way to build trust was to take a picture of the participant and to have the photo developed to give to them and their family. In addition to this, some participants were given souvenirs such as Lao skirts for young pregnant women, Lao shirts for the husband or elderly men, and cookies for children in the family. All of these methods were tools to build up the trust relationship with the informants in the community, especially the key people. These trust building exercises worked well as during the home visits the young women and old people were welcoming and willing to share information, especially about their cultural beliefs, their feelings and the challenges they faced in their life during their pregnancy and childbirth.

### 3.7.3 Reflexivity

Reflexivity refers to personal reflections by the researcher about the study being conducted, the researcher's roles in it, and how these roles influence the outcomes of the research. Thus, I have reflected on how my personal circumstances and feelings may affect the research process and the subsequent findings. As part of the ethnographic research, the researcher became a member of the community that was being studied. The aim was to come across as a friendly, sharing, open-minded, good observer, and to be helpful to the informants. The researcher learned from the community as a whole and not just from the key informants, and this helped in avoiding any bias from preconceived ideas acquired before living in the community. The aim was also to become an insider in the community. As a part of this effort, the

researcher shared her own experiences about being pregnant and visiting ANC facilities, but was careful not to portray the ideology and methods of contemporary medicine as being superior to the ways of the village, and to avoid biasing the data gained.

## 3.8 Ethical considerations

In social science, research should contribute to human well-being and not harm the informants of the study. If care is not exerted, social science research can easily harm the group being studied. Consequently, ethical issues need to be taken into consideration. Four dimensions are considered in this study: privacy, confidentiality, informed consent, as well as benefit and reciprocity.

### 3.8.1 Privacy

Upholding informants' privacy may require involving the informants themselves in decision-making about issues like the place to meet, the way information is exchanged, and what information can be made public and what cannot. All the interviews for this study were conducted in private spaces where nobody could overhear the conversation.

### 3.8.2 Confidentiality

Confidentiality is a key ethical concern in social science research. It means keeping secret private information about the informants. During the period of trust-building, informants were assured that if they gave private information it would be kept confidential. It was agreed that the informants will not be described in the thesis or subsequent publications in a way that could reveal their real identity. Pseudonyms are used to replace their real names and all raw data collected with a voice recorder and notebook, as well as resulting interview transcripts, are kept securely and will be destroyed after completion of the study.

### 3.8.3 Informed consent

Informed consent means that potential informants receive a comprehensive, unbiased and clear explanation of the purpose and process of a given study, and then make a free decision whether to participate or not. For this study, potential informants were given information such as an explanation about the processes and aims of the study, and they were then asked to decide on the basis of this information whether they wished to participate. Participation was voluntary and no coercion or pressure was exerted.

### 3.8.4 Benefit and reciprocity

In general, research studies must not harm participants, and should have potential benefit either to the participants directly or to a group of which the participants are members. This study has potential to make ANC services more accessible and useful to the reference group of the key population being studied (adolescent pregnant women in rural Lao PDR) through increasing understanding about the barriers that currently impede the use of these services, which in turn could improve health outcomes for the women and their children. The women in this study were given information about ANC visits at health care centers and in hospital, as well as information about vaccinations, how a pregnancy is monitored through checkups with ultrasound, together with more general knowledge about pregnancy and childbirth.

## 3.9 Definition of Antenatal Care (ANC) utilization

ANC visit in this study means that a young pregnant woman makes either four ANC visits or at least one visit during the pregnancy. ANC visits should take place as follows: the first visit at 8-12 weeks, the second visit at 24-26 weeks, the third visit at 32 weeks, and the fourth visit at 36-38 weeks of pregnancy and the services should be provided either at a health care center or in a hospital.

## 3.10 Definition of gender practice

Gender practice in this study refers to understanding the roles and responsibilities between men and women in their community. Of particular importance is understanding the role of men and women, in terms of work in the household and in their daily lives within their community, and as well to understand the differences in term of norms, behavior, and the social life of both genders in the community.

## 3.11 Background of research site

The Lao population is a young population that is estimated to total 6.2 million, with only 32% of the population living in urban areas (WHO, 2011). Lao PDR is located in the Indochina Peninsular (Mekong region), and the country has borders with China in the north, Cambodia in the south, Vietnam in the east, as well as Thailand and Myanmar (Burma) in the west and northwest respectively (see Figure 3.1). The capital of Laos is Vientiane.


**Figure 3.1** The capital of Lao PDR is Vientiane

Sources: .Source: https://www.unodc.org/laopdr/

Lao PDR is divided into three regions based on a geographical and economic development standpoint as follows: 1) the northern region, which is composed of 7 provinces: Phongsaly, Luangnamtha, Oudomxay, Bokeo, Luang Prabang, Huaphanh and Xayabury; 2) the central region with 6 provinces and 1 special region: Vientiane Municipality, Xiengkhuang, Vientiane province, Borikhamxay, Khammuane, Savannakhet, and Xaysomboon Special Region; and 3) the southern region with 4 provinces: Saravane, Sekong, Champasack and Attapeu.

### 3.11.1 Luang Prabang to Vientiane

The distance from Luang Prabang province to Vientiane, the capital of Laos, is 390 kilometers. There are two ways to reach Luang Prabang province: either by air or by car following the main route No 13. It takes around 40 minutes to reach Luang Prabang from Vientiane by domestic flight, while the journey by car takes around 9-11 hours because the road is in a poor condition and is also relatively narrow with sharp curves**,** especially in the mountainous areas.


**Figure 3.2** Map of Lao PDR showing Luang Prabang province and Vientiane
Source: http://ldpa.org.la/?page_id=6

### 3.11.2 Luang Prabang province to Pak Ou district

The distance between Luang Prabang province and Pak Ou district is about 30 km, or around 35 minutes by car or motorbike. Please see Figure 3.3: Map of Luang Prabang and Pak Ou district


**Figure 3.3** Map of Luang Prabang province and Pak Ou district

Source: http://www.ecotourismlaos.com/images/map/lpq/lpq_bg.jpg

### 3.11.3. Pak Ou district and Hatpang village

The distance from Pak Ou district to Hatpang village is around 32 kilometers and takes around one hour by motorbike to reach the village. Please see the map of Pak Ou hospital and Hatpang village.

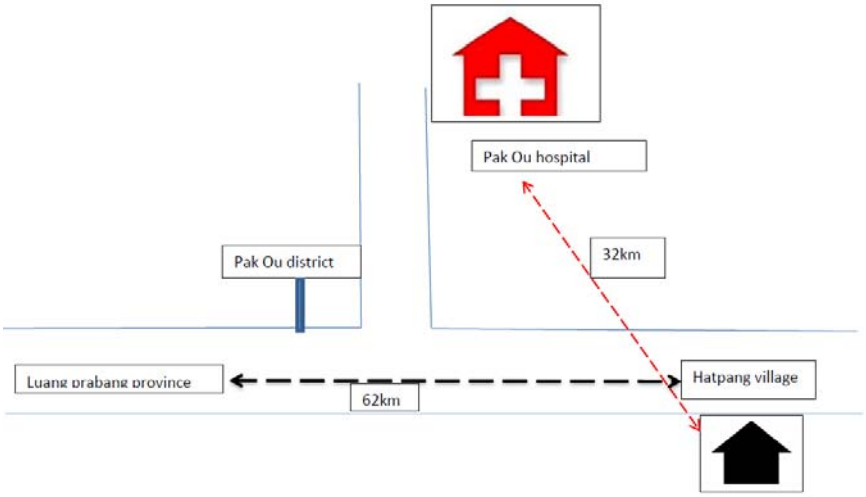


**Figure 3.4** Map of Hatpang in relation to Luang Prabang province and Pak Ou district hospital

**Table 3.1** Profile of the participants to maintain confidentially, all the participants' names have been changed in this study.

| No. | Name | Age | Religion | Educational status | Ethnicity | Type of family | No. of children |
|---|---|---|---|---|---|---|---|
| **Village headman** | | | | | | | |
| 1 | SomIn | 60 | Buddhism | Primary grade 2 | Lue | 1 | 6 |
| **Health care providers** | | | | | | | |
| 1 | Tong Seng | 30 | Buddhism | Diploma in primary care | Lue | 1 | 1 |
| 2 | Seng | 24 | Buddhism | Diploma in primary care | Lue | 1 | 0 |
| **Trained traditional midwife** | | | | | | | |
| 1 | Kounfon | 50 | Buddhism | Primary grade 3 | Lue | 1 | 4 |
| 2 | Sengchone | 61 | Buddhism | Primary grade 2 | Lue | 1 | 4 |

**Table 3.1** Profile of the participants to maintain confidentially, all the participants' names have been changed in this study. (cont.)

| No. | Name | Age | Religion | Educational status | Ethnicity | Type of family | No. of children |
|---|---|---|---|---|---|---|---|
| **Adolescent pregnant women** | | | | | | | |
| 1 | Young Mo | 18 | Spirit Religion | Uneducated | Hmong | 1 | 3 |
| 2 | Soo | 19 | Spirit Religion | Uneducated | Hmong | 1 | 2 |
| **Young mothers** | | | | | | | |
| 1 | Jing | 19 | Spirit Religion | High school grade 6 | Hmong | 4 | 2 |
| 2 | Joua | 19 | Christian | High school grade 6 | Hmong | 1 | 2 |
| 3 | Navilay | 19 | Spirit Religion | Primary grade 3 | Hmong | 4 | 3 |
| 4 | Sem Li | 19 | Christian | Primary grader 2 | Hmong | 1 | 2 |
| **Husbands** | | | | | | | |
| 1 | Ketsa | 30 | Spirit Religion | High school grade 6 | Hmong | 1 | 3 |
| 2 | Nakor | 30 | Spirit Religion | High school grade 6 | Hmong | 4 | 2 |
| 3 | Kam | 20 | Spirit Religion | Primary school grade 2 | Hmong | 4 | 2 |
| **Mother-in-law** | | | | | | | |
| | Jelai | 50 | Spirit Religion | Uneducated | Hmong | 4 | 6 |
| 2 | Me | 64 | Spirit Religion | Uneducated | Hmong | 4 | 11 |

**Table 3.1** Profile of the participants to maintain confidentially, all the participants' names have been changed in this study. (cont.)

| No. | Name | Age | Religion | Educational status | Ethnicity | Type of family | No. of children |
|---|---|---|---|---|---|---|---|
| **Father-in-law** | | | | | | | |
| 1 | Jai | 70 | Spirit Religion | Primary grade 2 | Hmong | 4 | 15 |

Note – type of family: 1 = 1 family, 2 = 2 families, 3= 3 families, 4 = nuclear family

**Table 3.2** List of women who make ANC visits during pregnancy and childbirth

| No | Name | Age | Visit ANC services at health care center/ hospital |
|---|---|---|---|
| 1 | Young Mo | 18 | 0 |
| 2 | Jing | 19 | 0 |
| 3 | Joua | 19 | 4+ |
| 4 | Soo | 19 | 0 |
| 5 | Navilay | 19 | 1 |
| 6 | Sem Li | 19 | 0 |

# CHAPTHER IV
# RESEARCH FINDINGS

## 4.1 Community setting

The community was surrounded by hills, mountains, jungle, a river, rice fields on hilly land, paddy fields, and some other agricultural crops that people need in their daily life. There were two ethnic groups in the community: the Lue and Hmong/Lao Soung ethnic groups (see figure 4). Hmong and Lue people live together but are located in different zones. The main road No. 13 North acts as a border between the two groups. The Hmong group lives on the other side of the main road. The Hmong village is mostly surrounded by hilly land and forest and a small stream passes by the village. The Lue group lives on the other side of the main road and their community is mostly surrounded by lowland, forest and a small stream passes by the village as well. The two groups are very different in the way that they live and have different practices, health beliefs, education, and gender roles in the community.

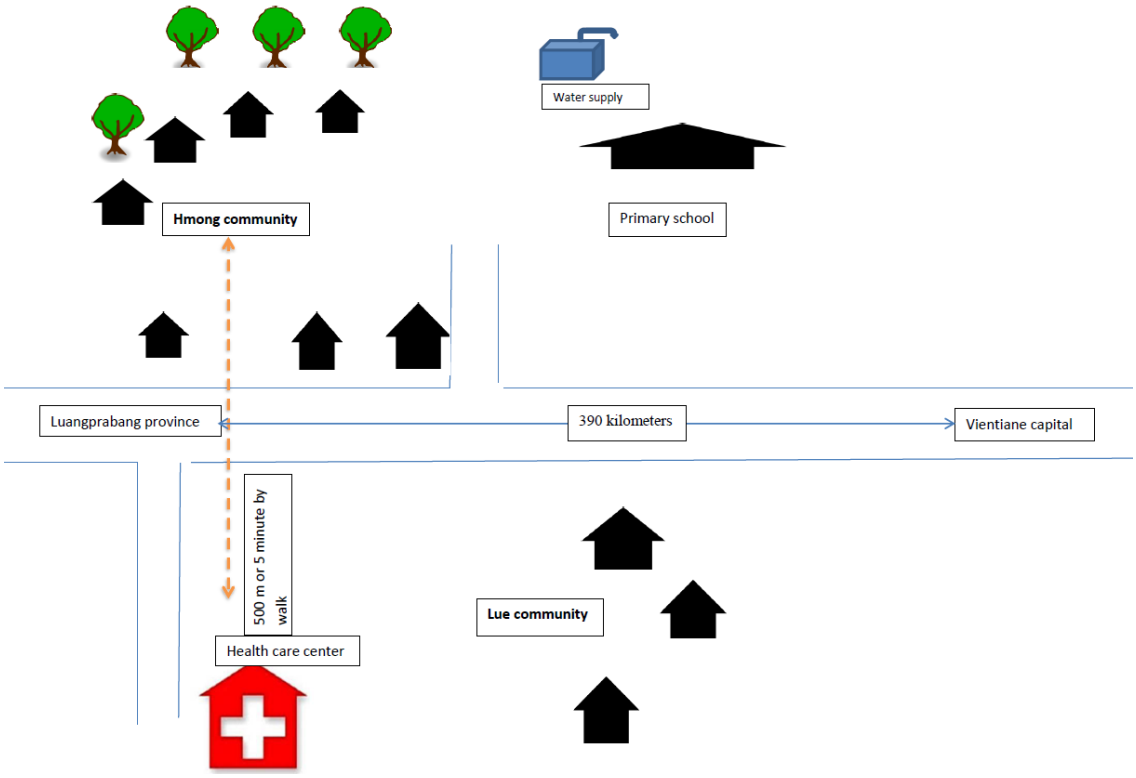


**Figure 4.1** Map of Hatpang village in the community

The Lue community covers a larger area than the Hmong community. There have been a lot of changes in the way Lue people live compared to the past. Before 1975, when Laos became independent, in general Lue houses were mostly built of wood and had a roof covered by grass or bamboo trees, and the house normally had only one floor. However, since independence, Lue houses in the community are more likely to be built with two floors (see the picture ). The ground floor is mostly built of bricks or stone and the second floor of wood. However, most of the houses in the research community were made of wood and brick. In addition to the actual style of the houses, the number of family members has also dropped and does not usually exceed more than 5-6 people in one household.

**Figure 4.2** New style of Lue house: Two floors with wood and brick. Photo by Phonesavane Sivialy

The Hmong community covers a smaller area than the Lue community. A traditional Hmong house has one floor, and the walls of the house are built of wood or bamboo tree and covered by grass or bamboo. However, since independence there have been some changes although not many. For example, there is still usually only one floor but concrete is also used. The walls of a house are built of brick, stone or some wood, and the roof will be covered by magnate or concrete. However, the style of new houses takes the form of small houses in the community and mostly the houses follow the same traditional pattern (see figure 6).

The size of a typical Hmong family has changed too. In the past, a Hmong family would have more than 10 people and be more like an extended family. One household would consist of 2-3 families, but nowadays the size of a Hmong family has changes and dropped to about 4- 6 people in one household. In the research community there are still 15 families living as a nuclear family in the Hmong community.

**Figure 4.3** Traditional Hmong house. Photo by Phonesavane Sivilay

**Figure 4.4** Style of new house made of wood, brick and magnate roof Photo by Phonesavane Sivilay

The government plans to enhance the quality of life of people in the community and help them have a better life, and therefore in Hatpang village the government is involved in the ongoing development process. In the past two to three years, Hatpang community has received several awards at the provincial and district levels, including the award for Hatpang Ban Pat Tha Na (Hatpang development village)(Figure 8); and Ban Hatpang Yut Ti Kaan Thang Pa hed Hai Pouk Kao Bep Leurn Loy, Pot Ka Di (which translates as Hatpang village has stopped shift cultivation and has no illegal drugs in the community); Ban Sa Tha La Na Sok Bap Yang (model sanitation village )(Figure: 9); Ban Vat Tha Na Tham (model cultural village); Sa Ha Pan Mea Ying Sam Di (three principles of a good woman union organization); Hat Pang Ban Sam Sa At (Hatpang has three principles for a clean village)(Figure: 10)


**Figure 4.5** Village sign: Photo by Phonesavane Sivilay


**Figure 4.6** Village sign: Photo by Phonesavane Sivilay


**Figure 4.7** Village sign: Photo by Phonesavane Sivilay

## 4.2 History of the community

Hatpang community has been located at several places. At first, Hatpang village was settled along one side of the Ou river, and at that time there were only a few households in the community. However, later on more people came to live in the community but there was not enough land to support everyone, so the villagers decided to move to the other side of the Ou river. However, although the villagers had moved to a larger land area, they felt that they were living too close to the river

boundary because the villagers had difficulty during the rainy season because the soil along the river became eroded. Moreover, during that time many children died as a result of the strong river current. Therefore, the villagers decided to move further away from the river to where it is nowadays.

In the past, there was no road transportation to Hatpang village, and people either had to travel by boat or walk. However, in 1997 the main road No. 13 north was completed. Improved transportation links allowed the villagers to have better connections with other villages and at some point a Hmong group came to live in the community. Merging ethnic minorities is one strategy of the Lao government to enhance accessibility of ethnic minorities to services that they would not otherwise be able to reach because of long distances. Therefore, the community ended up with two ethnic groups living together. However, some other villages have more than two minorities.

## 4.3 Demography

The community of Hatpang village is one of 50 villages in the Pak Ou district. It is located in the northern part of Laos. The northern part of the village is connected to Nam Bark village, and the southern part of the village is connected to Kok Hun village. The eastern part of the village is connected to Kiend village, and the western part of the village is connected to Houay Mak village, and finally the southwest part of the village is connected to Houay Paan village. There is a river running from the north to the south of the village called the Ou river, which passes by the village between Houay Paan and Kiend villages. Hatpang village has 313 households and a population of 1,493, comprising 700 females. Fifty-two households are from the Lao Soung ethnic group and 261 households are from the Lue ethnic group. Three religions are practiced in the village: Buddhism, Spirit Worship and Christianity. Lao Soung people are mainly spirit worshippers, and only seven families in the Lao Soung group are Christians. The Lue ethnic group mostly practice Buddhism.

The community has 3,537 hectares of land in total, which breaks down as follows: 165.64 hectares (ha) of rice areas; 148.50 ha of forest areas; 138.63 ha of agricultural crop areas; 320.16 ha of innovation forest; 285 ha of preserved forest; 1,547.62 ha of protected forest; 449.63 ha of animal fields; 29.71 ha of household areas; 114.40 ha of water stream areas; and 36.25 ha of fruit tree areas.

Hatpang community is connected to 9 villages, and this type of community is called a Kum Ban (a village group). The village group includes the following villages: Hatpang, Hat Kea, Kiend, Hat Kang, Kok Han, PhaanNai-Phaan Nork, Nonsavanh, Houay Mak, Hoauy Yan. The village group has an annual meeting where the activities of the group are decided and issues can be settled. This is also the forum to discuss the government's plans both at the provincial and district level.

Hatpang village has electricity and a treated water supply that the whole community can use. However, the water supply does not have a machine pump but is a holding tank just to keep water from the stream that passes by the community from the high hill. There are in fact two water tanks located in different places; one tank is located at a temple and the other tank is located in the Hmong community.

Hatpang community has one temple but has no marketplace although people sell food, vegetables and other items along the main road.

The economic structure and situation in the community is at an average level if compared with other villages and village groups. People mostly work as famers and mainly grow paddy rather than engage in upland rice cultivation. However, nowadays more people are engaged in business than become farmers and grow agricultural crops or trees to sell as cash crops, or alternatively open a small shop, or sell food. Some people provide transportation services such as truck services, or provide other shipping services in the community. Furthermore, some people have left home to look for a job in the province to earn income after they finish upland rice planting.

According to the observations of the researcher and interview with the village headman, it was clear that in general the economic situation of the Lue group in the community was better and they were wealthier than the Hmong group because most Lue have businesses and grow crops for the market in contrast to the Hmong, who are dependent on shift cultivation and some livestock for their income.

In terms of education in the community, most people in both ethnic groups have finished high school, and only a few people in the community had graduated with a bachelor's degree. The community has two schools: a primary school with two teachers and an upper secondary school with 11 teachers. In summary, the Lue ethnic group has a higher level of education than the Hmong because of better accessibility to education in the community.

## 4.4 Health care system in the community

The community has one health care center, which in the local language is called Souk Sa La Hat Pang. It is located in the Lue community (see Figure 3.5). There are three health care staff who provide health care services in the community, of which two were male and one was female. The first man, Tong Seng, is 30-years-old and he is head of the health care center and he has been working at the health care center for eight years. His main tasks include providing primary medical care and general treatment. In some cases if the diagnosis is difficult to make or he cannot treat the patient, he advises the patient to see a doctor at the hospital. The second health care staff worker is called Sone. Sone is 27-years-old, and he is a project staff supported by the Health System Development Project, and has been working at the health care center for two years. His main task is to dispense medicine, and is responsible for the medicine supply not only at the health care center but also in the community if they go on a field visit. The third staff member is female, and her name is Seng. She is 24-years-old, and she is also a project staff member supported by the Health System Development Project and has been working at the health care center for two years. She is responsible for the maternal and child unit, and is a volunteer staff member from the Save the Children project. Her main function is to provide maternal and child health services, as well as to monitor and report on pregnancy and childbirth in the community. The three health care workers are responsible for one zone comprising five villages including Kokhan, Houay Phaan, Kiend, Houay Kang, and Houay Mark villages. They have to visit all of these villages on a regular basis to provide health care services, such as health care information, vaccinations and other

health care related services. Hatpang village has a health care center, but two midwives have been available in the community for a long time. The first midwife is Mrs. Sengchone, and she is 61-years-old and has four children. She said that she finished grade 2 of primary school but became a midwife when she was about 16-17-years-old. The reason she became a midwife was because her father was the village headman, so she got the opportunity to gain midwife training at the provincial level. After she finished the training she continued to work as a midwife. She explained that in the past she helped a lot of women deliver children because at that time it was very difficult to access health care facilities. However, nowadays she has stopped helping because her husband died and her health was not good because she was old, and in addition the new generation are not interested in midwives. Moreover, the health care facility was easier to reach than before, so now a lot of people go to hospital instead of seeing her. The second midwife, Kounfon, is 50-years-old and she has four children. She said that after she finished grade 3 of primary school she continued with education in primary health care for two years. She explained that she stopped working as a midwife because she is old and no one is interested in midwives. Nowadays most young people look for a job in the province so not many stay in the village or become midwives. Furthermore, since the services were free of charge she mostly helped people who were poor who did not have money to give birth at the hospital or attend health care facilities.

Even though there is a health care center in the community, several other projects were being supported covering a wide range of health issues. For example, the Global Fund had a tuberculosis (TB) project, UNICEF was supporting vaccinations, the Health System Development Project focused on prevention and cure at the primary level, and Save the Children were encouraging pregnant women to utilize ANC services and give birth at the health care center or in hospital. However, the number of people who came to utilize the health care center was low. Seng reported that few women came for ANC visits, and even though the number increased every year the figures still remained low. For instance, according to a data report from 2011, the number of women attending a checkup for their first ANC visit was 92, and deliveries at health care center numbered just three. In the following year, 2012, 101 women attended a checkup for their first ANC visit but only four people gave birth at the

center. The figures for 2013 were 97 people attending their first ANC visit and five people giving birth at the health care center. These figures surprised the researcher while in the field, however, after meeting all the key informants in the community it became apparent to the researcher that the largest group of women who did not make ANC visits during pregnancy and childbirth was from the Hmong ethnic group. Therefore, the target group of this study was the Hmong/La Soung ethnic group and the aim was to understand and find out the cultural beliefs and reasons that prevented these women from attending ANC services. Before presenting the findings concerning the Hmong ethnic group, the paragraphs below provides some background on the beliefs of the Hmong community in Hatpang village.

## 4.5 History and migration of Lao Hmong

According to the Laos Country Report 2012, Laos is the most ethnically diverse country in Southeast Asia (Bertelsmann Stiftung, 2012). Although Laos has officially recognized 49 ethnic groups, most ethnic groups are normally divided into three major groups based on their prototypical location (government, 2006). The Hmong are one of the three major ethnic groups in Laos, and the Hmong together with other highland groups are officially referred to as *Lao Soung* (‘Lao of the mountain tops’) because they traditionally lived in areas located above 3,000 feet. The second major group is referred to as *Lao Loum* (Lao of the lowlands),and they traditionally live in lowland areas bordering the Mekong river. The last group is the *Lao Theung* (Lao of the mountain slopes) and they traditionally lived at lower mountain elevations and speak Mong-Khmer languages (John Duffy, Roger Harmon, Donald A. Ranard, Bo Thao, & Yang, 2004).

The origins of the Hmong are obscure and the subject of speculation and debate. However, because the Hmong retain cultural traces from the earliest forms of Chinese social organizations, some anthropologists have considered them to be among the aboriginal inhabitants of China, where about four million of the world’s six million Hmong still live today. Under French Colonialism, the Hmong first began migrating to Southeast Asia around 1800, to areas that are now Vietnam and Laos. However as

Hmong immigrants found that the best land at lower land levels was already occupied they built small villages high in the mountains (John Duffy et al., 2004).

In Laos there are still around 315,000 Hmong residing in the country, although the Hmong are also distributed in other countries such as in southern China, as well as an estimated 500,000 in Vietnam, 120,000 in Thailand and pockets of Hmong communities in Myanmar. Furthermore, an estimated 170,000-186,000 Hmong have resettled in United States (CDC, 2008; John Duffy et al., 2004). There are two groups of Hmong in Southeast Asia: *Hmong Der* (White Hmong) and *Mong Leng* (Blue Hmong) and both groups are distinguished by differences in language and customs. However, both groups are able to understand each another, and in Laos the two groups have a long history of intermarriage and harmonious relations (John Duffy et al., 2004).

## 4.6 Hmong/Lao Soung group in Hatpang community

Hatpang village is located in the northeast part of Lao PDR, and is a small village with only 52 households. The village still has 10 households that live in an unclear family structure. The village is surrounded by forests, trees, and mountains. La Soung were moved and settled in the village in 2001. During the first wave of immigration only five householders were moved from Houay Yen village, although later more households were moved. In the past, the Hmong household structure would likely include 2-3 families living together as an extended family. However, since the village is participating in an ongoing development process in accordance with government policy, the number of Hmong family members in a single household has dropped and the families live as a single unit in order to get a land certificate from the government. However, most men still prefer to have many children as they believe that they need labor to help with the family's work. There are still some households that did not receive enough land to grow rice, so they have to go back and work in their old village, which is very far from the community.

In terms of housing in the community. most households require fire wood, which they need for cooking, and some have a garden where they grow vegetables for

household consumption. A few households had poultry although people mostly kept poultry on rice fields. However, some families also had pigs and hogs.

All households had a toilet and electricity, although not many households had a TV, refrigerator, or fan. Most households use electricity just for lighting purposes.

One primary school is located in the Hmong community and there is one main road that is used to access the community. However the road was inconvenient to use during the rainy season because it was dirty and muddy.

The village has more than five shamans (spirit religion) that the villagers consult in relation to their health, and one village headman.

## 4.7 Overview of Hmong /Lao Soung culture and research findings

This section provides an overview of Lao Soung culture in term of ethnicity, language and communication, religion, education and literacy, food, courtship age and reproductive ideology. Other topics covered include family socialization of boys and the role of girls in Hmong communities, the mobility of men outside the community to earn income, the reproductive health status and problems of young women, and finally the research findings of this study on cultural beliefs and gender practices affecting ANC utilization among adolescent pregnant women in the Hmong community in Hatpang village.

### 4.7.1 Ethnicity, Language and Communication

As was mentioned previously (in the history of Hmong), the Hmong/Lao Soung ethnic group is one of the three major ethnic groups in Laos. The Lao Soung have their own language, and most of the participants did not know where the language originates from, although some refer to it as Pha Sa Lao Soung (the Lao Soung language). The literature review found that the Hmong in the United States speak one of two distinct dialects of the Miao-Yao language: White Hmong (Hmong Der dialect) or Green Hmong (Mong Leng Dialect). In Laos, there is no official preference for one dialect over the other, although White Hmong seems to be favored.

Most Hmong dictionaries only include the use of White Hmong, and the Hmong writing system (Romanized Practical Alphabet) is closest to the pronunciation of White Hmong. Green Hmong speakers are more likely to learn White Hmong than vice versa, and the younger generation is more likely to speak White Hmong (Centers for Disease Control and Prevention)(CDC, 2008). In the research village most people use their local language to communicate with each other. However, if they have to communicate with outsiders they use the Lao language. Most men can speak the Lao central language very well because most Hmong/Lao Soung men have a higher level of education than women. However, even though women receive less education some can still speak the Lao central language, especially older people, who often communicate with others outside the community.

### 4.7.2 Religion of the Hmong

The Lao Soung originally were spirit worshippers or practiced animism, and they believe that boys have a spirit that comes from the soul and that if a household has a boy then there will be happiness in the family. According to Hmong custom, men can bring their wife to live with their parents after marriage and the wife must look after the parents until they die. In contrast. daughters can live near the parents but have to live their own house.

The Hmong have two religions that they practice: Christianity and spirit religion. Some are Christian because during the second half of the 20th century, missionaries came to Laos and many Hmong were converted to Christianity before emigrating to the United States and other resettlement countries (CDC, 2008). Thus Christianity is the second alternative religion alongside spirit religion. Therefore, Hatpang village has seven households that practice Christianity in the village.

### 4.7.3 Education and literacy

Education is the main government policy tool for reducing illiteracy in the country. However, Laos still faces many constraints in the country’s overall development such as poverty reduction, as well as education. According to the results of the National Literacy Survey in 2001,the disparities between gender and different ethnic groups in terms of the literacy rate for the 15-59 age group was 45% for men

and 30% for women. However, the differences were greater by language family and were 56% for men and 48% for women of the Lao-Tai Language family; 36% for men and 23% for women of the Mon-Khmer language family; 26% for men and 16% for women of the Sino-Tibetan language family; and 39% for men and 12% for women of the Hmong-Iu-Mien language family (Outhaithany, 2011). This highlighted the fact that men in the Hmong group receive a higher level of education than women. A similar result was identified in this study such that of eight Hmong women only two had finished high school to grade 6. Moreover, some children in the community attended school less frequently during the rice cultivation season because these children had to accompany their parents to the rice field and work for the household in upland rice planting. However, some families left their children to be looked after by elderly people while their parents were away from home.

### 4.7.4 Food

Food is very important for the family, and most food is prepared by women. In some families both the men and women take care of preparing food but in different ways. Some men like to hunt wild animals in the jungle or collect wild vegetables. Women like to collect vegetables from their garden. However, the main household staple is rice. The researcher was invited by a young couple, Jing and Kam, to have dinner with their family, and Jing prepared a dish called Kao Het (fire pork with mushroom ). The Keo Het contained mushrooms and pork and was eaten with white rice and water instead of soup. Kam told me that normally Lao Soung traditionally eat what they can find in the household, and this normally means vegetables, bamboo shoots, mushrooms, wild vegetables, chicken, pork and other types of meat.

The family's older brother told the researcher that people mostly eat only vegetables and water. He explained that the reason why people eat rice with water was mostly because the Lao Soug eat Kao Jao (white rice) that is sticky and difficult to swallow, so it has to be eaten with water to help them swallow it more easily, and the other main reason is because they are poor. However, even if they have vegetables or meat they will still have water with every meal. As the elder son of grandfather Jai said:

*"oh, honestly I can say that Lao Song people are poor and lack food to eat, and mostly they eat only vegetables and water. Many people say that the Lao Song eat Kin Kao Kup Nam (eat rice with water) because basically it is the truth. The reason we eat white rice with water is because the rice is sticky and will stick in our throat when we swallow it, so water will help and make it easy to swallow. Every meal has to be eaten with water even if we have some vegetables or meat."*

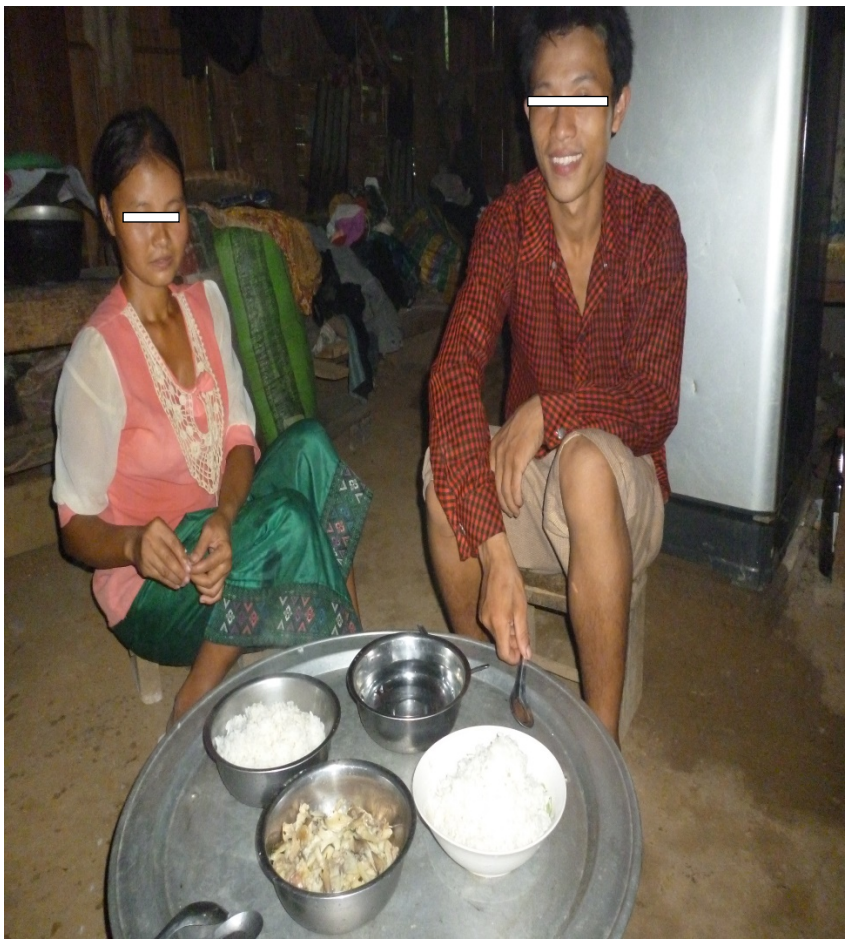

**Figure 4.8** A normal meal includes rice, water and fired mushroom with pork Photo by Phonesavane Sivilay

### 4.7.5 Courtship age and reproductive ideology

Men and women look for a partner at a very young age and are around 14-15 when they start to meet each other. There were many different courtship scenarios between young women and men including the following 1) the couple marry before having sex; if a girl and a boy love each other they will ask the parents to come to the girl's house and ask for their permission to marry, 2) having sex before marriage; if a girl and a boy are in love and then run away from home for a few days this means those people become husband and wife, and then both the boy and girl have to ask permission from and apologize to the girl's parents in order to follow their custom and organize the wedding, 3) forced marriage, if the girl does not like a boy but that boy really wants the girl, the boy might ask for permission to marry the girl and if the parents like him and agree, the girl cannot refuse her parents. In the community, there are certain occasions that help young couples to potentially meet, such as the New Year festival, weddings, and of course at school and other places. If the boy falls in love with a girl, he will try to visit and court her until she accepts him.

In the past, the wedding of Hmong took many days to celebrate, however, because the economic situation and times in general have changed, nowadays the wedding ceremony just takes one day. The wedding will take place at the bride's house and all the close relatives of both the groom and bride are invited to take part. There will also be a person to chant as well as someone to officiate the wedding ceremony. At the wedding ceremony there will be food, usually chicken and pork, and some soft drinks, which will be served at the home of the bride's family.

At the wedding ceremony, the person who does the chanting makes two key announcements. The first announcement is for the bride and groom when they become a new couple, and they follow the Hmong custom by both of them paying respects to their parents by bowing their heads to receive their parents' advice and blessing to have happiness in their new family. The second announcement is to announce the price of the bride to her parents and that their daughter will be leaving to live with her husband's family, which means that as of that day she no longer belongs to her parents. The blessing from grandparents and elderly people is mostly for the groom and to ensure happiness and wealth in the family. Women are advised that they have to love and obey their husband, and also to respect and obey their mother and

father in-law. The marriage ceremony is very meaningful for Lao Soung people because they believe that if someone does not have a wedding ceremony or follow their traditional customs, the couple will not be accepted as husband and wife. Furthermore, after getting married women are expected to have a child as quickly as possible so she can bring happiness to the new couple by producing a new family.

**4.7.6 Family socialization of boys and the role of girls in a Hmong community**

The gender role of boys and girls in Hmong society is dominated by boys and girls from the moment they become a fetus. One old man (grandfather Jai ) told the researcher that in Hmong custom a child is very important because children will take care of their parents when they get old and work for them as they grow up. Thus, many Hmong men and women prefer to have children as quickly as possible after they get married, and especially hope for a boy first. This is because the Hmong believe that a boy has spirit that comes from their soul, while a girl does not have one. However, both boys and girls are needed for family labor.

In childhood, there are differences between boys and girls in terms of their roles and responsibilities. Girls are taught that they need to be active but also be patient because the Hmong believe that by being active and patient, it will help girls to gain respect in the family, and girls with an active manner are less likely to find disfavor from the family of her husband. Therefore, many girls have to help their parents while they are still a child and do domestic work, as well as work in the rice fields and take care of younger children in the family. For boys in a Hmong community, they are taught be an active as well, although their focus is more on food production, earning money and being the leader of the family. Therefore, many boys are not concerned about domestic tasks as they believe household tasks are the responsibility of the girl. In general, boys will help with rice cultivation, join their father in earning money and hunting for food for the family. However, in terms of child care, generally the eldest boy and girl in the family will look after younger siblings instead of the parents if they are away from home to work or are working in the rice field.

Education is important for both boys and girls. However, not many girls get the opportunity to attend school if their family is poor or there is insufficient labor to work in the household. Boys are given a higher priority in terms of getting an education, since in Hmong society the man has to be the head of the family, and as such is responsible for the family, especially for earning money and communicating with people outside the family.

Boys and girls in Hmong society get married at a very young age. Most boys and girls get married between the age of 14-15-year-old, because they believe that at this age they are still beautiful, strong and healthy so they can start a family. They believe that if people get married early they can be happy at an early age. One young man (Ketsa) told the researcher that he got married when he was 14, and he would rather have children as quickly as possible because he said that if he has children when he is about 14-15-years-old his children can help him work by the time he reaches 30. This way he can work less hard than before because his children can help him. He also explained that if they get married when they are older they would have to work until they are older when it will be more difficult for them because they will not have much energy.

In terms of the number of children in the family, there are no expectations on how many children a family should have in Hmong society. However, in general men prefer to have a lot of children, even as many as 4-5 children so that the household has labor in the family. The Hmong believe that pregnancy it is a natural physiological state, and thus most young men and women let pregnancy happen as a natural process. Consequently, in Hmong society there are no birth control practices or family planning among adolescent Hmong men and young women. Furthermore, the high fertility rate among them has been perceived as a family asset.

Old men and women are expected to look after children. However, some old women still work in the rice fields and search for food for their family. Moreover, old women are not likely to participate in community activities because older Hmong did not get an education, and it is therefore difficult for them to communicate with people outside the community. The same is not true for older Hmong men because some Hmong join the village community and some old men become the village

headman. For example grandfather Jai became the village headman for the Hmong community since he moved to live in this community.

In terms of what Hmong women and men wear in the community, it is common for women to wear a long Lao skirt made of cotton. Women wear a normal shirt with long sleeves or short sleeves. Men normally wear long cotton trousers although younger men are more likely to wear jeans with a T-shirt or shirt. At special occasions, Hmong women will wear a more elegant dress and men will also dress more formally. One women told the researcher while visiting her house that she is the eldest daughter of grandfather Jai, who used to be the village headman in the Hmong community. She has two daughters and one boy in her family. She showed the cloth she would normally wear for a special occasion such as New Year or a wedding ceremony. There were two types of cloth: one for the men and the other for the women. The outfit women wear is more elaborate than for the men and consists of a headband, a white or multicolored shirt, and long pants. Young girls who are not married are more likely to wear a skirt than married women. For men, traditional clothing consists of a black long sleeve waistcoat on top of a white shirt, and long black pants with a belt at the waist made of an embroidered or plain red band.

**Figure 4.9** Special dress for women. Photo by Phonesavane Sivilay


**Figure 4.10** Special dress for Hmong men

Source: http://forums.soompi.com/discussion/2019952/how-often-do-you-wear-traditional-clothing

### 4.7.8 Mobility of men outside the community to earn income

Most participants in this study from the Hmong community told me that they mainly work in the rice fields to grow rice for their own consumption. However, some women also look for jobs to earn money, even though Hmong men consider that earning income was the duty of the man. However, there is not much work in the community that local people can easily find after the main crop is finished. Some men leave home to work in businesses, or sell animals or work in other communities. Some men do nothing while they are at home with the family. One young mother told the researcher that when her family finishes working in the rice field her husband has nothing to do at home because there was no job in the community and as she said:

> *"my husband does not have any job, he just works in the rice field and garden, however, when he finishes working in the rice field he does nothing at home"*
>
> (*Mrs. Sem Li,19-years-old, 2 children).*

Another young women told the researcher that her family just collect wild products or some vegetables in the garden to sell in the community after cultivating upland rice is finished. She said:

> *"For Hmong people, basically once we finish working on the rice field people just stay at home because there is no work to do, however, if we need money we just go for it and collect wild food from the forest or some vegetables from the garden to sell so we can get money"*
>
> *(Mrs. Navilay, 19-years-old, 3 children*).

### 4.7.9 Reproductive health status and problems of young women

#### Menstruation

Some young women told the researcher that they got married before starting menstruation because they were forced to by their parents. However, some

young women who are poor still follow the practice of using old fabric or cloth during their menstruation instead of using a proper sanitary towel. However, young women mostly use sanitary towels during their menstrual period since they are easy to buy and available in the community.

**Birth spacing**

Not many young women in Hmong society practice birth spacing or birth control, as in Hmong society children are very important as a source of labor for the family. However, among adult women over the age of 30 it is more common to practice birth spacing because they do not want any more children because they believe that it is not good to have a baby at an older age because they will not be strong and healthy.

**Family planning**

Family planning services are provided in the Hmong community, although not many young people consider this to be an issue. Most family planning practices are used among adult women, and they more likely take temporary family planning methods such as injections or medicine from the health care center or hospital. The health provider told the researcher that most young women did not understand about family planning or were aware of its benefits as the Hmong believe they need to have children while they are still young.

**Number of ANC visits at the health care center and hospital at the provincial level**

Most of the young women in the Hmong community were unable to attend all their ANC visits at the health care center or hospital during their pregnancy. The health care provider at the health care center said that most young women visit just one time during their pregnancy because most young women believe that pregnancy is a natural state and they will visit the clinic when they have a problem with their pregnancy, such as if the baby is not moving. Some young mothers were unsure whether they would have difficulty during childbirth because their belly was too big.

However, young women who attended the ANC clinic mostly came to the health care center when they were in their third or last trimester of pregnancy. Furthermore, the people who made ANC visits were not people from the community, but came from other villages. However, there were two pregnant women who came for ANC visits at the health care center and the hospital. The first was Navilay, who was aged 19, who had had three previous pregnancies. She told me she attended one ANC visit during her second pregnancy at the health care center in the community because she was not sure if her pregnancy would be safe because her baby was not moving. Therefore, she went with her husband. During her visit to the health care center, the health care provider said that she needed to go to the district hospital or provincial hospital because the health care center did not have ultrasound and could not therefore check her baby. However, they did not go and see the doctor because they did not have any money, and she also believed that pregnancy was a natural state, so she decided to let nature take its course. In the end her delivery was fine, and the baby was healthy. She delivered all of her children at home.

The second young mother is Joua. Joua is 19-years-old, and she has had five pregnancies. However, three of her young babies have died at around the age of two months. She said that her babies suffered from a disease. Joua said that she had attended all ANC visits for her first three pregnancies. She attended ANC services at a hospital (military hospital at the provincial level). The reason she utilized ANC services was because she was instructed by a medical doctor to go to hospital as she was sick and was admitted to the hospital. The doctor told her that if she got pregnant she should attend ANC services in order to check whether the fetus is healthy during the pregnancy. However, for her fourth and fifth pregnancies she did not attend the ANC clinic because after she lost her three babies she changed her religion to become Christian, after which she said her health was better, and she had two more children. One child is 3-years-old, and the second child is 8 months. She gave birth to all the children at home.

**Pregnancy**

Most young women become pregnant after they get married at a young age. Soo is a young women and one of the key informants for this study. She is 19-

years-old and has two children and was four months into her third pregnancy. She told me that she got pregnant soon after she got married at the age of 15. The reason for having children was because her husband wanted them, and that she knew that if she got married she had to have children, otherwise her husband will look for another wife. Moreover, she explained that if women have a baby for the husband she will receive good care from her husband and the family, especially if the child is a boy.

**Childbirth experience**

Most women in the Hmong community give birth at home because they believe that pregnancy and childbirth is a natural physiological state, and many people in the community are familiar with the experience of giving birth at home or even sometimes giving birth alone at home. In general, childbirth takes place at home, although some women give birth in the rice fields or in the jungle or even while traveling between home and the rice field. Some women said their delivery was easy. SemLi is 19-years-old and has two children. She recounted about her experiences during childbirth and said that her two deliveries were easy and they did not take a long time to deliver. SemLi explained that before giving birth she got support from her husband and mother-in-law to help prepare for the birth in the house. The material used to give birth was dry grass (Phai Ya) and old cloth instead of a bed. SemLi gave birth by herself although after the birth, her husband and father-in-law helped her to cut the umbilical cord of the baby, and the baby was cleaned and wrapped by the mother-in-law.

**Postpartum care**

There are food taboos practiced by women after childbirth. Grandfather Jai, who is 66 years old and has two wives and 15 children, said that after childbirth new mothers are not allowed to eat bamboo shoots, or fatty foods. Women can only eat chicken, and basics such as rice, and drink hot water, but are not allowed to eat the bones of chicken because it is believed this will damage their teeth. Only salt can be put into food but this has to be cooked or fried before it is used. They can also take a bath with hot water when they become a new mother. New mothers are not allowed to

carry heavy objects and are restricted in what they can eat for a month after childbirth, after which they can eat and work as usual.

**General women's health problem**

The research found that general women's health problems in the Hmong community included fever and uterus problems. However, in the Hmong community women traditionally first go to see the shaman, which they call Long Pi (spiritual practice). The shaman is a local healer who treats illness with spiritual practices. However, the shaman does not deal or treat pregnancy and childbirth. In general, the shaman will tell the patient what their illness is and that the illness comes from a spirit. For example, if the shaman says that illness comes from an evil spirit, the women has to drink magic water (Nam Mone) and follow the ritual practices as advised by the shaman. However, if the shaman says the illness comes from a disease, the sick person will go and see a doctor as the shaman does not deal with disease. Ketsa is one of the key informants for the study, and is a 30-years-old man with three children and his wife is pregnant with their fourth child. He said that during his wife's pregnancy if there was some concern about it or the actual birth, he would bring his wife to consult with his parents. However, if they were worried about an illness he would take his wife to see a shaman first. The reason he would take his wife to see the shaman first was because he respects the spirit religion, and shamans respected the spirits as well. Ketsa believes that if he goes to see a doctor, the doctor may not know about the spirits because they do not respect the spirit religion in the same way.

Juao is a young mother and one of the key informants. She is 19-years-old and has had five children, although she has lost three children after childbirth. The doctor told her that her babies had had a lung infection. However, during her last pregnancy she said that she had had a problem with her health and had a uterus infection. She said that she felt as if she had something coming out from her uterus, and it was a white liquid with a bad smell. She also felt itchy around her private area, and it made her feel uncomfortable about her health. She heard some people mention this syndrome in the community, and people called that disease Long Kao (Gonorrheal infection). She thinks that she may have that disease.

## 4.8 Cultural perceptions of ANC services at the health care center in the community context

**Perceived low quality of health care services related to ANC visits at the health care center**

The health care system has limitations in terms of the care services it provides within the community. With respect to ANC utilization among young women in the Hmong community, there is limited human resources capacity because there are only three health care providers working in the community. Moreover, the three members of staff are responsible for other tasks beyond working at the health care center and, for example, they provide health care services in other communities. For this reason the health care center sometimes closes while the three staff members visit other villages. In addition, in terms of technical skill, the three staff members have only studied to diploma level, and because they are all still young they do not have much experience with pregnancy and childbirth. Furthermore, the health care center lacks equipment because the goal in establishing the health care center was to provide primary health to support people in the community. However, if the patient's needs are beyond their capacity, the health care workers suggest that the patient goes to the district or provincial hospital. Another fact to consider is that the health care providers are from the Lue ethnic group, and thus cannot speak the Hmong language or provide services in that language. The health care center is located in the Lue community, which means there is a gap between the health care providers and Hmong women. These factors were the reason why Hmong women and men did not come to visit the health care center even though the community has a health care center. This would in many cases result in young pregnant women not attending ANC services during their pregnancy because most young women perceive the health care center as providing low quality services.

**Cultural gaps and miscommunication relating to ANC utilization in the community**

Due to the limited nature of the health care system in the community in terms of health care services, the center aims to provide primary treatment for all

people at the village level as priority services. The local health care staff are only responsible for primary health care problems. Therefore, if there are more severe cases or more serous conditions, the health workers would refer the patient for further treatment at the district or provincial level. For this reason, most young women perceive that health care workers have a poor knowledge of technical skills because there were some instances when the health care worker could not diagnose the problem with regard to a woman's pregnancy. One of the young mothers who attended an ANC appointment one time for her pregnancy is called Navilay. She is 19-years-old and has three children, the youngest being just two months old. She said that when she went to the health care center for her ANC visit for her second pregnancy, she felt that the health care center was not good because the health care provider lacked knowledge on what to suggest to her about her pregnancy. However, the health care provider suggested she go to see a doctor at the district or provincial hospital because her pregnancy needed to be monitored by a doctor. Navilay commented:

> *"I used to visit the health care center here for my pregnancy but when I went the health staff did not know about my case and they just suggested that I should go to the district hospital. The health staff here did not know how to do deliver a baby. But I didn't to want to go to hospital because there are so many people there and that makes me shy. But if we give birth at home there are no people around to watch me, only my husband or mother-in-law"*
>
> *(Mrs. Navilay,19-years-old, 3 children).*

The health care center also has a limited number of female health workers. This is a problem because the relationship between pregnant women and male health care providers is awkward in terms of ANC utilization. Tong Seng is head of the health care center in the community. His is responsible for general treatment and also for providing some support for services relating to pregnancy and childbirth. He said that one reason why most young women did not attend the ANC clinic during their pregnancy was because they were too shy to talk to a male health care provider. In

addition, they did not want to visit the clinic if the health care worker was a person who lives in the same the village. Tong Seng said:

> *"When it comes to ANC visits or delivery attendance, most pregnant women in this village do not visit the health care center, but they like to go directly to the provincial hospital because of the following reasons 1) they do not trust the competence of the health care providers here, 2) they are too shy to come and visit if the health care provider lives in the same village, 3), pregnant women don't come if they see that I am male although if they know the health care provider is female then they come to visit"*
>
> *(Mr. Tong Seng, 30-years-old, 1 child).*

Given the limited nature of the health care system and the limitations faced by the staff in the community, the working hours of care services cannot provide services 24 hours a day as a hospital can. Therefore, most young women perceive that the health care center is not available during the night. This was confirmed by Jing, one of the young mothers, who said that she did not visit the health care center during her pregnancy because she was afraid that the health care provider would not be available because her baby was delivered at night. Jing said:

> *"I gave birth to my son at home because my labor pain started during the night and it was too dark to go out. I did not have a motorbike at that time. We were also afraid that the health staff would not stay at the clinic"*
>
> *(Mrs. Jing, 19-years-old, 2 children).*

Some people perceived that the health care providers did not give good support after working hours. For example, Kam, who is one of the young men and a key informant, said that the health care center in the community was not good because he had called and asked for help for his wife's pregnancy, but the health care provider did not come to see his wife at home. Kam said:

> *"I called the health care provider to see if they would come and see my wife who was experiencing discomfort with her pregnancy. However, they did not come at that time"*
>
> *(Mr. Kam).*

Since the health care center was a new medical care treatment for people in the community, some young women were not aware of the possibility that they could attend ANC services, and some misunderstood what health care services were available because of a lack of information in the community.

Jing added that she did not attend ANC visits at the health care center because she thought that ANC visits meant that the health care providers would operate on her uterus or she would get an injection. She said that:

> *"I heard that if we go to the health care facility for ANC services, the doctor will operate on my uterus and put needle in my private areas, so I was afraid I would be hurt and I am afraid to get an injection*"
>
> *(Mrs. Jing, 19-years-old, 2 children).*

Soo told me that she did not attend ANC services at the health care center because she did not know that they were provided at the center. She did not know how she would benefit if she visited the clinic because she had not received any information about ANC services. She said that:

> *"I did not know what an ANC visit would be like, I had never heard about ANC services in the community. If we knew pregnancy was a risk, we might understand it was a risk as well, but we never thought being pregnant was risky but that it is a natural state"*
>
> *(Mrs. Soo, 19-years-old, 2 children).*

The language barrier is one factor that prevents most adolescent pregnant women from accessing ANC services because they have a poor level of education and did not attend school when they were a child. This means adolescent pregnant women have difficulty in communicating with health care staff because they do not speak the central Lao language. Some women said that they were afraid of the health care provider and do not understand what is being said to them if they are not accompanied by their husband. There were two young women who were informants for this study and who did not attend school. One was called Young Mo, and her husband's name is Ketsa. She is 18-years-old, and is in her eighth month of pregnancy and already has three children. She told the researcher that she never attended ANC visits during her pregnancies because she did not speak the Lao central language as a result of not attending school when she was a child. She said that her family lived far from school and that she had to help the family with field work. She therefore did not have an opportunity to get an education or get support from the family for studying. This is the reason why she did not attend ANC services during her pregnancy. She was afraid that the health care provider would not speak Hmong language as well. Young Mo said:

> *"I cannot speak Lao Lum, I am shy and I do not know how to explain things to health staff, so I did not visit the center"*
>
> *(Mrs. Young Mo, 18-years-old, 3 children).*

Soo is a young mother who also did not attend school and nor did she make ANC visits because she felt shy in explaining health matters to health care providers. However, if she were to go she would need her husband to accompany her.

Most women said that their deliveries took place mostly during the night. Some people said that they have difficulty in accessing the health care center or the hospital because it was far to walk and some families do not have a vehicle. Sometimes the weather is a factor because traveling in the rainy season can be difficult. Some informants were worried about leaving their family members at home if there was nobody to take care of them. One young mother said that all of her

children were delivered at home because she went into labor at the night, and was worried there was nobody to take care of her family.

One young mother, Jing, said that:

> *"I gave birth to my son at home and not in the health care center because I went into labor at night and it was too dark to go out. If I had gone to hospital my parents-in-law would worry about me, they were afraid that there would not be nobody to take care of me in the hospital or health care center here. I was also worried about my family and who would take care of the household, and since it was raining at times, it made it difficult to walk, because I could not walk due to pain from my pregnancy. I did not have a motorbike at that time. Each of my sons was born during the night and I gave birth to all of them at home and my husband took care of me. But if I have a problem, I can ask my parents-in-law to help me"*
>
> *(Mrs. Jing, 19-years-old, 2 children).*

Most adolescent girls prefer to give birth at home because it is a convenient place to deliver a child. Some adolescent mothers said that their delivery was easy and did not take a long time and that their husband and parents-in-law can take care of them easily at home.

Navilay, a new mother who just gave birth to her baby two months ago, said on the subject of pregnancy and childbirth that:

> *"I gave birth at home and my delivery was easy so I did not go to hospital because the baby's delivery did not take long time. However, if labor pain lasts more than one or two days we call this a difficult delivery"*
>
> *(Mrs. Navilay , 19-years-old, 3 children).*

Young mother Soo told the researcher at her house that:

> *"I gave birth to all of my children at home because I have a husband and mother-in-law at home. I believe that they can help me, especially to cut the umbilical cord because my husband learned from old people like his mother and father"*
>
> *(Mrs. Soo, 19-years-old, 2 children).*

Poor quality of care was a perception not only directed at the village and district level but also at the provincial level hospital. Some women said that ANC services were not good because health care workers do not speak respectfully with the patient, especially junior staff. One young woman attended ANC visits more than four times during her pregnancy and childbirth. Joua, who is 19-years-old and has had five pregnancies, had many ANC visits after getting advice from her doctor to get checkups for her first, second and third pregnancies. However, every time she went to the provincial hospital she found that the services were not good because the junior health care provider did not speak to her respectfully. She said that young staff were more likely to show their emotion at the work, and they did not speak with the patient in a kind manner compared with old health care providers.

> *"The junior staff at the hospital did not care much about treatment, and they did not speak nicely if we asked something, unlike the older staff, who were better"*
>
> *(Mrs. Joua, 19-years-old, 2 children).*

Joua also said that there were too many patients and health staff at the provincial hospital.

> *"Sometimes I dislike hospital because there are so many patients and doctors to see me, and sometimes two to three people come together."*

In addition, the utilization of ANC services was not free of charge at the provincial hospital, especially at the military hospital where she had her ANC visits. According to government policy, ANC services should be free of charge. However, in practice women have to pay for ANC services when they visit the military hospital. Joua said that she had to pay the registration fee to attend the ANC clinic at the hospital. However, this may not include other unexpected cost such as transportation, food, and medicine. Joua said:

> *"If I go to hospital I do not lose any money from work because if I want to go I finish my work first. However, when I go to hospital I have to pay for the services and I spent around 20,000 kip (80 baht) per time and that did not include transportation."*

If the policy of free ANC visits was really provided in the community it does not guarantee that adolescent pregnant women would not be discouraged from going to the ANC clinic because most of them come from poor families and to find money for ANC visits would be difficult for them in any case.

One young man Kaan, whom the researcher met while visiting grandfather Jai, talked about ANC visits for his wife's pregnancy. He said that he did not take his wife to any ANC visits or to give birth at hospital because they were poor and he could not support his wife even though his wife would like to go to the hospital. He said:

> *"I once took my wife to visit the hospital during the pregnancy, but after that we did not go again because we did not have the money to go, although my wife wanted to go again but we didn't have the money to use the health facilities" (Mr. Kaan, 18-years-old, 1 child, youngest son of grandfather Jai).*

Most young women prefer to give birth at home because at home there are no costs to pay.

## 4.9 Cultural beliefs on pregnancy and childbirth among young pregnant women

**Pregnancy as a natural state**

Most women said that pregnancy is a natural state, and there are many reasons that encourage them to believe that pregnancy and childbirth are natural for women. For example, young women had seen from old people what to expect, women did not get information that pregnancy was risky, some women had experienced childbirth without any complications, and some women had given birth alone. Therefore all these experiences and beliefs make women believe that pregnancy and childbirth are a natural state.

One of the key informants said that pregnancy was a natural state because if women get married she will become pregnant. However, some women could not conceive even after many years and believed that this was because of the nature of herself. As Nakor said:

> *"I think pregnancy is a natural state because when people grow up and a man and woman sleep together the woman will get pregnant and she will have a baby, which is natural for women. For example, some people are married for many years but they still did not have a baby although they try very hard to have a baby, but still don't have one, so that is because of nature that they can't have one"*
>
> *(Mr. Nakor, 30-years-old, 2 children).*

Some women also said that they never considered that pregnancy could be risky because women did not get any information about the risks. However, one informant said that pregnancy was still a natural state because if women have to die it could happen anywhere because it is a natural part of life. She said:

> *"Pregnancy may be risky or it may not - I do not know, but I believe that if it is time to die a woman will die even if we give birth at the hospital"*
>
> *(Mrs. Soo, 19-years-old, 2 children).*

Soo also added that pregnancy was a natural state because she had experienced giving birth alone. She had no problems after giving birth, and she could manage at home while her family members were not at home, and she said:

> *"pregnancy is a natural physiological state because I had a normal birth alone at home. A that time my husband was not at home, so I had to deliver the baby by myself. Soon after the delivery, I called my neighbors to cut the umbilical cord."*

**Size of fetus determines the risk and the way to manage fetus size by food restrictions**

Most young Hmong men and women believe that they can manage or control the size of the fetus by restricting food intake during pregnancy. Most women believe that the size of the fetus can be controlled. They believe that the mother and fetus are connected to each other, and whatever the mother eats will be transferred to the baby. Thus, if women prefer to have a small baby in order to have an easy delivery, the fetus must not have fatty oil on their skin. Therefore, in Hmong society most women practice food taboos and food restriction. There are many kinds of food taboo that women are not allowed to eat during pregnancy and childbirth.

**Food taboo**

There are some foods that pregnant women are not allowed to eat such as sweet food, Nang Yam (dried skin of buffalo), fatty food, smelly food, and some fruit such as banana. If women eat these foods the baby will become big, which means the woman will have a difficult delivery. In addition, women are not allowed to eat too much during pregnancy because they believe that if women eat too much food the baby will become too big and result in a hospital delivery due to an unsafe pregnancy.

Ketsa told me that he did not allow his wife to eat too much food because if she ate too much he would have to take his wife to see a doctor because they would be unsure if the baby might become obstructed during labor. He believes that if he and his wife can control her food intake, the baby will become small and there will be no need to see a doctor. He believes women need to eat special food because the unborn baby wants to eat it. Therefore, he and his wife routinely eat only rice, vegetables and a small amount of meat.

> *"If I see my wife eating food as normal, such as rice, vegetables, and chicken, then it is fine, but if she wants to eat something different I have to find it for her because we believe that if a woman wants to eat something it means the baby wants to eat it too. However, if I think my wife is getting too much food this will make us unsure about the pregnancy and make us worry about the baby that it may be too big or that something will happen so that we will have to see a doctor. So during the pregnancy we try not to eat too much but less instead"*
>
> *(Mr. Ketsa, 30-years-old, 3 children).*

SemLi told me that when she was pregnant she tried not to eat too much because otherwise the baby will become too big and will be difficult to deliver. However, if she does not eat much her baby will be small and easy to delivery. She said that:

> *"I had an easy delivery when I was pregnant because after I knew I had a baby in my belly I did not eat much food because I believed that if I didn't eat too much food my baby would be small so that when I gave birth it would be easy. However, I believe the opposite is true and if we eat too much food the baby will become big and I will have to go and see a doctor"*
>
> *(Mrs. Sem Li, 19-years-old, 2 children).*

Another older mother told me that she did not eat sweet food because she believes that it will make her have a difficult delivery. She said that:

> *"Some women practice food restriction like not eating the skin of animals or fatty and sweet food because they believe that it will make the baby have Kai (fat) on the baby's skin (kai is something white and oily that sticks to the baby's skin when the baby is born. Some babies have it but some do not). Sweet food will make the baby fat and that means a difficult delivery"*
>
> *(Midwife Seng Chone , 61-years-old, 4 children).*

**Taboo practices**

All the participants said that they had practiced some form of food restriction during their pregnancy. Some women said that pregnant women are not allowed to go out at night because they believe that evil spirits may possess the unborn baby at night and harm them. Some pregnant women are not allowed to kill animals such as snakes, and some are not allowed to dig things such as a fence because it is believed that the baby will stick inside the belly. Some women are not allowed to carry heavy objects or take things from high shelves because it is believed this can harm the baby. Sexual relationships are also restricted during pregnancy among adolescent women. Most women stop having sex when they are 4-5 months pregnant, as they believe it is not good for the baby.

Grandmother Jelai said that during pregnancy, women are not allowed to pick food and fruit from high hills or objects from high places and shelves because they believe that it will cut the umbilical cord of the unborn baby and the baby will die. Jelai said:

*"during pregnancy I was not allowed to take things from high levels as it will tear the umbilical cord between the mother and baby. This will make the baby become thin, and it will die"*

*(Grandmother JeLai, 50-years-old, 6 children).*

Another young pregnant woman told me that when she was pregnant she just tried not to fall because it was not good for her baby. She said:

*"When I was pregnant, I tried not to crash into anything because it would hurt my baby"*

*(Mrs. Young Mo, 18-years-old, 3 children).*

Soo told me that she stopped having sex with her husband once she was five months pregnant, and she said:

*"In terms of having sex with my husband, I stopped having it when I was around 5-6 months pregnant. We just slept and did not have any sexual activity"*

*(Mrs. Soo, 19-years-old, 2 children).*

Another man told me that he did not have sex with his wife after her fourth month of pregnancy, and said:

*"I have not had sex with my wife since her belly became big, which was at about 4-5 months of pregnancy"*

*(Mr. Nakor, 30-years-old, 3 children).*

## 4.10 Gender practices in the everyday lives of young pregnant women

Within the context of Hmong society, the gender practices of women revolve around hard work. Women go and work in the rice field, take care of children, and do domestic work. Hmong women have a low status in the family and community because most adolescent women have not had as much education as men. Therefore, most adolescent mothers have a low status in terms of household decision-making. Hmong society was traditionally a male patriarchy where men have power in terms of household decision-making and also when it comes to seeking care for women's health. This means adolescent women cannot go out or make decisions by herself and need to get permission from the husband. Therefore, most women have to work at home and stay in the community.

**Hard work in upland rice cultivation during pregnancy**

All of the female key informants said that they had to work hard during their pregnancy, especially with upland rice cultivation. Most women were not able to rest during pregnancy, and some pregnant women had to carry big baskets up the mountain and walk long distances to the rice fields. Some women work in the rice field until the child is delivered. Some women work until they get sick, forcing them to have a rest. After the baby is born, women only have a short period of time to rest, and after that they have to return to work. As one old woman told the researcher, she did not have a long time to rest after giving birth because she had to work in the rice field, and she said that:

> *"....Hmong people only have one month to rest after giving birth. After I gave birth, I had to go to the rice field every day.....". (Grandmother JeLai, 50-years-old, 6 children).*

One young mother told the researcher that she could not control her labor contractions while she was walking home with her husband, so she gave birth to her baby along the path. She said that:

*"I spent time mostly in the rice field until I was ready to give birth. I came back home but I could not control my contractions and because it was a long distance to walk home I had to deliver my baby on the path along the way home"*

*(Mrs. Sem Li, 19-years-old, 3 children).*

One of the old ladies also added that working in the rice field was very hard work because it continues until the rice was harvested. After growing the rice people have to slash the grass and look after the fields until the rice is harvested. She explained that: "women in this village mostly leave home to work on their rice fields and even once they have finished planting they have to go because they need to weed and slash the new grass in order to ensure the rice grows well in the field." Weeding and slashing takes a lot of time to finish because the rice area is large and they do not have much labor. She also said that weeding takes one or two months to finish depending on how large the area is. Grandma JeLai added that working on weeding and slashing is mostly done by women because after the rice farming is finished most men go to relax at home. Grandma JeLai said:

*".....I go to the rice field every day, and after the growing is finished I have to slash the grass four times until it is done. I do it alone, especially in my family "*

*(Grandmother Jelai, 50-years-old, 6 children).*

**Hard domestic work during pregnancy**

Most of the women who were key informants said that they do a lot of domestic work in the household when they become the family's daughter-in-law. Women are responsible for all of the household tasks in the family such as preparing food, taking care of the children, washing the clothes, carrying water, and sometimes looking for wood to prepare the meal. In addition to household tasks some women have to earn an income. One young mother explained about all the tasks she had to do every day from morning until she went to bed. She was worried about all the things

she had to do in the household and that her husband did not support her. She commented that:

> *"I am the daughter-in-law so I do everything in the household. For example, if I have to go to the rice field I have to wake up at 3 am in the morning, but if we finish growing rice I can wake up at around 5- 6 am. However, after waking up I cook food, take care of the children and wash the clothes as usual, but in the afternoon I only take care of the children. My husband does nothing at home once we finish shift cultivation"*
>
> *(Mrs. Sem Li, 19-years-old, 2 children)*

Sem Li also said that some women not only work hard in the household, but also have to earn money. She mentioned about her mother-in-law and said that:

> *"sometimes she looked in the forest for some products to sell, but if she did not go she stayed at home and sometimes she helped me to take care of the children."*

Another reason why women work hard is because of their husband. Sem Li told me that she had to work because her husband forced her to because he was the head of the family, and if she did work well in the household she thought her husband would find another wife. She said:

> *"my husband did not have a job, he just worked in the rice field and garden, but once he finished working in the rice field he did nothing at home. I told him to help but he did not help because he thought that he is the head of the family so he has power and did not help. If I complained to him, he told me that if I did not do it he would look for another wife because Hmong men have more power than women."*

**Figure 4.11** Adolescent mother with her baby selling vegetables. Photo by Phonesavane Sivilay

**Boys are the image of men's expectations**

Many of the female key informants mentioned that having a baby boy was very important for them after getting married because it affects their role as a mother, and their relationship with the husband because the Hmong believe that if women have a baby boy after they get married they will receive good care from her husband and good support from family members. In Hmong culture they believe that boys have special characteristics because they believe that boys have a spirit in their soul when they are born, while girls do not. Therefore, many of the women informants said that they were happy to have a child after getting married, and were very proud of their status if they had a boy. One young pregnant women said that she was happy to have a son for her husband, otherwise he would leave her and find another wife. As one young mother Soo said: *"I did not have any beliefs about the fetus, but I only know that if I got married I would have to have children otherwise my husband will get another wife"(Mrs. Soo, 19-years-old, 2 children).*

Another young mother, Sem Li, said that if a woman has a baby boy she will receive good care from her husband. She said that:

> *"if we do not have a baby and if we get sick, my husband will not take care of me well" (Mrs. Sem Li, 19-years-old, 3 children).*

**Desire for early pregnancy and a large family**

Most women and men in Hmong society prefer to have children soon after they get married. Moreover, they prefer to have a lot of children because they believe children can help them work and parents can also choose who can look after them when they get old.

Ketsa explained that he got married when he was at a young age, and that he wanted to have a child soon after that because he believed that the child could look after them when they were old. He said:

> *"I got married when I was between 15-16 because I wanted to have my own family, and I wanted to have children right away because when they grow up they can help me work and look after me when I get old"*
>
> *(Mr. Ketsa, 30-years-old, 3 children ).*

Grandfather Jai told me that he has a lot of children because he has two wives. He said he has 11 children from his first wife, Mea Thao Yai, and another four children with Mea Thao Noy. He explained that women not only had children for their husband but having lots of children was important because most Hmong prefer to have as many children as they can in the household. He said:

> *"Mostly when men get married they want to have a child first and they prefer to have as many as they can because they believe that when the children grow up the parents can choose which ones can feed and support them when they get old.*

*I got married when I was 16 and I wanted to have a lot of children so that I can visit them and eat with them when I can no longer work or when I get old. Then I can see which of my children are better off so I can rely on them and visit them for a few days and then go to another child in a different place''*

*(Grandfather Jai, 66-years-old, 2 wives, 15 children).*

**Women's body as a taboo and secret**

Most women said that they could not make use of ANC services because their body was a secret. Some women said that they felt shy and ashamed of letting other people see their body when they were pregnant, even health care providers. Some young women were embarrassed to show others in the community they were pregnant. Some women did not tell their husband they were about to deliver the baby. One young mother said that she did not visit other people in the community while she was pregnant because she was too shy to show her big belly to others, and she said:

*"When I was pregnant I did not have any restrictions about going out at night or in the day, but the reason I did not go out was because I was shy because I had a big belly"*

*(Mrs. Jing, 19-years-old, 2 children).*

She also said that she did not want to be pregnant because it will make her look like an old and unhealthy person, and as she said:

*"I was not happy because I did not want to be pregnant, I was not ready to have a child because I didn't want to be like an old person. Old people seem to look like their health and it is not healthy to have kids."*

Sem Li said that when she was pregnant she did not attend ANC visits because she was shy and felt uncomfortable showing her belly to health staff. She felt that her body was private and only her husband can see it. She said that:

> *"I disliked hospital because I felt shy to see health staff because my belly was big and I was afraid to show my belly and let the doctor see my body. For me, only my husband can see my private areas and my belly. I knew that I would give birth at home since I had a baby so there was no need to visit the ANC clinic"*
>
> *(Mrs. Sem Li, 19-years-old, 3 children).*

Mrs. Soo said that the body was private even though she knew that the delivery would be painful. However, because of her shyness it was more acceptable to her not to allow anyone else see her body even if they were a health care professional or her husband. She said that:

> *"I was shy and I did not want to let them see my private areas. There were a lot of people in the hospital and that made me even more shy. I did not tell my husband or let him see what was going on with me because I was shy to let him see my private areas. I did not tell my husband I was about to deliver even though I knew childbirth is risky. I believed I would rather die than give birth at hospital because my shyness was greater than caring about the risks"*
>
> *(Mrs. Soo, 19-years-old, 2 children).*

Another man told me that he did know that his wife was going into labor because his wife did not let him know, and said that:

*"Mostly, Lao Soung women do not talk or let their husbands know about their health, like my wife. Although it was painful to give birth she did not tell me, and she only let me know once she had already given birth to my fist child"*

*(Mr. Ketsa).*

**Rely on husband's decision**

Most women said that men made the decisions in the household. Some women said they did not complete all their ANC visits because they did not have the power to make decisions about seeking health treatment because the husband makes the decisions in the family. Some women can make a decision when her husband is at home. One young mother told me that she could not complete her ANC visits because her husband made the decisions about her visits. She said:

*"I only went once and at that time the health staff told me I was not due to deliver yet, so the doctor suggested that I should go to the district hospital to deliver my baby otherwise I might die because I might have a hemorrhage. I suddenly became afraid but I had no choice because my husband did not want me to go, and I felt that my belly would be okay, so we decided not to go at that time"*

*(Mrs. Sem Li).*

**Managing childbirth is handled through the extended family**

Most of the women informants said that they trusted their husband and father or mother-in-law when it came to the actual birth of the baby. Most men in the Hmong community were able to help at the childbirth, such as cut the umbilical cord of the new born baby. Some men, especially elderly men, believed they could predetermine the sex of the next pregnancy for the wife. One old man explained that in his family he cut the umbilical cord of all his children and he could also predetermine the sex of the next pregnancy as he wanted. He said:

> *"when the new baby is born, you take around three fingers in length of the umbilical cord then tie it very strongly to make sure that no blood comes out. Then you cut it with a sharp knife or if you do not have one you can use a small piece of sharp bamboo "*
>
> *(Grandfather Jai).*

Grandfather Jai also told me how he could predetermine the sex of the unborn baby, and said:

> *"If we think we have enough boys already in the family and we would like to have a daughter next, you just take the placenta and turn it upside down and dig it into the soil. However, if you want to get a boy, just leave it as normal to come out and dig it into the soil"*
>
> *(Grandfather Jai, 66-years-old, 2 wives, 15 children).*

Similarly, Kam was also able to deal with cutting the umbilical cord by himself for his children and he explained that:

> *"I cut the umbilical cord by myself because at the time there was nobody to help me so I had to do it by myself, and I remembered how from older people"*
>
> *(Mr. Kam,22 years-old, 2 children).*

**Baby boys the image of men's expectations**

Many female key informants mentioned that having a baby boy was very important for them after they got married because it impacted their role as a mother, and their relationship with the husband because they believed that if a woman has a baby boy she will be well cared for by the husband, as well as receive support from family members. Moreover, in Hmong culture they believe that baby boys have special characteristics because they believe that boys have a spirit in their soul on

being born, while girls do not. Therefore, many female informants said that they were happy to have a child after getting married, and were very proud of their status if the baby was a boy. One young pregnant women told the researcher that she was happy to have a son for her husband because otherwise he will leave her to find another wife. Soo said that:

> *"I did not have any beliefs about the fetus, I only knew that if I got married I had to have children because otherwise my husband will find another wife"(Mrs. Soo, 19-years-old, 2 children,).*

Sem Li, another young mother, said that if women have a baby boy, they will receive good care from her husband, and said:

> *"if we did not have a baby but became sick, my husband would not take care of me well" (Mrs. Sem Li, 19-years-old, 3 children).*

**Women do not participate in community activities or in the public sphere**

Women have a low status in the community. Hmong women do not pay much attention to participating in activities in the community because some Hmong women do not have a high level of education. Most people in the community viewed women as having low decision-making power in the household and they were not the head of the family. Therefore, there were not many Hmong women participating in community activities. Moreover, in Hmong custom, the men are respected as having a special characteristic because men have a spirit in their soul when they are born, while girls do not. One old woman explained that Hmong women have to be patient after getting married because women just have to accept the situation because men have a spirit and power. She said that:

> *"Hmong people prefer to have a son because we believe that a son has a spirit and power. For example, if a woman gets married to a man but the husband is from a poor family, the woman has to live and stay with him and accept the situation, even though they are poor"*
>
> *(Grandmother Jelai , 50-years-old, 6 children).*

**Summary: The significant factors influencing ANC visits among adolescent women at the health care center.**

There are several factors influencing why adolescent women do not visit ANC services during their pregnancy and childbirth, and these included the perceived quality of care, cultural gaps and miscommunication, language barriers, financial concerns if ANC services are not free of charge. There is a cultural belief that pregnancy is natural state, and that the size of fetus can be managed through restricting food and practicing food taboos. There is also inequality in terms of responsibilities between boys and girls. Women have to work hard in the rice field and do domestic work, but women also have to rely on the husband's decision-making. Childbirth is also managed by the husband's family, and no women participate in community activities or in the public sphere. All these factors influenced adolescent pregnant women and whether they attended either some or then no ANC visits in their community.

## 4.11 Case examples of ANC utilization among young pregnant women

In this study I give three detailed case examples from among six adolescent pregnant women of women who either attended some or no ANC visits during their pregnancy and childbirth.

The first case was of a young women who never visited ANC services at the health care center or hospital. The second case involved one women who made a single visit to ANC services at the health care center. The third case is a young women who attended ANC visits for four pregnancies.

**The first case: Never attended ANC visits during the pregnancy**

The first young mother is Jing, who is 19-years-old and has two sons. The first son is 3-years-old, the second son is 5 months. She got married after she finished high school at the age of 15 and moved from Houay Hin village. She has lived in Hatpang for five years. Her family is a nuclear family and there are eight members in the family including the parents, her family and two sons, the sister of the husband and two young brothers and a young sister. She has never earned money but used to collect food from the forest and did not have any position in the community. She was just a housewife in the community. During her pregnancy she never visited ANC services, and she gave birth to all her children at home. The mother-in-law helped her during the birth to clean the baby and cut the umbilical cord. The reason why she did not visit any ANC services was because she heard that if she went to the health care facility the doctor would operate on her uterus and put a needle in her private areas. She was afraid she would get hurt and was afraid to get an injection. In addition, she felt shy to show her private areas to health staff. She also knows that other people in the community also thought the same way, and did not use ANC services because they were shy. She felt going to the health care center was not necessary because her mother in-law would look after her during her pregnancy and childbirth. Other reasons why she did not visit and give birth at the health care center were because 1) her labor took place at night and it was dark to go out, 2) if she had to go to hospital her parents-in-law would worry about her because they were afraid there would be nobody to take care of her in the hospital or health care center, 3) she was worried about her family and that there would not be anybody to take care of the household, 4) sometimes it was difficult to walk outside when it was raining, 5) her labor was painful and she could not walk and they did not have a motorbike at that time, 6) they were afraid that the health care staff would not stay there. Both of her sons were born during the night and she gave birth to all of them at home with only her husband to take care of her.

The second young mother, Sem Li, is 19-years-old, and she got married at a young age. She finished grade 2 of primary school and moved from another village four years ago. She has two children in her family, but lives with her parents-in-law. During her pregnancy, she did not attend any ANC visits because she dislikes hospital because she felt embarrassed about her showing her big pregnant belly to health staff,

and also was afraid to let the doctor see her body because in her opinion only her husband can see her private areas. Once she knew that she was pregnant, she decided that she would give birth at home so there was no need to visit ANC services at the health care center or hospital. Her delivery was quick and took just one day. Her labor was easy because she had practiced food taboo since the time she knew she was pregnant and she had not eaten much food because she believed that if she did not eat too much the baby will be small and easy to deliver. However, she believed that if she ate too much food her baby would become big and she would have to go to hospital. Furthermore, when she was pregnant she had to work a lot because of her role as a daughter-in-law. She did everything in the household, for example, she had to wake up at 5- 6 am and cook food as well as take care of the children. In the afternoon, she only had to take care of the children. She worked a lot during the rice cultivation and she spent time mostly in the rice field until she was ready to deliver the baby. She wanted to give birth at home, but could not control her labor because it was a long way to reach home, and her first birth happened along the path along the way home.

**The second case: One ANC visit during pregnancy and childbirth**

One young mother visited the ANC clinic at the health care center during her pregnancy. Navilay, aged 19, had three previous pregnancies, and has two daughters and a son. She finished grade 3 of primary school. She moved from another village and has lived in Hatpang community for around 5 years. During her three pregnancies, she told me she attended one ANC visit during her second pregnancy at the health care center in the community. The reason why she went was because she was not sure if her pregnancy was safe because her baby was not moving so she went with her husband. However, the health care provider said that she should visit the district or provincial hospital because the health care center did not have an ultrasound to check her baby. However, she and her husband did not go because they did not have any money to go, and she also believed that pregnancy is a natural state, so would let nature take its course. Her delivery turned out to fine, and her baby was healthy. She gave birth to all her children at home, and her delivery was easy.

**The third case: Complete attendance at ANC clinic during pregnancy and childbirth**

The second young mother is Joua, who is 19-years-old and who finished grade 5 of high school. She has been pregnant five times. However, her first three children died after childbirth because of illness. Joua said that she attended all her ANC visits for her first three children. She attended ANC services at the provincial military hospital. The reason for her ANC visits was because her health was not good and she was told by a medical doctor that she was sick and should be treated at hospital. The doctor told her that if she became pregnant she should attend ANC visits in order to check how the baby was developing and if the baby was healthy. Therefore, during from her first pregnancy up to the third she made ANC visits all the time because she felt that her health was not good. However, for her fourth and fifth pregnancies she did not attend the ANC clinic because after she lost her three babies she changed her religion and became Christian. She said her health was better, and she had two more children. However, she gave birth to all her children at home.

She also added that the reason she could attend visits was because he husband supported her, and she had some money that she had saved and some animals to sell to help pay for her sickness. When she attended the ANC clinic, she had time because she had finished working in her rice field and all her tasks at home.

# CHAPTER V
# CONCLUSION, DISCUSSION, AND RECOMMENDATIONS

## 5.1 Conclusion

This study is an ethnographic study and uses a qualitative methodology aimed at increasing our understanding of cultural beliefs and practices affecting ANC utilization among young women in rural areas in Laos, especially within the Hmong ethnic group and Lao Song people in Hatpang village, Pak Ou district, Luang Prabang province. Seventeen people were interviewed in this study including three husbands, six young mothers, two elderly women, one elderly man, two health care providers, two midwives, and one village headman from Hatpang village. The literature on this subject and specifically the context of young pregnant women from the Lao Song group proved inconclusive on several vital question relating to the discourse on the subject. This study sought to provide information on three key findings to answer questions concerning cultural beliefs and practices influencing ANC utilization.

The first key finding is that women have poor perceptions of ANC services at the health care center and hospital. The opinions and concerns expressed included: health care providers have poor knowledge about technical support, there was a poor service at night, misunderstandings during the ANC visit because of a lack of information, health personnel do not provide full support when asked for help, health care workers are male, and there is a language barrier. At the provincial hospital, junior health care providers have a poor relationship with patients, and there are too many patients and health staff in the hospital. In addition, ANC utilization was not free of charge and childbirth was convenient at home.

The second key finding is about cultural beliefs on pregnancy and childbirth among adolescent pregnant women. The beliefs held by women include the belief that pregnancy is a natural physiological state, the size of the fetus can be managed by food restrictions, and women practice food taboos.

The third key finding is about gender practices in the everyday lives of young pregnant women. Women have to work hard in upland rice farming, and do all the domestic work even when pregnant. Baby boys are considered the image of men's expectations, and a woman's body is a taboo. Women rely on their husband's decisions when it comes to seeking hospital care but the childbirth is managed through the extended family of the husband. No women participate in community activities or in the public sphere.

## 5.2 Discussion

In the discussion section, I have noted the views presented and reflected on the theory for the study in Hatpang community, and these finding form the basis to the discussion section below.

**Adolescence concept - Hmong society has no concept of adolescence**

According to definitions of the WHO, adolescence is classified as a period of transition from childhood to adulthood from the ages of 10-19, and is related to psychological and physical changes (WHO, 2013). However, according to Dehne and Riedner (2001; pp. 11-13), adolescence is a dynamic concept and is related to social, economic and cultural issues. In this regard, there is no concept of adolescence within Hmong society. In Hmong society, people marry at an early age, usually between the age of 14-19, and have their own family with one or two children or more, since they need children to help with labor in the rice fields. Therefore, it seems that both boys and girls change their status from being a child and enter adulthood by getting married and having a family right away. The adolescent period is missing in this society.

**Concept of gender practices: responsibility of boys and girls**

In Hmong society there is inequality between men and women in terms of gender practices. According to the concept of gender practices in Lao society by Ireson-Doolittle and Moreno-Black (2004), the authors explain that women have to have "three goods and two duties". The term "three goods" means women should be a

good citizen, a good mother, and a good wife, and the “two duties” means women have to work in service of the country and enhance women’s empowerment. These practices make Hmong women responsible for domestic work in their role as daughter-in-law. Women not only have to work hard with domestic work but also continue to work in the rice fields slashing the grass. Men work outside the village or do nothing at home after rice cultivation is finished. In daily life, women are busy taking care of the children. However, there was little support from husbands in child care. Women have to work a lot and be active in order to be accepted by the husband’s family. Young mothers felt that being a good mother is a very difficult task in everyday life, since they must maintain both the mother’s nurturing role and reproductive role for the family at the same time. Ussher and Antonis (Ussher 1990; Antonis 1981; cited in Ann Phoenix and Anne Woollett, 1991, p 13) stated that that the task of mothering is learned in everyday life, and it is extremely difficult to be a good mother.

**Preference for baby boys in Hmong culture**

Baby boys have a very powerful meaning in Hmong culture, especial for women. In Hmong society, boys are thought to have special characteristics and power and have a sprit with their soul. Thus, most men are admired and get more opportunities than girls in terms of education, work, and family support. Therefore, most men in Hmong society get a better education, and some men can rest after rice farming and harvesting. Women get good care if she has a baby boy. Furthermore, men have power in making decisions for the family and most men are able to manage the pregnancy and childbirth. Thus, there are many factors influencing the preference for a baby boy in Hmong society in terms of gender norms, customs, and religious beliefs. Most women are viewed as having a low status, and have no decision- making power, less knowledge of traditional childbirth skills, and less education, which results in women not seeking health care for their health problem. Therefore, men have more space than women in Hmong society.

Demographic issues were another factor resulting in Hmong women not accessing the health care center. Women practice traditional customs and spiritual practices, and have low incomes, a low level of education and have poor access to

transportation especially in the rainy season. In addition, it is difficult for women to walk out of the village because the road is too dirty and it is difficult to walk along the road. These factors resulted in most women not visiting ANC services even though there is a health care center in the community.

## 5.3 Recommendation and further study

### 5.3.1 Recommendations

**For the health care system**:

- Provide health education and health care information in the community to Hmong women by visiting the community
- Provide a mobile health unit that can reach people in the community
- Increase the number of health care providers at basic health care centers, allocate female health staff to maternal and child health units
- Health care staff should be able to speak ethnic languages
- Distribute media on health information through posters, pamphlets and the radio. This Information Education communication (IEC) can be in their local language in the community
- Health care insurance provision for all pregnant women
- Provide safe ‘Childbirth Tool Kits’ for Hmong communities so that they can safely deliver their child

**For adolescent pregnant women:**

- Provide vaccinations to prevent tetanus only for adolescent mothers but also for new born babies in order to avoid the risk of infection after birth due to the use of unsafe tools that are used to cut the umbilical cord.

**Further study**

- More in-depth ethnographic study on gender practices among adolescent Hmong women in order to understand the gender inequality in Hmong society and design interventions to empower women
- Further studies on child birth practices focusing on procedures during delivery of the child i.e. practices relating to cutting the umbilical cord of the baby so that health interventions can be designed to help prevent infections and harmful practices.
- Further studies on the role of spiritual practices among the Hmong during their pregnancy and childbirth

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# APPENDIX

# Data collection guidelines

1. Guidelines for entering the research site

This section briefly outlines the processes used in preparing the research and beginning the field research.

- **1.1 Provincial level**

- Obtain official permission before going to the village
- Self-introduction as a student and researcher
- Explain the purpose and procedure of the research

- **1.2 District level**

- Obtain official permission before going to the village
- Self-introduction as a student and researcher
- Explain the purpose and procedure of the research

- **1.3 Community level**

- Self-introduction as a student and researcher
- Explain about the purpose and procedure of the research
- Make friends and build trust with local people in the study area
- Observe and look around the study area

## 2. Guidelines for data collection

**2.1 Observation/in-depth / ethnographic interview guidelines:( for young pregnant women)**

**2.1.2 Introduction**

Self-introduction as a student and researcher; explain the research purpose and procedure; make friends and build trust with local people in the study area; review and test the interview guidelines and modify if necessary

**2.1.3 Personal data of informants**

Name, age, gender, marital status, religion, educational status, types of occupation, ethnicity, number of years in the village, migration history, economic status, type of family: extended or nuclear family, number of family members, position(s) in the community: traditional healer, community leader, etc.

**2.1.4 Perception of ANC visits and health**

Have you ever visited a health care center for your health needs?

What do you think about the health care facility in your community? Is it good for you or everyone in the community?

Have you ever heard about antenatal care? What do you think about ANC services?

How many times have you visited an ANC clinic during your last pregnancy? Can you explain to me what services you received at each ANC visit? Was the experience different every time that you visited?

Can you tell me what you were told at every ANC visit?

What is the benefit of ANC services? What are the advantages and disadvantages for your health or pregnancy of using ANC services? What do you lose if you go for health care or visit an ANC clinic for your pregnancy?

What do you think about relationship between health staff and you during your visit? Do you feel any social gaps between you and the health staff in

terms of age, education, health beliefs and knowledge? How do you feel when you are with health staff? Do you feel comfortable or uncomfortable?

## 2.2 Gender practice: Interview guidelines and observation in the family

### 2.2.1 Interview guidelines: Activity in the family

What do you/adolescent woman do every day? From morning up until bed time? How much time do you/women have for taking care of your own health? How do you/woman divide the time between housework, child care, outside work, taking care of your own health, etc.?

How is labor divided in your family? How is the labor divided between you and your husband? How is the labor divided between you and your mother-in-law?

### 2.2.2 Observation in the family

What are the different roles and social status of men and women in the community? What are the power differences in terms of decision-making in the household between men and women, husband and wife, daughter-in-law and mother-in-law? Who makes the decisions in terms of household spending, health visits, or ANC visits?

Who takes care of you when you are pregnant or sick? Who takes care of family members when they are sick?

Who takes care of your child? Does your husband help you in raising your child? How much does he help and in what way? Do you have any other family members to help you take care of your child? Who takes care of your child when you are sick?

**2.3 Cultural beliefs related to pregnancy and childbirth**

What are your beliefs related to pregnancy at a young age in terms of food restrictions, food preferences, sitting, walking, sleeping, working, resting, cleaning, taboo practices, sexual practices, going outside, etc.?

Is pregnancy during adolescence a natural or risky state? Explain.

What is your belief about your fetus? How can the fetus remain healthy? Why do some adolescent women die during childbirth? Why do some infants of adolescent women die during labor ? What happens to them? Can multiple ANC visits prevent maternal and infant death during delivery? Why or why not?

What are your belief(s) related to maternal care in terms of health beliefs and practices?

Who do you consult when you have problems with your pregnancy? Do you think the traditional birth attendant in your village can help you in antenatal care or child delivery?

Do you use special herb medicines or food during your pregnancy?

What are your beliefs about childbirth? Is it a risky or natural state when compared with older women? Who should be the person to deliver the child of an adolescent woman?

**2.4 In-depth / ethnographic/semi-structured interview guidelines:(for husband/mother-in-law**

**2.4.1 Introduction**

Self-introduction as a student and researcher; Explain the research purpose and procedures; Make friends and build trust with local people in the study area; Review and test the interview guidelines and modify if necessary

**2.4.2 Personal data of informants**

Name, age, gender, marital status, religion, educational status, types of occupation, ethnicity, number of years in the village, migration history, economic status, type of family: extended or nuclear family, number of family members, position(s) in the community: traditional healer, community leader, etc.

### 2.4.3 Cultural belief related to pregnancy and childbirth

What are your beliefs related to pregnancy at a young age in terms of food restrictions, food preferences, sitting, walking, sleeping, working, resting, cleaning, taboo practices, sexual practices, going outside, etc.?

Is pregnancy during adolescence a natural or risky state? Explain

What is your belief about her fetus? How can the fetus remain healthy? Why do some adolescent women die during childbirth? Why do some infants of adolescent women die in delivery? What happens to them? Can multiple ANC visits prevent maternal and infant deaths during delivery? Why or why not?

What are your belief(s) related to maternal care in terms of health beliefs and practices?

Who should adolescent pregnant women consult when they have problems with their pregnancy? Do you think the traditional birth attendant in your village can help them with antenatal care or child delivery?

Do adolescent pregnant woman use special herb medicines or food during their pregnancy?

What are your beliefs about childbirth among adolescent pregnant women? Is it a risky or natural state compared with older women? Who should be the person to deliver the child of an adolescent women?

## 2.5 Observation/in-depth / ethnographic/semi-structure interview guidelines:( for health care providers)

### 2.5.1 Introduction

Self-introduction as a student and researcher; Explain the research purpose and procedure; Make friends and build trust with local people in the study area; Review and test the interview guidelines and modify if necessary

### 2.5.2 Personal data of informants

Name, age, gender, marital status, religion, educational status, types of occupation, ethnicity, number of years in the village, migration history,

economic status, type of family: extended or nuclear family, number of family members, position(s) in the community: traditional healer

### 2.5.3 Cultural beliefs related to pregnancy and childbirth

What are adolescent women's beliefs related to pregnancy at a young age in terms of food restrictions, food preferences, sitting, walking, sleeping, working, resting, cleaning, certain taboo practices, sexual practices, going outside, etc.?

Do they believe that pregnancy during adolescence is a natural or risky state? Explain

What do adolescent pregnant women believe about their fetus? How can the fetus remain healthy? Why do some adolescent women die during childbirth? Why do some infants of adolescent women die in childbirth? What happens to them? Do they believe that multiple ANC visits can prevent maternal and infant death during delivery? Why or why not?

What do adolescent pregnant women believe in relation to maternal care with respect to health beliefs and practices?

Who do adolescent pregnant women consult when they have problems with their pregnancy? Do they think the traditional birth attendant in the village can help them with antenatal care or child delivery?

Do they trust health workers to deliver the child? Which one would they prefer for ANC and child delivery: a traditional midwife or health worker? Why?

Do adolescent pregnant woman use special herb medicines or food during pregnancy?

What do adolescent pregnant women believe about childbirth? Is it a risky or natural state when compared with older women? Who should be the person to deliver the child of an adolescent women?

## 2.6. In-depth / ethnographic/semi-structured interview guidelines:( for midwife, community leaders)

### 2.6.1. Introduction

Self-introduction as a student and researcher; Explain the research purpose and procedure; Make friends and build trust with local people in the study area, Review and test interview guidelines and modify if necessary

### 2.6.2 Personal data of informants

Name, age, gender, marital status, religion, educational status, types of occupation, ethnicity, number of years in the village, migration history, economic status, type of family: extended or nuclear family, number of family members, position(s) in the community: traditional healer, community leader, etc.

### 2.6.3 Cultural beliefs related to pregnancy and childbirth

What do adolescent women believe about pregnancy at a young age in terms of food restrictions, food preferences, sitting, walking, sleeping, working, resting, cleaning, certain taboo practices, sexual practices, going outside, etc.?

Do they belief that pregnancy during adolescence is a natural or risky state? Explain

What do adolescent pregnant women believe about their fetus? How can a fetus remain healthy? Why do some adolescent women die during childbirth? Why do some infants of adolescent women die during delivery? What happens to them? Do they believe that multiple ANC visits can prevent maternal and infant deaths during delivery? Why or why not?

What do adolescent pregnant women believe about maternal care in terms of health beliefs and practices?

Who do adolescent pregnant women consult when they have problems with their pregnancy? Do they think the traditional birth attendant in the village can help them with antenatal care or child delivery?

Do they trust health workers to deliver the child? Which would they prefer for ANC visits and the child's delivery: a traditional midwife or health worker? Why?

Do adolescent pregnant woman use special herb medicines or food during pregnancy?

What do adolescent pregnant women believe about childbirth? Is it a risky or natural state when compared with older women? Who should be the person to deliver the child of an adolescent women?

**2.7.Community level: In-depth interview guidelines and participation observation (for village headman)**

**2.7.1 Demographic data**

Population distribution: Education, migration, ethnic identity

**2.7.2 Social structure**

Sense of community, relationship with outside world, social class, kinship, pattern of residence, type of family structure, decision-maker within the family, marriage and divorce, women's roles and status in the family

**2.7.3 Economic structure**

Type of occupation, everyday economic life, economic level, market place

**2.7.4 History and location of the community**

History of the community, location, connection to the township, road and transportation in and out of the community

**2.7.5 Belief system**

Ultimate goal of villagers' life, religious beliefs and practices, belief about what constitutes a perfect life, why are some people poor or rich?

### 2.7.6 Health care system

What are the existing government and private health care facilities that are available for community members? How accessible are they in terms of location, traveling time, quality of services, cost, etc.

Who are the existing local traditional healers, herbalists, etc. that are available for community members? How accessible are they in terms of location, traveling time, quality of care, cost, social distance, etc.

What are the existing individual/self-care practices, family care practices that exist in the community? How accessible are they in terms of quality of care?

What are the common health problems among community group members: male, female, children, adolescents, adult, and the elderly? How do community members explain the causation of each of these health problems and how are they treated?

# BIOGRAPHY


| | |
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