Beyond Women's Empowerment: Exploring the Role of Men in Family Planning among the Mangkong Ethnic Group in Lao PDR

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Abstract

Since the 1994 International Conference on Population and Development (ICPD) in Cairo, men's involvement in family planning (FP) has been actively promoted as the pinnacle to women's empowerment, and consequently, gender equality. Previous studies have found that when men are involved in FP, they can become more supportive when decisions about reproductive issues need to be made, which has positive implications elsewhere.

Laos as an ethnically diverse country, means making FP universally accessible for its people has been challenging. It is especially problematic for ethnic minorities in rural areas where women are more vulnerable and marginalised, resulting in a high level of unmet need for FP among ethnic women. With ethnic minorities even less participation is evident, coupled with the fact there is a paucity of research on topic.

This thesis therefore aims to explore the involvement of Mangkong men in FP. The fieldwork was conducted in seven villages in Nong District, Savannakhet province, Lao PDR. The research is qualitative in design and data was collected via semi-structured interviews with 13 couples, two women and five key informants. Other methods included informal observation, used as part of building rapport and learning about gender roles and lifestyle among the Mangkong, as well as document analysis.

This study found that men's involvement as FP service providers raised awareness of FP among men and women, while men's involvement as targets of FP programmes improved and increased participation in counselling, integrated outreach, for example. However, this suggests that men's involvement in FP alone cannot increase women's empowerment unless broader strategic and practical gender needs are also addressed. Theoretically, the study calls for culturally specific models of empowerment, as the empowerment framework adopted in this study, which was based on Western feminist theories, cannot fully explain Mangkong women's understandings of empowerment. Findings also suggest that if true empowerment in FP is to be achieved, it is necessary to focus on both men and women as individuals, couples and clients who have the rights to access FP information and services, thus meeting their individual needs. Both men and women are necessary agents of change for gender equality.

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List of Abbreviations

ANC	Antenatal Care
ASEAN	The Association of Southeast Asian Nations
BCC	Behavior Change Communication
CIDA	Canadian International Development Agency
CIEH	Center of Information and Education for Health
CIP	National Family Planning Costed Implementation Plan
CBD	Community-based Distributor
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
DAWN	Development Alternatives with Women for a New Era
FDI	Foreign Direct Investment
FGM	Female Genital Mutilation
FP	Family Planning
FP2020	Family Planning 2020
FPSA	Family Planning Situation Analysis
GAD	Gender and Development
GDP	Gross Domestic Products
HIV/AIDS	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome
ICPD	International Conference on Population and Development

IEC	Information, Education and Communication
IUD	Intrauterine Device
LARCs	Long-Acting Reversible Contraceptives
LWU	Lao Women's Union
LDC	The Least Developed Countries
LECS	Lao Expenditure and Consumption Survey
LSIS	Lao Social Indicator Survey
MMR	Maternal Mortality Rate
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHC	Maternal and Child Health Center
MDGs	Millennium Development Goals
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
PHC	Primary Health Care
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STDs	Sexually Transmitted Diseases
UN	United Nations
UNFPA	United Nations Population Fund

VHC	Village Health Committee
VHV	Village Health Volunteer
VHW	Village Health Worker
WB	World Bank
WID	Women in Development
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

1.1 Introduction

Globally, women have been the primary target of family planning programmes since the inception of family planning (FP) in the 1950s. This resulted in the adoption of a women-centred approach with the belief that women's empowerment is central to the ideals of gender equality. Increasingly, there has been a recognition that women's empowerment, and gender equality with the emphasis on women alone are insufficient, and the involvement of both men and women is a more effective approach. Both the International Conference on Population and Development (ICPD) in Cairo, in 1994, and the Fourth World Conference on Women in Beijing, in 1995, actively promoted men's involvement as an essential contributor for women's empowerment and gender equality. It was assumed that integrating men into sexual and reproductive health (SRH) including FP would lead to an increase in women's autonomy and decision-making power, that is, empowerment. In turn, this would have a significant impact on the well-being of women and men.

FP is embedded in the principles of human rights. The ICPD recognised "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice" (UNFPA, 2018). FP not only prevents unintended pregnancy and reduces the number of abortions, but as mentioned, it is argued that it also promotes women's empowerment. As such, access to FP means women can plan and make informed decisions on whether or not to have children and how many children to have, including which contraceptive methods they want to use. Also, women who have access to FP have an increased level of autonomy within the household and have more opportunities for education and making economic contributions (WHO, 2018; UNFPA, 2018).

Yet, millions of women in developing countries lack access to FP information and services due to various barriers. These obstacles include opposition from

husbands, cultural and religious factors, as well as social and economic factors that hinder women's contraceptive use (WHO, 2018). Other factors, such as geographical location, and other barriers, such as low availability of services, can limit women's access to FP services, especially among poor women with limited education in rural areas. Given that the Lao government aims to make FP universally accessible to all Lao citizens by 2020, understanding these issues in a more nuanced way is significant for addressing barriers to achieve positive outcomes.

In many countries, men hold a higher status than women and have control over many aspects of women's lives including reproductive health and access to FP information and services. Therefore, engaging men in FP is crucial. As such, there has been an increased focus on human-rights, with SRH, including FP programmes, having a gendered lens applied to the planning and implementation of programmes. The aim is to challenge harmful gender norms and the existing unequal power relationship between men and women by engaging men as clients, supportive partners and the agents of change (UNFPA & EngenderHealth, 2017).

1.2 Rationale for This Study

There is a growing literature on men's involvement in FP and its relationship with women's empowerment and gender equality. Many studies found that engaging men in FP programmes can encourage men to become more positive and supportive of women's choices (Maharaj, 2000; Sternberg, 2004; Rosliza & Majdah, 2010; Bayray, 2012; Adango et al., 2013; Ezeanolue et al., 2015; Koffi et al., 2018). However, studies on the implications of men's involvement strategies are still limited. At the time of conducting this research, no such studies for Laos were found. The Mangkong is an ethnic group in Laos with one of the highest poverty rates, as well as a high level of unmet needs for FP. Understanding the challenges and barriers that hinder men and women's access to FP information and services can help strengthen planning and promote more effective implementation of FP programmes for the Mangkong context. However,

research on FP that involves Mangkong men, as well as gender relations in FP, have not been undertaken. Thus, this research was conducted based on three rationales. At the broader level, this research attempts to contribute to the body of literature regarding sexual and reproductive health and family planning (SRH/FP) with specific reference to men's involvement. Second, this study aims to fill this particular research gap by investigating the topic in the context of Laos and, therefore, contribute to the current database of knowledge. Lastly, due to my interest in women's empowerment and gender equality which is reinforced also by my previous work experience with the United Nations Population Fund in Laos, I have a strong passion and interest in this topic.

1.3 Research Aims, Question, and Objectives

This research aims to explore the role of men in FP, and discover whether men's involvement promotes and/or increases women's empowerment in FP. There is one primary research question and two objectives (Table 1.1).

Table 1.1 Research Question and Objectives

Research Question
Does men's involvement in family planning increase women's empowerment, and in what ways?
Research Objectives
1. To investigate men's involvement in family planning programmes and men and women's views of this. 2. To investigate if family planning involving men results in an increase in Mangkong women's self-confidence, autonomy and decision-making power regarding family planning, and influences their ability to negotiate with their spouse with a focus on making joint decisions and sharing responsibilities.

1.4 Thesis Structure

This ***Chapter 1*** provides brief background information about the study, outlines the rationale for the study, the research aim, question and objectives, and outlined the thesis structure.

Chapter 2 – Family Planning in the Developing World contains a literature review, which presents a brief history of FP, including its concepts and the approaches that have evolved since the 1950s until the 2000s. The chapter also provides the definition of FP, which stems from the ICPD, and is the concept applied throughout this study. Programmatic and operational successes and challenges faced by FP programmes that involved men, including a discussion of masculinity in the context of FP are also covered.

Chapter 3 – Empowerment Conceptual Framework discusses the concept of empowerment including critiques. The work of Rowlands (1998) and Kabeer (1999) focusing on two dimensions: personal and relational are to be used. This chapter further provides an empowerment conceptual framework in the context of FP.

Chapter 4 – Methodology describes the overarching methodology and specific methods adopted for this research, such as semi-structured interviews, informal observations, and document analysis. The research location, participant recruitment, and ethical considerations are presented. The fieldwork experience and challenges, as well as the limitations of this study are described.

Chapter 5 – Family Planning in Lao PDR provides an overview of the country and the reproductive health (RH) and FP services and issues in the context of Laos. The national FP programme including policies, strategies and action plans, as well as men's involvement and how this is strategically incorporated into community-based interventions are discussed.

Chapter 6 – Findings presents the results of the interviews, observations and document analysis combined within two main themes: men's involvement and women's empowerment. The themes are discussed at both the policy and

operational levels. Barriers and influential factors that have impacted on the level of men's involvement and women's empowerment are presented.

Chapter 7 – Discussion critically analyses the findings based on the empowerment conceptual framework. This framework provides understanding of whether or not women feel confident, whether they have autonomy and feel empowered in their decision-making regarding their RH/FP, and whether or not the men's involvement influences the women's decision-making power.

Chapter 8 – Conclusion discusses the implications of this study comprising four main points. Recommendations for future research as well as practical recommendations for the Lao government and international development agencies working in this area are stated.

CHAPTER 2: FAMILY PLANNING IN THE DEVELOPING WORLD

2.1 Introduction

Family planning (FP) has been a contentious topic in population studies and the development field since the 1950s. Actors from government and the development field, feminists, environmentalists, and religious fundamentalists, have been involved in the often heated debates around the issue. Conventional FP interventions have been criticised for being motivated by goals of population control, the violation of human rights, the ineffectiveness of the programmes and the focus on women in isolation, as well as cultural insensitivity. Meanwhile, the feminist movement around the world has pushed women's rights, women's empowerment and gender equality into the FP and development agenda. The feminist movement played a critical part in the evolution of the FP concept and approach over time. This has resulted in the theoretical focus shift from women as the target to both men and women working in partnership together.

This chapter discusses literature on FP in the developing world by starting with the conceptualisation of FP in Section 2.2, followed by a brief overview of the evolution of FP since the 1950s in Section 2.3. Section 2.4 explores FP programmes in developing countries since the International Conference on Population and Development (ICPD) held in Cairo, in 1994. This section focuses on how the incorporation of FP into reproductive health and rights (SRHR) policy has been translated into practice, including its progress and challenges, as well as FP within the context of the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). Finally, Section 2.5 discusses approaches to men's involvement in FP.

2.2 Conceptualisation of Family Planning

The meaning of FP has been contested since the 1950s. Conceptualising the term depends much on its users and their agenda. From the neo-Malthusians

standpoint, FP has served as an instrument for economic development. They believe that not only do high birth rates prevent women's individual rights in fulfilling their potential, but these high birth rates also impede economic development. The assumption is that poor people often have more children, which prevents them from having more choices in life. Thus, birth rates should be reduced among the poor (Frey, 2011). With such an emphasis, FP was deemed to be contraceptive methods for population control.

A consensus on the definition of FP seems to have been reached at the ICPD held in Cairo, in 1994. Article 7, paragraph B (7.12) states that FP is the fundamental rights of individuals and couples to decide freely and responsibly the number and spacing of their children and to have access to safe and effective methods (UNFPA, 2004).

Based on the ICPD, UNFPA (2017) refers to FP as access to information, a full range of methods and means, so that individual men and women, and couples, can plan whether and when to have children, as well as the number and spacing of children. Starbird, Norton and Marcus (2016, p.1) agree that FP means "the services, policies, information, attitudes, practices, and commodities, including contraceptives that give women, men, couples, and adolescents the ability to avoid unintended pregnancy and choose whether and/or when to have a child".

According to the above definitions, FP can be conceptualised as the rights of individual men and women, couples and adolescent boys and girls to have access to contraceptive information, counselling and services, and a wide range of contraceptive methods. With this access, they can voluntarily and responsibly decide on timing, number, and spacing of their children based on making an informed decision.

According to the ICPD, FP does not promote nor include abortion as a method, while recognising the woman's right to have access to legal and safe abortion if required. Instead, FP helps prevent sexually transmitted diseases (STDs), including HIV/AIDS and unwanted pregnancy, hence abortion (UNFPA, 2018). Importantly, FP promotes women's empowerment, men's participation, and

gender equality. As such, UNFPA (2019) argues that women and girls will have increased access to education and increased participation in economic activities; increased decision-making power and autonomy within the household, as well as working in partnership with men to achieving gender equality.

2.3 The Evolution of Family Planning

Rooted in the neo-Malthusians[1] thinking, FP was implemented in developing countries as a solution to the overpopulation problem which had become evident over the 1950s-1960s (Robinson & Ross, 2007).

2.3.1 Critiques of Family Planning

While FP gained favour with governments in developing countries, a growing criticism arose. FP was narrowly defined, as the purpose was merely to increase the number of users by pushing women to accept contraceptive methods. The programme was designed and implemented by international agencies whose agenda was driven by neo-Malthusian thinking (Seltzer, 2002). Thus, the local culture and circumstances were not taken into account and other RH issues were neglected (Hartmann, 1995).

The programme was criticised for being racist and discriminatory. Upper-class and middle-class couples had the right to voluntarily decide on timing and number of children, whereas the poor were restricted in their fertility (Hartmann, 1995). In Singapore, for example, the government encouraged increased fertility among educated women while it limited that of poor and uneducated women (Sen & Grown, 1987).

[1] The Malthusian Theory originated from “An Essay on the Principle of Population” by Thomas Malthus in 1798. The theory assumed that population rate would grow excessively and that the level of population would outstrip the food supply and natural resources. Hence, population check is needed in order to balance the population and resources. His theory was further developed and built on by Social Darwinism concept, which argues that rich people have superiority over the poor and are “biologically and socially more fit to reproduce” (Lopez, 2008, p.4).

Moreover, FP violated human rights and the principle of voluntarism. The violation included the limited contraceptive choices and the lack of informed consent from the users — for example, forced sterilisation in Puerto Rico in 1968, and China's one-child policy, which imposed abortion and sterilisation (Kabeer, 1992; Robinson & Ross, 2007), and the massive coercive sterilisation campaign in India in 1975 (Eager, 2004).

2.3.2 Feminists Critiques of Family Planning

Feminists and women's health advocates have been sceptical about a FP programme that treated women's body as a means for population control. Women were targeted but they were neither involved nor consulted in the process of contraceptive development, including programme design and implementation, and only female contraceptive methods were produced (Eager, 2004; Dixon-Mueller, 1993). Targeting women alone put greater pressure and burden on women and excluded men from their responsibilities. Adolescent and young people's needs were also omitted (Sen & Grown, 1987).

The quality of contraceptive methods was also often unsafe and ineffective. The providers did not provide information on the side-effects to their clients (Hartmann, 1995). Moreover, the Depo Provera was considered dangerous and banned in many developed countries but continued to be injected into women in developing countries. The IUD was inserted into women, including poor rural women without checking on their health condition. The lack of sanitation and attentive care by medical professionals worsened women's health conditions (Sen & Grown, 1987).

However, the feminist movement was not without disagreement, especially in terms of Western feminism versus Third World feminism. The Western feminism[2] called for women's rights and personal freedom to have control over their reproduction by claiming that motherhood should be voluntary and seen as a skill

[2] The western feminist movement stemmed from the birth control movement, led by Margaret Sanger in the U.S, in 1914 (Lopez, 2008).

and choice for women rather than an “instinctive practice” (Hartmann, 1995, p. 95). On the contrary, Third World feminists argued that such a view is inappropriate in developing countries, where women’s conditions and circumstances are diverse. These include barriers such as poverty, the impacts of structural adjustment programmes, economic subordination, religious and cultural restrictions, as well as limited access to the healthcare system (Hartmann, 1995).

In many developing countries[3], dominated by men in a patriarchal system, women are internalised as subordinate; women are often deprived of their rights to control their RH (Petchesky & Judd, 1998). Most pregnant women in developing countries, especially in rural areas, give birth without a trained birth attendant or quality postnatal care. Consequently, the risk of maternal death due to pregnancy is around 50-200 times higher in developing countries than that of Western women (Eager, 2004).

While Western feminism emphasises individual freedom and rights, Third World feminists see those rights linked to family, community, and society. Correa believes that “‘self’ cannot be isolated from larger social conditions – conditions that often, in fact, determine which choices become available to women” (Correa,1994. p.77). Sen and Grown (1987, p.49) agree that "women know that childbearing is a social, not a purely personal, phenomenon".

Moreover, Third World feminists argue that the Western feminist’s narrowly limited women’s rights to merely reproductive rights, while failing to address women’s reproduction, production, and community work or triples roles (Johnson, 1995). They contended that FP should be defined beyond contraceptive methods and in the context of full RH, inclusive of women’s empowerment and gender equality.

Therefore, Third World feminist network Development Alternatives with Women for a New Era (DAWN) urged integrating women’s productive role and cultural

[3] This is not to say Western or developed countries are not patriarchal.

role into RH and rights. DAWN argued that RH should also cover broader issues, such as safe and legal abortion, STDs including HIV/AIDS, prenatal care, mental health, and other preventive health issues. Importantly, women's reproductive rights should link to human rights that guarantee the rights to a quality standard of living, education, health, employment, plus political and legal rights, in addition to reproductive rights (Correa, 1994).

2.3.3 Paradigm Shift from Population Control to Sexual and Reproductive Health and Rights

The population and development issue was first publicly and internationally debated at the World Population Conference in Bucharest (1974). A key realisation was that fertility control could not solve overpopulation problems, thus the interrelationship between population and socioeconomic development was recognised (Johnson, 1987). As a result, the conference adopted a Plan of Action, which promoted human rights, by stating that individuals and couples have the right to decide freely and responsibly the number and spacing of their children and have means to do so (Hunter, 1976).

This shift towards rights was located alongside an increased interest the role of Third World women in development, specifically due to the rise of Third World feminist organisations such as DAWN; the launching of the Decades for Women 1975-1985; and the adoption of the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Overall more attention was being placed on ensuring women's full participation in social, economic, and cultural development alongside men's engagement in promoting gender equality.

Despite ongoing controversies and debates since the 1950s, the 1994 International Conference on Population and Development (ICPD) in Cairo marked the end of population control and the turning point for a paradigm shift. Alongside the influence from feminists, the focus shifted from population targets to concern over human lives and sustainable development, especially reducing

maternal and child mortality and promoting women and girl's empowerment and education.

Inspired by the feminists[4], the Draft Programme of Action adopted contained the women's rights perspective described above. Also, a commitment was made to provide universal access to comprehensive SRH. FP was reiterated to be based on the principle of voluntary and fundamental rights of individual men and women and couples to decide on the number, timing, and spacing of childbirth, based on an informed decision and having "access to safe, effective affordable and acceptable family planning methods" (UNFPA, 2019). Although men's participation had been mentioned in Bucharest, it was explicitly emphasised and reinforced in Cairo. The rights and needs of adolescent and unmarried young people regarding SRH were once excluded but were now recognised and promoted.

Women's empowerment and gender equality were also reinforced at the Fourth World Conference on Women in Beijing, in 1995, through the adopted Beijing Declaration and Platform for Action. The Declaration reaffirmed commitment to advancing women's rights and men's participation in ensuring equal and shared power and responsibilities between men and women (UN, 1995).

In summary, Table 2.1 presents the focus of each UN Population Conference. This focus has been developed and modified from Bucharest to Cairo. The conference in Bucharest marked the realisation of the interrelationship between population and socioeconomic development based on human rights principles. The Cairo conference was a turning point for a paradigm shift and marked the end of population control.

[4] The ICPD was a feminist-inspired conference. Prior to the conference, a series of preparatory meetings were conducted. Among these, the International Women's Health Conference gathered women from all over the world and NGOs networks to agree upon a strategy for ICPD. The outcome was a Declaration which highlights RH and rights as women's human rights and emphasised that a gender power relationship is central to reproductive rights (Correa, 1994, p. 66).

Table 2.1 UN Population Conference in Bucharest, Mexico City, and Cairo

Bucharest, 1974	Mexico City, 1984	Cairo, 1994
• Focused on the interrelationship between population and social, economic and cultural development • Recognised other population concerns such as maternal and child health, mortality and morbidity, migration, women's status and gender equality • Called for integrating population policy and programme into social and economic development in accordance with human rights principles • Called for international assistance to respect state sovereignty of recipient countries	• Reviewed progress made and reaffirmed principles adopted in Bucharest • Reinforced Men's involvement in family responsibilities including FP • US announcement to withdraw funding from any FP programme supporting abortion	• Inspired and influenced by feminists • Marked the end of population control • Emergence of reproductive health and rights • Focused on broader population and development issues in the context of sustainable development • Called for FP to be integrated into comprehensive sexual and reproductive health • Reaffirmed human rights standards to be applied in all aspects of population programmes • Reaffirmed women's empowerment and gender equality to be central for reproductive health and rights • Reinforced men's involvement especially in FP

According to the FP evolution, the definition and approaches of FP have evolved from a narrow, top-down technical perspective to a broader perspective encompassing SRH and human rights, women's empowerment and gender equality. Table 2.2 summarises this theoretical shift including various critiques, which are then expanded upon in Table 2.3.

Table 2.2: Summary of Theoretical Shift on Population Policy and Programme from the 1950s

The 1950s	The 1960s	The 1970s	The 1980s	The 1990s
• Emergence of the neo-Malthusians • Focus on population control	• Inception of FP programmes • Coercive target-oriented approach	• Concern for human rights and voluntarism • FP integrated into socioeconomic development	• Quality of care • Concern for users' perspectives and experiences	• Emergence of SRHR • Human rights-based approach • Integration of SRH in primary health care

Table 2.3: Criticisms of Family Planning

Criticism of FP		• Narrow definition, based on Western agenda, for the purpose of population control in developing countries • Designed and implemented by Western agencies, who failed to address broad sexual and reproductive health needs • Racism and bias: certain groups have the right to reproductive choice, while others are restricted • Focused on women in isolation with women's bodies treated as instruments for fertility control • Women are pushed to accept and use contraceptive methods without informed consent or knowledge of the side-effects • Supply-side approach ignores safety and effectiveness of contraceptive methods • Cultural insensitivity: local culture and circumstances ignored
Feminist Critiques	**Western feminist**	• Influenced by birth control movement led by Margaret Sanger in 1914 • Focus on women's reproductive rights and access to contraceptive information and methods • Call for women's personal freedom and self-determination and control over their body • Motherhood as voluntarism
	Southern feminist	• Focus on women's reproductive rights as human rights (e.g. rights to quality of life, education, health, employment) • Call for consideration of differences in women's circumstances and experiences: poverty, subordination, cultural barriers, social status • Personal rights link to family, society and community • Motherhood as social phenomenon
Religious Fundamentalist		• Against abortion and sterilisation • Family planning is immoral and leads to marital infidelity • Abortion is a form of murder, which is against the right to life

2.4 Post-ICPD Family Planning Policies and Practices

As discussed in the previous section, FP has been integrated into a broad sexual and reproductive health (SRH[5]) scheme including rights. The ICPD calls for provision of integrated SRH within the context of the primary health care system (PHC[6]) and promotes local participation through decentralisation. This section discusses some operational achievements and challenges involved with the implementation of SRH since the ICPD.

The ICPD places a strong emphasis on the integration[7] of SRH in the context of primary health care, which they considered cost-effective and essential for achieving the ICPD agenda. The primary health care should provide a minimum package of SRH components together at a one-stop location or through a referral system to higher healthcare levels (UNFPA, 2004).

The ICPD also promotes decentralisation, which emphasises local community participation in planning and implementing SRH policies and programmes in response to the needs of local people. Further emphasis has been placed on the quality of care, which aims to meet clients' needs. Quality of care comprises six elements: *choice of methods*; *information given to clients*; *technical competence*; *interpersonal relations*; *follow-up/continuity mechanisms*; and *a constellation of*

[5] According to ICPD Programme of Action (PoA) Chapter VII (A), reproductive health means "a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and to its functions and processes." (UNFPA, 2004, para 7.2, p.45). Therefore, RH implies that individuals and couples "are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so". In addition, it highlights the rights of men and women to have access to safe, effective and affordable FP information and services (,UNFPA, 2004,Chapter VII (A), para 7.2, pp 45-46).

[6] Primary health care is "essential health care based on methods and technology made universally accessible to individuals, families and communities through their active participation and at an affordable cost. PHC is an integral part of a country's health system and, ideally, its main focus. It is the first level of contact for individuals, families and communities and enables health care to be delivered as close as possible to where people live and work. PHC is therefore the first element of the care continuum" (WHO, 2019, para 1).

[7] According to UNFPA, WHO, and IPPF, integration of services "can be understood as joining operational programs to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc…)" (Warren et al., 2017, p.102). Integration of SRH comprises RH, maternal and child health (MCH), FP, and sexual health including STIs and HIV/AIDs.

services (Kumar & Gupta, 1999). Hence, integration, decentralisation, and quality of care are mutual reinforcers for achieving comprehensive SRH.

2.4.1 Progress of SRH since the ICPD

Positive progress has been made since the ICPD. Many developing countries have adopted RH language and developed SRH policies and programmes based on the ICPD recommendations (Correa, 1999). For example, population policies on birth spacing and safe motherhood were adopted in 1997 in both Laos and Cambodia; Nepal's Reproductive Health Strategy was implemented in 1996; RH service policy and standards drafted in partnership with NGOs were accepted in Ghana in 1996; and the Reproductive and Child Health policy 1997 was approved in India (Khanna et al., 2002). Maternal mortality has declined, and unmet needs for FP have decreased from 29% in 2003 to 26% in 2012 (Darroch & Singh, 2013).

Many governments focused on increasing competence among community health workers. In Ethiopia, Malawi, and Rwanda, the government focused on rural development through decentralisation. Community health workers have been trained to provide contraceptives including injections and implants. The programmes in these countries were all integrated into the primary health care system (Cates & Maggwa, 2014).

The role of community health workers is vital in providing health education. A study by Scott et al. (2015) supports the effectiveness of the community-based programmes in Bangladesh, Ghana, Pakistan, and Uganda. They found that not only did the community health workers increase contraceptive use among local community in remote areas, but they also played a key role in providing health education by encouraging and referring clients to seek healthcare at health facilities.

2.4.2 Challenges in Implementing the ICPD Agenda

Despite such progress, enormous challenges remain regarding policy formulation and programme implementation based on the ICPD recommendations. The first major challenge is the lack of a clear understanding of SRH and the lack of practical guidelines for implementing such a broad agenda has caused confusion for governments in setting policies and translating these into practice (Hardee et al., 1998; Kantner & Kantner, 2006; Gillespie, 2004; Mayphew, Cleland & Walt, 2000). The ICPD definition of SRH is too broad and complex and it has been perceived inconsistently by different people. SRH is not a stand-alone issue, as it embeded within gendered social relations (Kane et al., 2016). However, there is lack of understanding of SRH and its interlinkages between women's empowerment, gender equality, and men's involvement, as well as other infleuntial factors, which has hindered implementation of the full ICPD agenda (Correa, 1999; Dudgeon & Inhorn, 2004).

Secondly, it is not clear how decentralisation of the SRH programme, planning and implementation is translated into practice (Hardee et al., 1998). The majority of decision-making power remains at the central level due to the hierarchical system of many developing countries. Decentralisation also implies increased responsibilities at local levels, but this is difficult to manage due to limited capacity of staff and a lack of understanding of the true SRH concept (Mayphew et al., 2000). Decentralisation requires time and resources for proper planning and preparation. Yet, many governments have pushed too fast resulting in inadequate planning, staff, and budgets; local staff insufficiently trained; and insufficient resources provided. Further to these insufficiency problems, accountability of the local government is often absent, monitoring and evaluation (M&E), initial data collection to support planning may not occur, and existing healthcare may be poor due to issues such as poor infrastructure and lack of essential equipment (Byrne, Morgan, Soto & Dettrick, 2012).

The third challenge is the quality of care required. This quality not only involves the quality of supplies and facilities, but also health providers' attitudes, sensitivity,

and skills, including an understanding of clients' needs. In reality, neither the existing healthcare system nor the performance of health providers may meet the standards of quality of care (Mbizvo & Phillips, 2014). For example, a study of a FP programme in Ethiopia (Tafese, Woldie & Megerssa, 2013) found there to be issues of quality of care, such as a lack medical equipment, a shortage of trained staff, a lack of an effective design and use of information, education and communication (IEC) materials during the counselling service. Too often, health providers do not discuss a full range of methods and information about the side-effects, and many providers make recommendations without learning about their clients' health conditions (Kantner & Kantner, 2006; Kumar & Gupta, 1999). Providers' attitudes towards clients' status, ethnicity, age, and class are crucial for clients to obtain an equitable quality of healthcare.

Fourth, political and financial barriers often impede implementation (Cates & Maggwa, 2014). Notably, the Global Gag Rule or the Mexico City Policy[8] under the Bush Administration not only led to a shortage of funding to UNFPA but also impacted the high donor-dependent countries.

Finally, cultural and religious barriers remain significant challenges to women's empowerment and gender equality. These barriers include: the patriarchal system; misconceptions and social norms; and the perception that SRH is a sensitive and taboo issue (Byrne et al., 2012). Although FGM has been globally recognised as a violation of women and girls' human rights, these practices continue. Adolescent and young people are particularly vulnerable, as the government is reluctant to include them in SRH policies and programmes. Health providers are often reluctant to provide SRH to adolescents and young people,

[8] Mexico City Policy, also known as the Global Gag Rule was first announced by the Reagan administration at the second population conference in Mexico in 1984. The policy does not accept abortion as a form of FP and restricts NGOs under U.S funded and other funding sources from promoting and/or providing abortion information and services (Cincotta & Craine, 2011). The politics of the Mexico City Policy were grounded in the U.S political struggles between Republican (anti-abortion) and Democrats (pro-choice) (Crane & Dusenberry, 2004). The implementation and abolishment of the policy depended on each presidency. For example, during the Clinton administration in 1993, funding for FP programme was resumed (Kantner & Kantner, 2006). Currently, under the Trump administration, the policy was rescinded and renamed "Protecting Life in Global Health Assistance" (Kaiser Family Foundation, 2019, para 1).

and they are often required to obtain parental consent before they can access the SRH service (Barroso, 2014).

2.4.3 Sexual and Reproductive Health in the Context of MDGs and SDGs

SRH, especially FP, was pushed aside in the 2000s when the Millennium Development Goals (MDGs) took centre stage regarding development. SRH was excluded, and it was reduced to merely maternal mortality reduction via goal 5; other SRH components were missing. It was assumed that FP lost its importance due to two main factors: First, low fertility was the result of conventional FP in developing countries, thus, it was perceived that fertility control was complete. Second, competing domains, such as HIV/AIDs and poverty reduction, further drew attention away from FP.

The MDGs have been criticised as top-down, technocratic, reductionist, and simplistic (Yamin & Boulanger, 2013). Particularly, Goal 5 limited the women's role to merely motherhood and/or their pregnancy status, without any reference to the ICPD. It was not until 2005 that evidence showed that the MDGs Goal 5 was lagging. At this point, SRH was realised to be crucial for reducing maternal mortality. In response, the UN incorporated universal access to SRH into Target 5B in 2007. FP was also revived through FP2020, in 2012 (Dixon-Mueller & Germain, 2007; Culwell, Vekemans, Silva, Hurwitz & Crane, 2010; Haslegrave, 2013).

Based on the lesson learned from the MDGs, the SDGs have explicitly included SRH, repeating the concern of the ICPD and the Beijing Declaration, especially documented in Goal 3 on health and well-being[9]; and Goal 5 on gender equality and women's empowerment[10]. UNFPA, WHO, and IPPF have collaborated to

[9] Target 3.7: by 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes (UN,2017).

[10] Target 5.6: ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences (UN,2017).

create guidelines for the integration of SRH and deliver better implementation of the ICPD agenda, in the context of SDGs.

2.5 Men's Involvement Initiatives

While discussion about the importance of men's involvement has been ongoing since the Population Conference held in Bucharest in 1974, only recently has this discussion had any application. Such a shift was due to the women-focused thinking of the Women in Development (WID) approach in the 1970s evolving into Gender and Development (GAD) in the 1980s and then into the recent masculinities' approach. This approach reiterates acknowledgment and inclusion of both men and women in development policies and programmes. Men's involvement is essential to women's empowerment in the decision-making process, particularly within the context of SRH/FP, as it concerns gender power relations within the household.

The limitations of WID led to the emergence of GAD in the 1980s; gender was brought into the development discourse. Gender was defined as the social relationship between men and women. This relationship is socially constructed and shaped by various factors, such as culture, ethnicity, and history, amongst others (Moser, 1989; Razavi & Miller, 1995). GAD recognised women's triple roles. Within GAD, women were not seen as passive beneficiaries but active agents (Stewart-Withers, 2007), with recognition of their ability to make decisions of their own. Therefore, GAD's focus was beyond the solely practical gender needs, as it focused on strategic gender needs, and challenged the unequal power relations that cause women's subordination. Meanwhile, the rise of Third World feminists initiated an empowerment approach to challenge women's subordination, not only within the relationship between men and women, but also as a result of other factors, such as colonialism and the global economic order that shaped women's experience of oppression in Third World countries (Stewart-Withers, 2007). Although the shift from WID to GAD integrated gender into the

development discourse, the focus on women still outweighed men, which led to the discourse on masculinity.

2.5.1 Toward Masculinity

Masculinity is often equated with hegemonic masculinity. Hegemonic masculinity is understood as the negative aspects of masculinity (Greene et al., 2011; Estrom et al., 2015). For example, men should 'take risks', 'endure pain', be 'independent providers', 'sexually aggressive', 'controlling', and/or 'abusive'. Too often, feminists and women's rights advocates tend to emphasise such dominant versions of masculinity and ignore others. Hence, men are assumed to be 'the problem,' 'the oppressor' and 'the obstacle' to women's development (Cornwall, 1997; Cleaver, 2002; Sweetman, 2013).

Based on this idea of men as problematic, WID and GAD are argued to be unfair and unjust to men (Connell, 1995). Men are simply positioned in terms of their heterosexual relationship with women, neglecting any other roles and experiences. For example GAD overlooked relationship between mothers and sons, fathers and daughters, brothers and sisters, female employers and male employees, leaving "no space for men's experience of powerlessness, love or dependency in their relationship with women" (Cornwall, 2000, p. 20).

It is essential to analyse the underlying processes which determine the behaviours of men and women, for instance gender norms. Gender norms "…are the specific social norms that relate to how men, women, boys, and girls are 'supposed' to act and behave throughout the various stages of the lifecycle" (Estrom, Hassink, Shahrokh & Stern, 2015). As such, gender norms construct the dominant version of masculinity, undersood to mean the particular pattern of social behaviours or practices that is associated with ideals about how men should behave and their position within gender relations" (MenEngage, 2014, p.15). In this way, it puts greater pressure on men if they do not achieve the

expectation that is created by the society[11]. Gender norms also influence the health-seeking behaviour and the health outcome of both men and women. As masculinity is constructed, there is also a need to consider historical, social, cultural and economic factors that influence the construction of masculinity in any society (Dworkin et al., 2015).

Not all masculinity is hegemonic as portrayed by WID and GAD however. Men can also be disadvantaged. Men have a higher risk of getting an infection from HIV, and more significant exposure to violence in situations of, conflict and war. Thus, men also need support from development programmes. Cornwall (1997, p.11) argues that "not all men have power and not all of those who have power are men".

There are also inequalities among men. Dworking et al. (2015) concluded that men experience masculinity differently, just as they also experience violence, poor health, and the pressure related to gender norms. It is thus necessary to understand various forms of masculinity: hegemony, subordination, complicity, and marginalisation (Torres, Goicolea, Edin & Ohman, 2012). It is also important to consider 'intersectionality' which refers to race, class, ethnicity and socio-economic status all of which shape men's experience of masculinity (Dworkin et al., 2015; Hartmann, 2016).

2.5.2 Men's Involvement in Family Planning

As discussed above, the conventional approach to FP focused solely on women, while men were excluded. Gender norms have shaped the perception that RH including FP is a women's issue (Maharaj, 2000; Sternberg, 2000; Estrom et al., 2015; Slauson-Blevins & Johnson, 2016; Hardee, Groce-Galis & Gay, 2017). It is universally recognised that in a patriarchal society, men often make decisions on behalf of women regarding RH/FP (Dudgeon & Inhorn, 2004; Mboane & Bhatta,

[11] Connell (2017) referred to the patriarchal dividend, whereby the "social definition of masculinity includes being the breadwinner and being strong" (p.1811).

2015; Tilahun, Coene, Temmerman & Degomme, 2015). Thus, men play a predominant role in the RH of both men and women.

Since the 1990s, men's involvement has been further reiterated as crucial to SRH. Particularly, the ICPD Programme of Action affirmed men's role in bringing about gender equality [12] (UNFPA, 2014). This statement shows that the ICPD recognises men's dominance as a decision-maker in the family, with the assumption that involving men in SRH leads to gender equality within SRH through spousal communication, joint decision making and shared responsibilities. The Beijing Platform of Action 1995 reinforces men as a vital contributor to gender equality and women's empowerment, especially in the sphere of SRH.

Critiquing Men's Involvement in Family Planning

There is some concern that involving men in women's development may exacerbate gender inequalities. Some scholars raise concern that men's involvement may undermine the work of GAD and they fear that the resources will be allocated to focus more on men (Cornwall & White, 2000; Sweetman, 2013). Others are concerned about the commitment and willingness of men in working with women's development. It is unclear whether men's involvement contributes to women's empowerment, or whether it provides more power to men over women (Sternberg, 2000; Sternberg & Hubley, 2004, Greene et al., 2006).

Such concern raised the question of how men should be involved or what should men's involvement looks like. According to Adamou, Iskarpatyoti, Agola and Mejia's (2017) document review examining the definition of men's involvement, including monitoring and evaluating men's involvement in FP, there is no universal definition for men's involvement. Rather, there is a commonly held

[12] "Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government" (UNFPA, 2014, p.36, para 4.24,).

understanding: that men's involvement in FP "is the inclusion of men in FP programming as clients of FP services, supportive partners, and agent of change in family, community and society" (Adamou et al., 2017, p.13).

From this common definition, it seems that approaches that have been commonly used are aligned with the framework of Greene et al. (2006), which indicates men's involvement in three aspects: *men as clients*; *men as supportive partners*; and *men as agents of positive change*. An explanation of each approach is shown in Table 2.4.

Table 2.4: Approaches to Men's Involvement in Sexual and Reproductive Health[13]			
Approach	**Purpose and Assumption**	**Programme Implications**	**Limitations**
Men as clients	Addressing men's RH needs.	Extend same range of RH services to men as to women. Employ male health workers.	Focusing on men's needs potentially maintains men's dominant position Not analyse gender relations nor address gender inequalities that influence RH of women and men. Does not support broader change at the societal level.
Men as partners	Men have central role to play in supporting women's health	Recruit men to support women's health, e.g., teach husbands about danger signs in labour, how to develop transportation plans, the benefits of FP for women's health.	Views men as either supporter or opponent of women's access to RH/FP services (similar to *men as clients*). Does not address power relationship between men and women, rather reinforces the notion of men as the decision maker. Does not support broader change at societal level.
Men as agents of positive change	Promote gender equity as a means of improving men's and women's health and as an end in itself. Addressing inequity requires men's full participation and cooperation	Paradigm shift in how programmes are structured, and services are delivered Broader range of activities: working with men as sexual partners, fathers, and community members. Encourage men's role in supporting women's RH. Challenge harmful gender norms.	

[13] Source: Adapted from Greene et al., 2006.

		Attempt to make change at societal level.	

While most programmes involve men as clients and supportive partners, programmes that focus on men as agents of change have been rare (Adamou et al., 2017). Indeed, change at individual level is not easy, not to mention change at societal level. In addition, there is a lack of monitoring and evaluation, as most programmes have not paid attention to men's involvement or lacked clear objectives, and hence, lacked indicators (Greene et al., 2006; Adamou et al., 2017). While there may be policies with an intention to involve men, it is often inadequately translated into concrete action (Greene et al., 2006).

Notwithstanding various concerns, it is the responsibility of policy makers and development practitioners to be clear on the definition of men's involvement in FP and how they involve men, including setting clear and effective indicators for men's involvement. Importantly, they need to ensure that the concerns over men's involvement discussed above will not occur. As discussed earlier, in order to involve men in a more nuanced and meaningful way, it is essential to have a better understanding of masculinity alongside gender norms and intersectionality that shape masculinity.

2.5.3 Successes and Challenges with Men's Involvement in Family Planning Programmes

Various studies conclude that men's involvement as *supportive partners* in FP leads to increased communication between couples, a change in men's attitude to become supportive, for example making joint decisions, supporting their wife to use contraceptives and, thus, increase the use of FP methods, as well as shared responsibility regarding childcare and household work (Maharaj, 2000; Sternberg, 2004; Rosliza & Majdah, 2010; Bayray, 2012; Adango et al., 2013; MacDonald et al., 2013; Ezeanolue et al., 2015; Koffi et al., 2018). In addition, a

study conducted in Northeast Ethiopia by Kassa, Abajobir and Gedefaw (2014) found that some men expressed an interest to know more about FP information.

Some studies also conclude that men become more willing to use male contraceptives. The FP programme in Ghana (Maharaj, 2000) engaged men by sensitising men on gender issues, as well as raising awareness among men using the Information, Education, and Communication (IEC) campaign. The result was that men become aware of gender issues and FP, which lead them to become more responsible in SRH. Also, their attitudes and behaviours positively changed; they became more willing to use modern contraceptive methods such as condoms.

Similarly, a study by MacDonald et al. (2013) in Vietnam and India found that men's attitudes and behaviours changed as they started to share responsibility within the household, for instance caring for children and helping out with household chores. Moreover, they also started to discuss RH with their partners, as well as considering the use of modern contraceptive methods, such as condoms and male sterilisation. However, a study about condom use among Lao men in Vientiane Capital (Natoli, Holnes, Chanlivong, Chan & Toole, 2010) found that while men use condoms when they engage in extramarital affairs, it was not common for them to use condoms within marriage. Condoms are, therefore, often associated with trust issues.

Challenges

Despite the positive results of men's involvement in FP, challenges remain due to various factors. Firstly, IEC are essential for increasing the awareness of FP and promoting the positive role of men in FP. However, there are common difficulties concerning such strategies in practice, for instance, there is a lack of IEC tools and materials, which are poorly designed and an inadequate use of such materials in counselling services (Tafese et al., 2013). Other issues, such as limited capability and skills of community staff to provide counselling that engages men, are also common (Adango et al., 2013; Tafese et al., 2013; Mbizvo

et al., 2014). Limited male contraceptives also impede the full engagement of men in FP. Globally, there have been only two male contraceptive methods, namely condoms and vasectomy (Adango et al., 2013; Mbizvo et al., 2014; Koffi, 2018). In the context of developing countries, the lack of access to male FP methods is often associated with the high cost of vasectomy (Mbizvo et al., 2014), misconceptions and fear.

Secondly, men's involvement strategy is often adopted as an instrument for women's empowerment – *men as supportive partners*, rather than including men as beneficiaries – *men as clients* (Dudgeon & Inhorn, 2004; Sternberg & Hubley, 2004; Anderson, 2005; Hardee et al., 2017). The ICPD and the Beijing Declaration promote men's involvement within the notion of hegemonic masculinities, which views men as the 'problem' (Hardee et al., 2017). Both at the policy level and operational level, men are seen to be the sole supportive partner for increasing women's use of contraceptives. The human-rights-based approach usually equates to women's rights. As such, men are added to FP merely to support women's rights and empowerment. Such incorporation of men in FP tends to exclude men's SRH rights and needs.

Therefore, there has been little progress in FP programmes that reach out to men as clients resulting in little-shared responsibility regarding the use of contraceptives (Hardee et al., 2017). Women continue to bear the burden as the main contraceptive users. Male contraceptive users account for less than 30 percent globally (Estrom et al., 2015). Hardee et al. (2017) reviewed 47 FP programmes in 27 countries across Asia, Africa, Latin America, the Caribbean, and the Balkans and they concluded that only a few countries had promoted men as contraceptive users in the FP policy, planning, and intervention. Cambodia was one of these few.

The exclusion of men as clients is one of the factors causing fewer men to be involved in FP. Rosliza and Majdah (2010) studied men's involvement in FP in Malaysia and found that FP mainly targets women and neglects the men's role as clients, which resulted in less meaningful participation of men in FP. Kassa et

al. (2014) also concluded that men's participation in FP was low in Northwest Ethiopia, due to the programme's failure to involve men as clients, which contributed to less utilisation of condoms and vasectomy. They also found other factors that influenced the level of men's participation. These included structural and cultural issues, and misconceptions.

Thridly, the cultural perception of SRH/FP, being the woman's domain is common. Reproduction is often disproportionately seen as the women's responsibility, due to their reproductive role and biological aspect (Sternberg, 2000; Bayray, 2012; Estrom et al., 2015; Slauson-Blevins et al., 2016; Koffi et al., 2018). The critical issue is that the perception of health providers often leads to the exclusion of men in obtaining SRH/FP counselling and services (Bayray, 2012; Adango et al., 2013; Estrom et al., 2015; Slauson-Blevins, 2016). Such a perception is fundamental, as it shapes the attitudes and behaviours of individuals. Failing to shift this perception may exacerbate the inequality between men and women regarding FP.

Lastly, misconceptions about contraceptives is a common issue. While there is a favourable view of FP and some men agree that there should be joint decision-making among couples, some are concerned that if women have control over their SRH, they may have extra-marital affairs (Bayray, 2012). Some fear that vasectomy would undermine their manhood and fatherhood in the future (Sternberg, 2000). A study by Kabagenyi et al. (2014), conducted in rural areas of Uganda, concluded that one of the barriers to men's involvement in FP is that men fear harmful side-effects of contraceptive methods that would affect sexual activity and lead to the unfaithfulness of women.

The common aspects of the achievements and challenges outlined from the studies discussed are summarised in Table 2.5. As mentioned above, these challenges can be addressed through awareness raising and education among men and women, with support and enabling from legal, political, social and cultural environments.

Table 2.5 Summary of achievements and challenges with men's involvement in FP programmes

Achievements	Challenges
• Increased awareness of RH/FP for both men and women • Increased communication between the couple • Increased joint decision-making and shared responsibilities • Positive change in men's attitudes to become more responsible and supportive of their wife's choices	• Gender norms that shape perceptions and behaviours of both men and women • Misconceptions about FP methods • Limited awareness and lack of understanding of FP • Limited availability of a wide range of contraceptive choices

2.6 Gender-Focused Approach

It is necessary to involve both men and women in a synchronised manner. However, the gender-transformative approach promoted by the ICPD and Beijing often targets one sex or another unilaterally (Greene & Levack, 2010). For example, men are incorporated into the existing women-centred SRH programme, which seems to be an oversimplification. The definition of men's involvement tends to be limited to involving men as supportive partners, rather than combining the three aspect of men's involvement.

As previously discussed, although men have been incorporated into SRH and FP as supportive partners, there has not been much progress. While it is universally recognised that change at societal level requires involving men as agents of change, there is very limited evidence of FP programmes using this approach, let alone adopting the full approach that combines *men as supportive partners*, *men*

as clients, and *men as agents of change*. Thus, men's SRH needs have not been seen as important as those of women.

Within the gender norms, not only do women internalise their subordination, but men also internalise their dominance (Dworkin et al., 2015). Such internalisation often has a negative impact on the RH of both men and women. Therefore, recognition of men's disempowerment, vulnerabilities, and needs for SRH is the first step towards incorporating both men and women jointly in SRH programmes (Dworkin et al., 2015; Estrom et al., 2015). It is important to recognise that men are interested in learning about FP and need access to FP information and services (Comrie et al., 2015; Koffi et al., 2018).

Greene and Levack (2010) insist that special attention should be given to the attitudes and bias of the health providers, and whether they often focus more on women than men. Hardee et al. (2017) advise that there is a need to move beyond men as supportive partners while ensuring that this will not exacerbate the unequal power relationship between men and women. Thus, there is a need to "engage men—as partners, clients, and agents of change—as allies in the effort to promote the benefits of more gender-equitable relationships for the whole community and promote positive male role models" (Greene et Levack, 2010, p.20).

2.7 Chapter Summary

This chapter discusses the ways concepts and approaches of FP have evolved and shifted over time. It was not until 1994, at the ICPD in Cairo, that there was the paradigm shift to incorporate FP into the broader SRH and a human rights-based approach was endorsed to implement the SRH/FP programme. Men's involvement gained strong recognition as a critical element in achieving women's empowerment and gender equality. However, such involvement merely focuses on men as an instrument for women's empowerment. As a result, men's roles as individuals and clients who have the rights and needs for SRH are neglected. Various lessons learned from the past studies, as discussed above, present a

strong signal for promoting a more gender-inclusive approach. The literature review in this chapter shows that most SRH/FP programmes failed to meet the needs of women, let alone men's involvement. The valuable lesson is that targeting women alone is not working. It is more difficult to effectively implement men's involvement in a meaningful way by simply adding men within the confines of narrow masculinities and without considering the intersectionality and other barriers.

CHAPTER 3: CONCEPTUAL FRAMEWORK OF EMPOWERMENT

3.1 Introduction

Women's empowerment entered the development discourse several decades ago. Since the 1970s, the concept of empowerment has emerged from grass root and bottom-up approaches as well as women's movements in response to the failure of the conventional top-down development approach. Women's empowerment and gender equality have increasingly gained visibility and been claimed to be crucial for achieving development goals. Empowerment was mainly promoted through the International Conference on Population and Development (ICPD) in Cairo, in 1994, which emphasised that women's empowerment is central to sexual and reproductive health and rights (SRHR). The Beijing Platform for Action of the Fourth World Conference on Women, 1995, reinforced women's empowerment as fundamental to achieving gender equality. Women's empowerment and gender equality are also reflected in the Millennium Development Goals (MDGs) and remain significant in the Sustainable Development Goals (SDGs), especially Goal 5 – Gender equality.

The conceptualisation of empowerment varies depending on its users. From the perspective of feminist from the Third World, women's empowerment is about redistributing power relations between men and women, so that women have increased self-confidence, autonomy, and decision-making power equal to men. Empowerment is both a process and an end; it is multi-dimensional and context-specific. Importantly, if true empowerment is to be achieved, men's involvement and enabling factors are essential.

This chapter discusses the definition of empowerment by providing a glimpse of its root-concept *power* in Section 3.2; followed by a variety of empowerment conceptualisations in Section 3.3 and its critiques in Section 3.4; Section 3.5 discusses women's empowerment in the context of family planning (FP), and finally, a dscussion of dimensions of empowerment within the context of this study

is in Section 3.6. Since it is multi-dimensional and context-specific, the conceptualisation in this discussion is used as a guiding framework to investigate how men's involvement in FP influences women's empowerment in FP among the Mangkong ethnic group in Laos.

3.2 Power

There are numerous works on the conceptualisation of women's empowerment in development literature. Rowlands (1998) argues that in order to explore the meaning of the term, it is essential to explore its root-concept *power*. Speaking of power, one might think of Foucault's concept of power developed in the 1970s. For Foucault, *power* is exercised by individuals at various levels. He argues that power does not solely operate from above, but in individuals, interpersonal to the state level. It is relational, so is not possessed but exercised by subjects within a social relationship (Lynch, 2011). Similarly, Charmes and Wieringa (2003) insist that individuals in a society exercise their power through their agency, in order to address their problems in life.

In supporting Foucault, Rowlands (1987) argues that there is a need to understand power beyond a zero-sum game. Rowlands calls for an analysis of power of various types, such as *power over*; *power to*; *power with*; and *power within*. *Power over* like the traditional meaning is understood as dominant or controlling power. *Power to* refers to one's ability to resist existing unequal power relations and make a decision on one's own. *Power with* is about a collective action, for instance working as a group to make a change in society. The last type of power is a *power within,* which stemmed from the perspective of feminism. This type of power is about the individual's internal strength or inner power, which are argued to be central to women's empowerment.

According to these definitions, power seems to be exercised by individuals everywhere, even among marginalised and oppressed groups. When they accept their oppression, which Lukes (cited in Rowlands, 1999) refers to as *internalised oppression*, they exercise their power to comply with the rules in their society and

use this power as a survival mechanism. The *internalised oppression* concerns women's perceptions and awareness of their current situation, whereby they accept it and perceive it as natural. They can exercise power to either resist or accept the oppression (Charmes & Wieringa, 2003) Such *internalised oppression* is common in patriarchal society. Kabeer (1999) argues that women in a patriarchal society are influenced by culture and belief. Thus, they internalise their social status by accepting social structures, such as women being a subordinate group who have less value in society, and violence against women is, therefore, acceptable. Hence, these become "aspects of tradition and culture which are so taken for granted that they have become naturalized" (Bourdieu, as cited in Kabeer, 1999, p.441).

3.3 Women's Empowerment

The previous discussion provides a glimpse of the meaning of *power* exercised by individuals in society at various levels. As discussed in Chapter 2, empowerment emerged out of critiques of WID and derived from Third World feminists calling for strategic gender needs to be addressed alongside practical gender needs. Empowerment or *Power within* has been highlighted, by many scholars, as fundamental for the individual to have the *power to* act upon their aspirations. Collective power (*power with*) is also important for changes at a wider level. While feminists tend to lean toward *power within*, other scholars insist that it is difficult for women to empower themselves (*power to*) without an external enabling environment. This tension is discussed below.

Empowerment from Within

Feminists place much emphasis on *power within* as central to the definition of empowerment. Rowlands (1999) argues that women's empowerment should be understood in a way that helps women to be aware of and perceive themselves as capable of and entitled to make a decision that affects their lives. Similarly, Moser (1989) understands empowerment as the capacity of women to gain their

self-confidence, self-reliance, and internal strength, in order to gain the ability to choose (*power to*) and take control over their life, including both material resources and non-material resources. Kabeer (1999) defines empowerment as "the expansion in people's ability to make strategic life choices in a context where this ability was previously denied" (p.437). This strategic life choice is the choice beyond basic needs, when the individual makes his/her own life decision, such as when and whom to marry, and whether and when to have children. Therefore, in order to be empowered, the individual must have previously been disempowered and denied the right to make such life choices. Thus, the feminist definition seems to see women's internal strength or *power within* as the essential foundation of empowerment.

Feminists, such as Rowlands, Kabeer, Batliwala, also see empowerment as both a process and an end. Similar to Foucault, these feminists recognise empowerment as relational, which is displayed at various levels. Rowlands (1999) considers empowerment to be a process "by which people become aware of their interests and how those relate to those of others, in order both to participate from a position of greater strength in decision-making and actually to influence such as decision" (p.143). Batliwala (2007) argues that empowerment is a process concerned with the redistribution of power, for example, changing the unequal power between men and women within the household. She insists that it requires not only a change of mindset at the individual level, but also the community, society, and state level.

However, understanding of empowerment among these feminists is not without contradiction. Although Rowlands and Kabeer drew on Foucault's concept in defining power not as a zero-sum game, Batliwala thought otherwise. She acknowledges that there is indeed some loss in men's power if women become empowered, as she states that:

> women's empowerment, if it is a real success, does mean loss of men's traditional power and control over the women in their household: control of her body and her physical mobility; the right

> to abdicate from all responsibility for housework and the care of children; the right to physically abuse or violate her; the right to spend family income on personal pleasure (and vices); the right to abandon her or take other wives; the right to take unilateral decisions which affect the whole family; and the countless other ways in which poor men - and indeed men of every class - have unjustly confined women (cited in Rowlands, 1997, p.24).

Batliwala seems to place a strong emphasis on negative aspects of masculinity, such as abusiveness, control and aggression. However, as discussed in Chapter 2, while it is necessary to recognise hegemonic masculinity, masculinity does not conform to a homogenous group (Greene & Levack, 2010; Dworkin et al., 2015; Hardee et al., 2017). Defining empowerment within one aspect of masculinity is inadequate.

External Enabling Factors

The discussion of empowerment above seems to focus more on psychological aspects or *power within*. Many scholars suggest that while *power within* is essential, an external enabling environment is necessary to facilitate the process of empowerment. While Rowlands (1998) and Kabeer (1999) highlight *power within* as central to empowerment, Batliwa (2007) contends that empowerment cannot be achieved without challenging the existing unequal power structures and social inequality, including the inequality regarding access to and control over resources, and change at the institutional levels that reinforce existing power structures. Thus, in order to have the *power to* act, women need to access resources that enable their action.

Power within and external resources are interconnected. Kabeer proposed considering such a connection between the *agency*, *resources* and *achievement* aspect of empowerment. Agency comes from within (*power within*), influencing perceptions, beliefs, and abilities of individuals to make decisions. Resources refer to both materials and non-materials that facilitate women to take action.

Without access to resources, they are not able to act on their aspirations through their agency. Achievement refers to the outcome of the integration of agency and resources. Importantly, she argues that social, economic and political structures shape these dimensions. In supporting Kabeer and Batliwa, Eerdewijik et al. (2017) point out that institutional structures such as law and policies, social norms, rules and practice at family, community and state levels influence the agency of women.

In supporting some of the feminist definitions of empowerment above, UNFPA (2000) recognises that changes at both institutional and individual levels are essential for empowerment. UNFPA seems to support the idea of Foucault and the feminists in that it saw power as relational and exercised at various levels. UNFPA believes that for women to gain empowerment, the government needs to provide an enabling social, economic and political environment.

In sum, women's empowerment can be explained by saying that women become aware of their problems in their current situation and couple this awareness with *power within.* In other words, it is at this stage that women begin to enter the process of empowerment by having their sense of agency. In order to act upon their agency, it is crucial to provide women with access to resources, so that they have the *power to* make decisions that affect their lives.

Empowerment is Multidimensional and Context-specific

Empowerment is multidimensional; empowerment in one dimension does not necessarily bring about empowerment in other dimensions. Women who are empowered in the economic sphere may not be empowered within the domestic sphere. Empowerment is also context specific. Many factors shape women's experiences, and these may vary on class, caste, ethnicity, family position, power relations, and so forth (Mosedale, 2005; Rowlands, 1998, Eerdewijik et al., 2017). Age is also crucial as women of different ages have different experiences. As Mason (cited in Narayan, 2005) argued, empowerment is socially/culturally

constructed through social norms, traditions, beliefs, and practices that construct the position and status of society members. In this way, some members are given more power and greater justification rights to exercise their power and rights in society. These include unequal power relations between: the powerful rich and the powerless poor; dominant men and subordinate women; as well as the elders who control those younger. These relationships are constructed by society and culture.

Men's Involvement

Apart from external factors at all levels discussed above, men's involvement is seen to be vital in facilitating women's empowerment. UNFPA emphasises the role of men in women's empowerment, declaring that, "male participation and acceptance of changed roles are essential for women's empowerment" (2000, p.2). The idea stemmed from the International Conference on Population and Development (ICPD), and the Fourth World Conference on Women in Beijing, which actively and strongly advocated the men's role as supportive partners in achieving gender equality and women's empowerment. Beijing reaffirms the equal rights of both men and women in both the public and private sphere throughout the course of life. Kabeer reminds us that women's empowerment is not merely a women's issue but also involves gender relations, which "ultimately require changes of men as well as women" (1999, p.30).

3.4 Critiques of Empowerment

Empowerment is not without criticism. Empowerment is one of the buzzwords in development discourse, with a vague meaning which differs when applied by users with a hidden agenda (Cornwall, 2007). It is often depoliticised and converted into a technical term rather than seeking to transform power relations. The meaning is far beyond the understanding of the layperson and usually understood by development experts. Moreover, empowerment sounds hopeful, positive, promising and ambitious, thus it became popular and was used

extensively in development proposals, policies to attract funding and to provide people with hope. Hence, Cornwall (2005) calls for reflection on the use of the term, whether it results in significant policies and practices or it remains 'nice-sounding words to dress up business as usual' (p. 1044).

Empowerment has been used in global development and has become a common concept in most local communities. In Laos, for instance, there is no such term 'empowerment', instead it has been translated by the development agencies. However, the translation may also differ between agencies. For example, some agencies translated 'empowerment' as "ຄວາມເຂັ້ມແຂງ" (Strength), some translated it as "ຄວາມອາດສາມາດ" (Capacity). Since the concept and term is introduced, translated, understood and used by international development agencies, it is debatable whether people, and ethnic people in rural areas in particular, understand the concept or have even heard the term, let alone participated in defining the term within the local context using local perspectives.

This raises an important point. It is generally assumed that women are a homogenous group who are weak and incapable. As a consequence, it is believed that women in general need to be strengthened or provided with opportunities to build their capabilities in the areas where the development actors think the women's needs are supposed to be. As Rahnema,

> When A considers it essential for B to be empowered, A assumes not only that B has no power – or does not have the right kind of power – but also that A has the secret formula of a power to which B has to be initiated. In the current participatory ideology, this formula is, in fact, nothing but a revised version of state power, or what could be called fear-power (cited in Sachs, 2009, p. 135).

Empowerment has been framed to be a simple, doable and measurable goal. It is easy to measure women's access to resources, for example, women's access to opportunities for generating income or entering the labour force, or women's

access to health facilities or FP methods. Measurements related to access to resources is necessary, but it does not assess other critical dimensions, such as power relations and decision-making power. As Kabeer (1999) urges, we need to measure beyond simple access to the resources and look into control: can/do women have a say and make a decision.

Even though empowerment was defined from the perspective of Third World feminists by remarkable scholars such as Naila Kabeer and Srilatha Batliwala, the term is defined wihtin context of South Asia. However, it is important not to assume that all Third World women experience the same subordination. It is necessary to recognise thatc gender roles are changing with time. In some societies or families, women are the head of household and men are not always dominant or powerful in the household. South Asia differs to other parts of Asia. For example, Southeast Asian women may have a slightly higher status with respect to men (Ireson, 1996). Even within countries, the society, community, ethnicity, individual identities, and personalities are important determinants for empowerment.

3.5 Women's Empowerment within the Family Planning Context

Drawing from the definition of empowerment above and FP conceptualisation in Chapter 2, this study argues that within the FP context, women's empowerment implies that women are aware of SRH and FP. This awareness includes knowing their rights and having knowledge of and access to FP information and services in the first place. Empowerment indicates they have the internal strength and perception that allows them to exercise their rights to decide on their family size and contraceptive use, including having the ability to negotiate and communicate with their spouse to make the joint decision and share the responsibilities. Such empowerment is relational in that it requires men's awareness, attitude and behaviour changes, and cooperation. In other words, it requires awareness of both men and women, as well as changes of mindsets, attitude, and behaviour of both as an equal partner. For women to fully empower themselves, external

factors, such as social, cultural, economic and political considerations must be in place.

According to the United Nations Population Fund (UNFPA, 2018), FP is central to women's empowerment and gender equality. When women can plan for timing and spacing of childbirth, their autonomy within the household is increased; their health is improved, and their earning ability is also increased. These benefits will ultimately contribute to a family's well-being, as well as to the community's prosperity as a whole.

However, the availability of FP may not necessarily increase women's empowerment. There are several reasons for this. First, the attitude and behaviour of health providers causes them to frequently provide FP methods, based on their prescription, without providing space for women make their own decision. Second, health providers, who do not provide adequate information including, method options and side-effects, leave women vulnerable as they accept a prescription that might not be compatible with their actual health conditions (Hartmann, 1995). Third, women may not be able to visit health facilities without permission from their husband or other powerful older family members, which is usually the case in a patriarchal society (Petchecsky & Judd, 1998). Lastly, although they use some FP methods, the final decision for which methods to use may be made by their husbands. Therefore, simply providing access is insufficient, as it is important to recognise that empowerment is complex and multi-dimensional and requires analysis within gender relations where power relations interplay, and within the specific social, cultural and political contexts.

3.6 Women's Empowerment Dimensions

This study aims to explore the role of men in relation to women's empowerment in family planning (FP) in order to understand whether and in what way men's involvement in FP increases women's self-confidence, decision-making power

and autonomy in FP, through spousal communication, joint decision-making and shared responsibilities within the household. Therefore, this study adopted the feminists' conceptualisation of empowerment combining scholar's views regarding external enabling factors. Based on Kabeer's and Rowlands' work, I focused on two dimensions: 1) personal empowerment (*power within*) or agency (women's decision-making power, self-confidence, autonomy in FP including family size, timing, birth spacing, and FP methods); and 2) empowerment in close relationships or the power relationship between women and their spouse (communication, negotiation and joint decision on number, timing and spacing of childbirth and FP methods), as illustrated in Table 3.1.

Table 3.1: Dimensions of Women's Empowerment in Family Planning

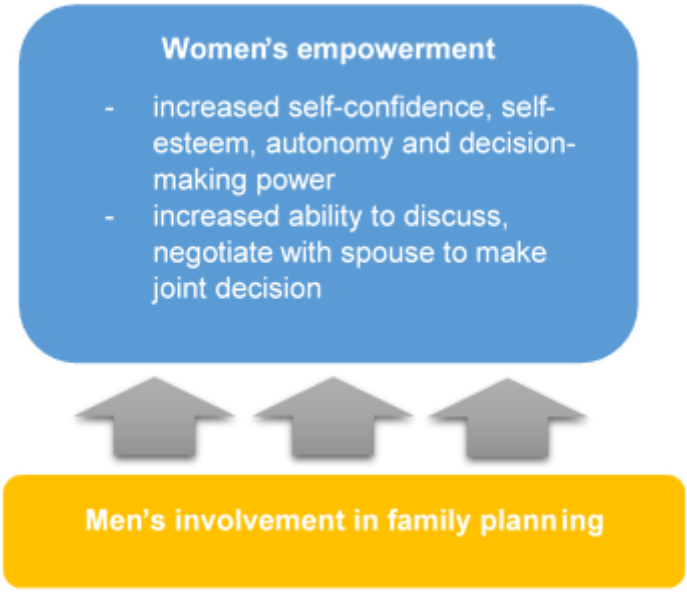
Dimensions of women's empowerment in family planning	
Power within	• self-confidence, autonomy, decision-making power • awareness of their rights and FP information and service
Empowerment in close relationship	• ability in negotiation and communication with spouse • joint decision and shared responsibilities

This thesis is based on the hypothesis that women who have been using FP became aware of FP and their rights to access to FP and made a decision regarding FP. Further, they can plan and make a decision on whether and when they want to have children and how many children they want to have. They are more confident in seeking FP information and services, and are able to decide on what methods of FP they want to use, based on a wide range of contraceptive methods. More importantly, they are also empowered to discuss and negotiate with their partners to plan for family size, including timing and spacing of childbirth, as well as the use of FP methods. In addition, men's involvement in FP impacts on men's perceptions, attitudes and behaviour, and they become supportive of

their spouse's reproductive health, joint decision-making and shared responsibilities with regards to the use of FP methods, child-rearing and housework. Men's support, understanding, and respect for women's rights enables women to feel more confident and promotes increased autonomy to discuss and negotiate with their spouse, which leads to the outcome of improving spousal communication and joint decision-making.

It is important to acknowledge that in order to achieve real empowerment, legal, political, social, economic and cultural factors must also be enabled. However, my study does not focus on how these other facets influence women's empowerment; rather I focus on how men support women's empowerment, particularly in the process of negotiation or communication between couples making a joint decision on FP. Figure 3.1 illustrates the assumption that men's involvement increases women's empowerment in FP.

Figure 3.1: Hypothesis: Men's Involvement Leads to Increased Women's Empowerment



3.7 Chapter Conclusion

This chapter discusses the conceptual framework of empowerment. It has been noted that, the meaning of empowerment varies, depending on its users and their underlying agenda. For my study, I adopted Rowlands' and Kabeer's conceptualisation of empowerment, which is defined as the awareness of women of their own situation, the realisation of their rights, and perceptions of themselves as capable of and having access to resources to take actions upon their aspirations. To achieve the aim of my study, I focused on two dimensions: personal and relational. Based on the hypothesis above, I explored whether men's involvement had an impact on women's *power within* and an influence on their ability to discuss and negotiate with their spouse about issue such as family size, number and spacing of children, and thereby increase spousal communication and joint decisions about FP.

CHAPTER 4: METHODOLOGY

4.1 Introduction

Methodology not only provides researchers with an overarching and broad strategy, but also informs the choice of techniques and methods for data collection (Sumner and Tribe, 2008; O'Leary, 2017). I used a qualitative approach to explore the roles and implications of Mangkong men in FP, for two reasons. First, a qualitative approach allows the researcher to access unquantifiable facts, observe and interact with people, hence, it leads to understanding people's attitudes and behaviours (Berg, 2009). Second, the approach aims to get "in-depth information which provides the potential for understanding the complexities of social life" (Stewart-Withers, Banks, Mcgregor & Meo-Sewabu, 2014, p, 59). Qualitative research requires an open-minded, flexible, ability to listen to people telling their own story, and the ability to interpret the meanings of their story (Hennik, Hutter & Bailey, 2011).

This chapter discusses the methodology that I used in data collection including the research location, recruitment of participants, data collection, ethical issues, fieldwork experience, data analysis and limitations of the research.

4.2 Research Location

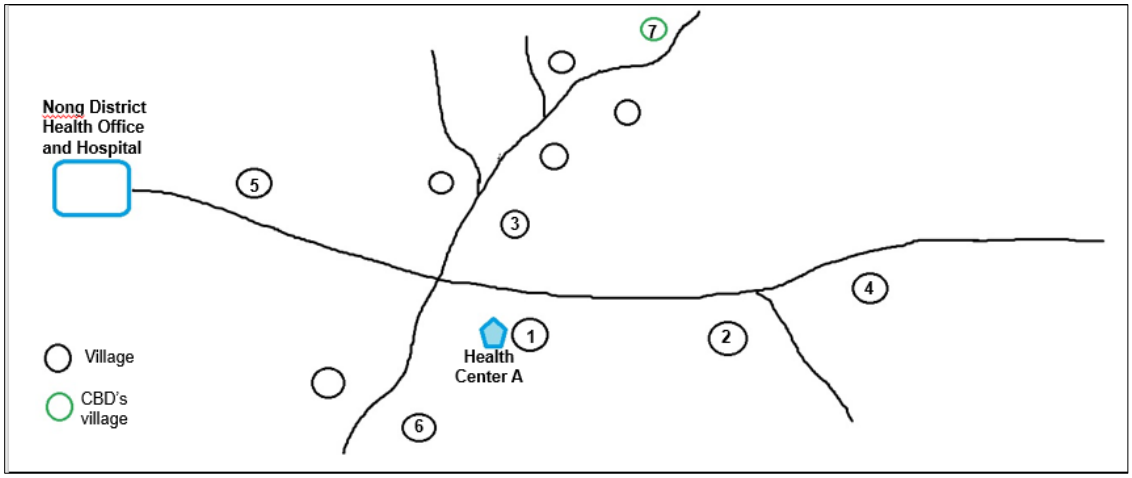
There are several rationales for selecting the research site. First, Mangkong ethnic group belongs to the Mon-Khmer ethnolinguistic families who have the highest poverty rate in Laos (Lao Statistics Bureau, 2015), as well as high unmet needs[14] for FP. The majority of Mangkong reside in Nong District, which is one of the poorest districts in the province. Implementing the FP programme with an empowerment approach is challenging among ethnic minorities, due to geographical and cultural constraints. Second, the National Family Planning

[14] The Mangkong belongs to the Mon-Khmer, which has the second highest unmet needs for FP at 26% (Lao Statistics Bureau, 2018). The Mangkong specific data on unmet needs is not available.

Costed Implementation Plan (CIP) identified Savannakhet province as having the largest funding gap in implementing FP programmes (MoH Laos and UNFPA Laos, 2017). Third, I could not locate any other studies on men's involvement in FP and its impact on women's empowerment in the context of Mangkong at the time of conducting this research. Fourth, when working for UNFPA[15] Laos I had been to Savannakhet. Thus, a connection had been formed with the provincial health coordinator, who was consulted concerning the specific location.

In consideration of accessibility and feasibility, Nong district is now more accessible because of the road construction which was completed last year. The health centre is situated approximately 15km from the Nong District Health Office, where there was access to the district health staff for assistance. The health centre covers ten villages with distances of 5 – 20km between the villages (See the Figure 4.1). Thus, interviews with the Mangkong couples were able to be undertaken in these villages.

Figure 4.1: Research Site Map



Adapted from Nong District health centre A covered zone map

[15] Savannakhet province is one of UNFPA's target provinces, however, this study was not in its programme site. I had never been to the health centres and villages where the research took place. Thus, there was no conflict of interest.

4.3 Research Team

The research team included myself as a student researcher, a research assistant (RA), and a local translator. The RA is educated and has experience working with the ethnic communities. The role of RA was to help take notes during the interviews. Before commencing the fieldwork, I met with the RA to give her a briefing about the research project, process, and ethical issues included in her role (McLennan, Storey & Leslie, 2014). With the note taking help from the RA, the researcher could concentrate on engaging with the participants during the interview.

A local translator was also hired to help translate the Mangkong language to the Lao language. By consulting with the Head of the health centre, the village health volunteer (VHV) was recruited to be the translator. The translator is Mangkong who had been a VHV for several months, and he had experience as a volunteer for NGOs in Nong before taking his current role. As a VHV, he works under the health centre to coordinate with the village chiefs. He serves as a first contact point, for example, informing the people about child vaccinations in the villages. He was also an intermediary to coordinate with the village chiefs to gain approval for interviewing the people.

4.4 Participant Recruitment

The participant's recruitment commenced upon arrival at the research site with support from the Head of Health Centre A and the village chief. Upon gaining the approval from the village chiefs, the research team started to recruit participants based on random talks with people. I briefly introduced myself and the research topics and asked the couples if they were willing to take part in the interviews. The details relating to participation recruitment from the stage of coordination to actual practice on the ground is discussed below.

4.4.1 Communication and Coordination

Communication and coordination were established based on the Lao government's protocol. Once the Ministry of Health approved the field work, the relevant official informed and coordinated the approval internally through the hierarchy order from Ministry of Health in Vientiane Capital to Savannakhet Provincial Health Department. Meanwhile, informal communication was made with the Provincial Health Coordinator in Savannakhet Province through e-mails and phone calls. Upon arrival in Vientiane Capital, detailed consultation was held with the coordinator regarding the research project.

In Savannakhet province, after meeting with the coordinator, she referred me to the Head of the health centre A in Nong District to facilitate the fieldwork. At the health centre, I met with the Head and his staff (a female midwife and a female nurse) and discussed the research project with him including what support might be needed.

4.4.2 Protocol

Protocol was followed by coordinating with the village chief in advance. This was achieved with support from the Head of Health Centre A. Before visiting each village, I asked the Head to contact the village chief to inform him about the project and arranged a time for the visit. Once we met with the village chief to talk about the research project and ask for permission, we then walked around and randomly talked to the people. Visiting the people's rice fields allowed a more developed personal interaction before asking those who are using FP if they would be willing to take part in the interview.

As the research is about empowerment, it makes the research meaningless if the research process is disempowering. Therefore, it was essential to ensure that the whole research process was empowering, including respecting people's decision whether or not they were willing to participate. Respect was fundamental to avoid disempowering the couples during the interviews. This was done by employing the appropriate attitude and manner, as well as listening to their stories without

judgment. The team was made fully aware of such ethical issues and kept all information confidential.

4.4.3 Participant Criteria

This research focused on married couples aged in their 20s – 30s who are currently using FP methods. The interview also included key informants, such as the village chief, primary health worker, District Health Staff, Community-Based Distributor (CBD), the community midwife, and Health Official from the Maternal and Child Health Centre in Vientiane Capital. Tables 4.1 and 4.2 show the list of primary participants and the key informants.

Table 4.1 List of Primary Participants

Primary participants: the Mangkong couples who are currently using FP methods					
Participants	**Age**	**Occupation**	**FP methods**	**No. of children**	**Village**
Couple 1	M35, F32	M: repairman F: teacher	Injection	2	1
Couple 2	M32, F29	Farmers	Injection	3	1
Couple 3	M33, F28	Farmers	Implant	4	1
Couple 4	20s	M: employee F: housewife	Injection	3	1
Couple 5, unrecorded	M25, F23	Farmers	Pill	2	1
Couple 6, unrecorded	The 30s	Farmers	Injection	5	2

Couple 7, unrecorded	20s	Farmers	Injection	2	3
Couple 8	M30, F29	Farmers	Implant	3	4
Couple 9	20s	Farmers	Injection	4	4
Couple 10, unrecorded	Unknown	Farmers	Injection	2	5
Couple 11, wife unrecorded, husband recorded	30s	M: village chief F: Farmer	Injection	6	6
Couple 12, unrecorded	Unknown	Farmers	Implant	4	6
Couple 13, unrecorded	M30, F25	Farmers	Injection	4	1
Woman 1, the husband was not home	25	Farmers	Injection	6	5
Woman 2, the husband was not home	Unknown	Farmers	Injection	3	1

Table 4.2 List of Key Informants

Title	Number
Health Official, MCHC, Vientiane Capital	1
Nong District health staff	1
Head of DSN health centre	1

Village chief	1
Community midwife	1
Primary health worker	1
Community-based distributor (CBD)	1

4.5 Data Collection

For the data collection, methods of semi-structured interviews; informal observation; and documents analysis were used. Each method will now be discussed.

4.5.1 Semi-structured Interview

> Remember: your job is to talk only enough to facilitate someone else's ability to answer. It is your interviewees' voice that you are seeking, and it is their voice that needs to be drawn out – (O'Leary, 2017, p. 239)

A semi-structured interview is similar to a face-to-face conversation between an interviewer and interviewee on a specific topic (O'Leary, 2017). Interviews were conducted with 13 couples and two women aged in their 20s-30s who are currently using FP. These interviewees lived in six villages near the central research location (see Figure 4.1). Interviews were also held with key informants, such as a village chief; a midwife; the head of the health centre; community-based distributor (CBD); and district health staff. Each interview took approximately 30-40 minutes. Couples were interviewed in the evening when they returned from the field. The research objectives, process, the rights of participants and how data will be used were explained to the participants before the interview.

The couples were also asked if they would allow their voice to be recorded using an audio recorder. While some couples were happy to be recorded, others did not feel comfortable. The interview commenced with a basic conversation to get to know them and slowly got into the pre-defined questions, which were not strictly followed in order and remained flexible throughout the process (Gibson & Brown, 2009). After the interview, a small amount of compensation (50,000LAK, approximately 10NZD) was offered to the participants to express our appreciation for their cooperation and time.

4.5.2 Informal Observation

> Participant observation is a method which a researcher takes part in the daily activities, rituals, interactions and events of a group of people as one of the means of learning the explicit and tacit aspects of their life routines and their culture. (Dewalt & Dewalt, 2010, p.1)

Some issues of building trust, which need to be kept in mind, are the imbalance of power between the researcher and the participants. This is partly due to the different social and economic status, and educational background. Such a power relation has the potential to distance the relationship between the researcher and the participant. Thus, being aware of this power-related issue is the first step toward managing and minimising the power imbalance (O'Leary, 2017).

Coming from a different social, economic and educational background, there is a certain distance between me as a student researcher and the Mangkong people. In order to approach the people and gain their trust, I tried to dress appropriately and behave respectfully. I learned the basic greeting in Mangkong language from the translator. By learning the language, I could greet the people walking along the field and received a warm greeting back from them.

Visiting the people in the rice field and engaging in farming activity brought me closer to the people. Participating in people's daily activities is a way to learn

about their culture (Dewalt & Dewalt, 2010). Since the interviews were conducted in the evening when the couples returned from their farm, during the day the team visited the people's rice field. During the visit, I observed the role of men and women in the field. I engaged in the people's farming by learning how to grow rice. The team also had an opportunity to share a meal with the translator's family and his relatives in his rice field. I realised that sharing a meal is one of the best ways to get to know the people and reduce strangeness.

Field notes were used to record observations. According to Bailey (2007), there are many types of field notes. Among others, some types of field notes used were what Bailey refers to as 'analytical ideas and inferences[16]'; 'personal feelings'; and 'reflexive thoughts'. Notes included people's behaviours, gender roles, and other things that I learned. I also kept a personal journal to reflect on my experience and thoughts from such observations at the end of the day.

4.5.3 Document Analysis

Document analysis is "a research tool for collecting, reviewing, interrogating and analyzing various forms of written 'text'" (O'Leary, 2017). These include official documents, reports, and online materials ranging from government, multilateral organizations, NGOs to online resources. Document analysis was used in the Chapter 5 and as supplementary to interview methods. Document analysis aims to critically review how the policies have been translated into practice on the ground.

Good document analysis requires an awareness of 'contextual integrity'. That is: "being aware of the political purpose of the repository and the values, etiquette, and choice of words at the time in which the records were created" (McLennan & Prinsen, 2014, p. 83). Furthermore, not only does the researcher need to be

[16] Since the conceptual framework was based on exploring people's experiences, this type of observation helped me notice patterns that emerged from the observation, which aided in identifying 'potential insight' (Bailey, 2007).

aware of the bias and credibility of the existing documents, but also needs to be aware of the researcher's own bias in analysing and interpreting the data.

The primary documents focused on included *Reproductive Health Policy 2005; Reproductive, Maternal, Neonatal, and Child Health (RMNCH) Strategies and Action Plans 2016-2020;* and *Costed Implementation Plan* (CIP) *2017*; as well as other online documents sourced from both the government and grey literature.

4.6 Ethical Considerations

Ethical considerations are crucial when undertaking research. There are a number of key principles to consider when commencing research, especially research that involves fieldwork in a different cultural setting. The researcher has the responsibility of ensuring both the physical and mental well-being of all people involved in the research (O'Leary, 2017). Banks and Scheyvens (2014, p.161) argue that the researcher "must ensure the participants' dignity, privacy, and safety". They also stress that it is essential that the researcher behaves respectfully and sensitively when going into the field to engage with the participants.

4.6.1 Ethics Application

Under the guidance of supervisors, and following the ethical principles outlined in the Massey University Code of Ethical Conduct for Research, Teaching, and Evaluations Involving Human Participants a full ethics application was submitted, as required by Massey University's Ethics Committee. Researcher and supervisors discussed the potential risks and sought solutions to minimise harm to the participants as a result of the research. A series of ethical questions were answered on the application form and submitted online to the committee for review. A meeting was held with the Ethics Committee Southern A to justify and clarify the issues that emerged from the application. The Committee then made comments accordingly and notified their approval of the application via e-mail.

The ethics principles were applied throughout the fieldwork. The following discusses these key principles.

4.6.2 Providing Information

All information about the research was outlined in the information sheet. The information sheet clearly stated the research topic and objectives, how data would be collected, when and where data will be used and published, as well as who will have access to the data, participants recruitment and the rights of the participants. The information sheet was sent to the Ministry of Health in Laos and sent to the Savannakhet Provincial Health Department. The information sheet was also explained verbally to the Provincial Coordinator and the Head of Health Centre at the Health Centre A to ensure their understanding of the research.

At the village level, I made sure that the research team had a good understanding of the information sheet and the research process, including these ethical issues. Importantly, the rights of the participants were carefully explained verbally to all the primary participants and the key informants. Following Bank and Scheyvens (2014) advice concerning good practice, once the fieldwork was completed, an informal debriefing session was conducted to provide an oral presentation of the preliminary findings with the Head of Health Centre A and the coordinator and the Deputy Director of the Provincial Health Department.

4.6.3 Informed Consent

The researcher must get informed consent from the participants and respect their rights to decide on whether they are willing to take part in the study without any coercion. Generally, there is a standard written consent form for participants to sign before the interview. However, it may not be appropriate for this case. This is because the participants are ethnic people, most of whom neither read nor speak the official Lao language.

The requirement to sign the form may made them anxious as if they might do something wrong. Stewart-Withers (2016) argues that written consent "may not be that practical or valuable when working with poor, illiterate people" (p.37). Banks and Scheyvens support the point that "seeking written informed reinforces an inappropriate relationship of power between the researcher and the research participants that can undermine the trust and relationships that the ethical researcher needs to do good qualitative research" (p. 166). They further argue that it is appropriate, in certain circumstances, to obtain verbal consent informally.

During the fieldwork, the consent was obtained from the participants verbally. The information sheet was clearly explained, especially the section concerning the rights of participants, so as to ensure their understanding and the participants were asked if they are willing to take part in the interview (Hennik, Hutter & Bailey, 2011).

4.6.4 Confidentiality, Privacy, and Anonymity

The researcher must keep the participants' identities and personal information confidential. I am aware of my responsibility as a researcher to protect the participants from any potential harms or risks that may occur as the result of participation in this research. The researcher can use anonymity to keep confidentiality of participant's identities (Banks & Scheyvens, 2014). Hennik et al. refer to anonymity as "removing any identifiers from the interview transcripts that may provide a clue as to the identity of the participant, but it also includes not writing the name of the participant on the tape or not using participants' names as the file name" (p.72). Pseudonyms, numerals, and letters were used to identify key informants, primary participants, and villages. To ensure that information obtained from the interview is kept securely, all data is kept in a password-protected laptop with backups on google drive and these are accessed exclusively by the researcher.

4.6.5 Cultural Sensitivity

When researching in the context of other ethnic groups, it is essential for the researcher to be culturally sensitive. When research involves women, especially ethnic women, the researcher must consider that some people may feel uncomfortable or reluctant to speak to outsiders (Scheyvens, Scheyvens & Murray, 2014,). Therefore, prior learning about the Mangkong culture and lifestyle from the Provincial Health Coordinator, the Head of Health Centre A, and the translator who is from the Mangkong community was essential. All researcher behaviour attempted to be non-judgmental, respectful and culturally appropriate while being aware of facial expressions and body language (Scheyvens, 2014).

Another point to note is the positionality which informs the researcher's subjectivity and influences the research process. I may assume or view the reality based on my worldview. Awareness of subjectivity including background, experience, assumption, and worldview is central to being neutral in order to obtain the genuine voice and perspectives of the participants. O'Leary (2017, p.57) makes the point that "working towards credible research, therefore, demands reflexive awareness of our worldviews and a conscious effort for us to take them into account as we enter into the research journey".

4.7 Fieldwork Experience

Field work experiences are discussed in the light of this personal focus. There were some surprising things and challenges that were encountered throughout the fieldwork experience.

4.7.1 Surprises

During the fieldwork, the reaction of the villagers, especially the women, surprised me. In the beginning, I was concerned that their reactions might affect their responses to the questions. For example, they might be too shy or feel uncomfortable to talk about FP with an outsider. Based on general assumptions

and my previous work experience in the field, I expected that young ethnic women tend to be shy and do not talk much, particularly around such a sensitive topic (see Scheyvens, 2014 who highlights this issue). It turned out that the women were very open. Because women are the contraceptive users, they spoke much more than their husbands, and they tended to know more about FP than their husbands. When we talked about FP, the people appeared to naturally think that it is a women's issue, so the husband just allowed his wife to take charge.

The overall preparation required to do fieldwork, which is entirely different from previous work experience, was also a surprise. There is a difference between a donors' mission and student research regarding coordination, preparation and participant recruitment. While the gatekeepers prepare and make an appointment with the people for a donor field mission, they do not do so for students. As such, there was more space and freedom to do the fieldwork, while still respecting the local protocols.

4.7.2 Interview Process

For some interviews, we were directed by gatekeepers (see Banks and Scheyvens, 2014). For example, in village 4, we were encouraged to talk with specific couples suggested by the head of the health centre. I was concerned that his presence might affect the couple's response, due to his role as a provider. Fortunately, he did not interfere or interrupt during the interview and he sat aside quietly. Thus, his presence might not have had an impact on the reaction or the response of the couple. Later, before seeing the second couple, he was politely told that we can interview without him, so that he can continue his work in the health centre without the interruption to his time. Eventually, the second couple was interviewed without him.

Neighbours came to see the interview in some villages. When the couples were interviewed, they were always asked where we should sit down and talk. Many of them suggested that we interview them in the bottom section of their house 'Kong Ta Laang'. In a Mangkong house, the lower level of the house is an open

space where people usually weave, store firewood, and relax. During the interview, their neighbours[17] including children came along and watched the fun. Some people just came and joined us, and sometimes they interrupted. For example, when we interviewed one couple in village 1, a man came along and sat down and talked with us in the middle of the interview. Sensing that he would not leave anytime soon, the interview was paused and the couple were asked if I could come back later when they were free. So, we did the second interview with them in the evening.

A similar situation occurred in village 4, where there were a bunch of people and children surrounding and watching us, a man was sitting beside the couple and interrupted our interview. I politely asked him to let the couple talk. I always checked with the couples whether they felt comfortable to talk while surrounded by so many people, and they said that it does not matter. I observed them during the interview, and they honestly seemed to be fine as they could talk and laughed at ease. Conversely, some couples were interviewed inside their house with privacy[18].

[17] It was common in the village that the neighbours come along and watch the interview. I double checked with both the translator and the couples if it was fine for them to be surrounded by other people. The translator and the couples said that it is alright because the people know each other. This might be because of their culture that value trust and harmony in the community. I also observed that during the interviews it seemed that the crowds did not affect the couple's willingness to talk. As Stewart-Withers (2016) argues that as a researcher, we are a guest and that we do not have the rights to say who can or cannot be there. Adding to this point, respect for the local culture, by making sure that participants feel comfortable in given circumstances, is essential.

[18] There is a slight difference regarding interviews performed inside the house and outside. While the couples interviewed outside the house laughed more than those interviewed inside the home, this is because their neighbours who came to watch the interview got to hear about the topic we were discussing. As it is a sensitive topic, the people often laugh about it. It is important to note that in their culture, trust and harmony between people are essential. While western culture might see it as a breach of privacy, it is not the case among the Mangkong. We need to respect the local culture and acknowledge that some institutional ethical principles may not work well in practice, particularly in a developing countries' context (Stewart-Withers, 2016).

4.7.3 Challenges

Overall, three factors might affect the research findings. The first of these is my own beliefs and values, including my previous work experience in an international organisation, my education and socioeconomic background, which influence the way I see, talk, perceive and behave. I may unintentionally judge data based on my worldview, which is influenced by my education and work experience (O'Leary, 2017).

Secondly, recruiting a local translator and RA had both positive and negative impacts. On the positive side, the local translator was an excellent intermediary, just like the gatekeepers, bringing the researcher closer to the people (Scheyvens, 2014). He knows the people and the people know him and that made them willing to participate and talk at ease. He was also a local guide who guided me to each village. The RA could help by taking notes, which I might not have been able to do while concentrating on interviewing the couples. It was also better to have company for my own safety.

There were some challenges when recruiting a local translator and RA. The positionality of both may influence the research (McLennan et al., 2014). After the translator gets to know what is wanted for answers from the participants based on their understandings, he might cross the line between the role of the translator and the participant. He might answer on behalf of the participants, or he might guide them how to answer the questions. There is no term for 'Family Planning' in the Mangkong language, so he elaborated to include contraceptive methods, such as the pill, injections, implants, and so on. So, it was essential that he translated the question precisely along with the couple's reply and did not answer on behalf of the couples. He was reminded of this before every interview. Even when he translated precisely what the people said, it was quite challenging for him, especially with his limited Lao vocabulary.

Similarly, the RA might try to understand the answer before noting down the information. Even though she was always reminded to write down exactly what the couples said and try not to understand the answer, there is no guarantee that

this was the case. Also, it was quite challenging for the assistant as well, because she had to keep pace with the conversation. She had to multitask by carefully listening, while noting down everything literally. I was not sure if she could catch every single word, especially when the people did not want to be recorded, in which cases it is hard to check the accuracy. Thus, the notes were discussed with the assistant at the end of the day to ensure my understanding.

4.8 Data Analysis

All data collected from the interviews were transcribed and then translated into English with a little editing, while keeping the authenticity of the original data. I identified and logged the pattern or theme which emerged from the interviews while transcribing (Stewart-Withers, Banks, McGregor & Meo-Sewabu, 2014). The next step was reading the transcript and coding the data. Applying thematic analysis, a manual mind map was created to identify the themes that applied to the research objectives by using different colours to highlight the themes (O'Leary, 2017). After coding, I critically read through the transcript and the mind map and started interpreting the data using deductive logic (O'Leary, 2017). Field notes, observation and government documents were used alongside the data analysis.

4.9 Limitations

This study was based on a small sample size, which cannot represent the Mangkong community as a whole (Mayoux, 2006; Stewart-Withers et al., 2014). As mentioned earlier in this chapter, 13 Mangkong couples and two Mangkong women were interviewed, as well as five key informants. In consideration of the concepts of involvement and empowerment, it is important to take into account the socio-economic and educational background of the people. The research scope was limited to only the zone covered by the research site, in which the infrastructure and living conditions are better than those of people living in remote and hard-to-reach areas.

The final data presented in this study has gone through several channels. All data collected from the interviews were translated from the ethnic language to the Lao language and then to the English language. Therefore, the final data may have been filtered along the way (Mayoux, 2006). However, in a qualitative approach, assessing rigour should be by trustworthiness, rather than validity (Stewart-Withers et al., 2014). It is essential to be aware and acknowledge researcher bias, so as to be more neutral.

Also, this study applied a conceptual framework built on the theory of western feminists, such as Rowlands (1998) and South Asian feminists, such as Kabeer (1999). The term empowerment itself is a buzzword, a loanword, multidimensional and context-specific, and is coupled with a few selected empowerment indicators. Therefore, empowerment discussed in this study may not represent empowerment from the perspectives of the Mangkong women. This challenge is discussed further in the discussion chapter.

4.10 Chapter Summary

This chapter discusses the approach taken to planning and undertaking the fieldwork. A qualitative approach was adopted for the research and it used three methods: semi-structured interviews, informal observations, and document analysis. Ethical issues have been discussed, which highlighted a series of ethical questions and potential risks, as well as raising the question of how to manage personal bias during the fieldwork and the data analysis stages. The ethical principles presented here were strictly applied during the fieldwork. This chapter also discussed my experience during the fieldwork, including surprises and challenges and how these obstacles were overcome.

CHAPTER 5: FAMILY PLANNING IN LAO PDR

5.1 Introduction

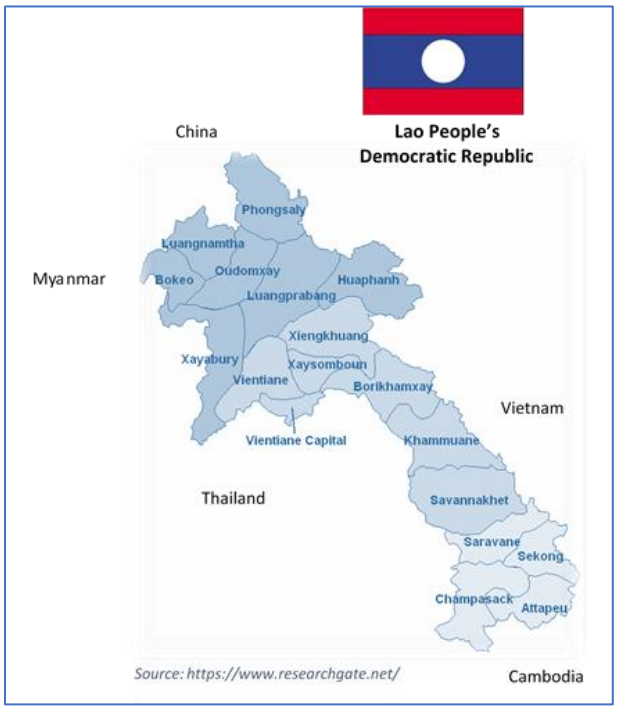
Lao PDR is classified by the United Nations as a least developed country (LDC). Despite the rapid growth of the GDP since the economic reform in the 1980s, Laos still has low social development, especially in the health and education sectors. The government has a strong commitment and supportive laws and policies for guiding the implementation of social development. The emphasis has been particularly given to health and education. Among the health sector, the government recognises the importance of sexual and reproductive health (SRH). As stated in the Reproductive Health Policy, an improved SRH outcome for the people is essential for the quality of life of the people, and ultimately for the broader national development. Laos also supports, promotes and ratified various international conventions and agreements, such as the Convention on Eliminating All Forms of Discrimination Against Women (CEDAW), and the International Conference on Population and Development (ICPD) which Laos became a signatory of, in 1994, among others. Laos has been actively involved in the international community for development, such as the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). In 2016, Laos made its commitment to the FP2020 aiming to make quality and voluntary FP universally accessible to all Lao people by 2020.

This chapter provides an overview of the FP programme in Laos, with the focus on the men's involvement strategy through community-based interventions. Commencing with Section 5.2, a brief country profile is provided, followed by Section 5.3, which discusses the issues, policies, programmes, and challenges for family planning in Laos. Section 5.4 provides an overview of the study site including the Mangkong ethnic group, while Section 5.5 sums up the chapter.

5.2 Lao PDR at a Glance

Lao People's Democratic Republic or Lao PDR (also known as Laos) is a landlocked country bordered by Thailand, Cambodia, China, Vietnam, and Myanmar. With a total population of over six million, half of whom are young people aged under 25 years old, the young population is considered a core labour force for the country. As such, Laos will benefit from the "demographic dividend", where the working-age population is greater than the non-working population (UNFPA, 2015), by investing fully in young people. The Lao government has been focusing on improving and developing human resources, especially by increasing the investment in education and health sectors, which are crucial for poverty eradication.

Figure 5.1: Map of Lao PDR



5.2.1 Economic Development

Since its market-oriented economic reforms in the 1980s, Laos has opened up to international trade and foreign direct investment (FDI), allowing exploitation of its abundant natural resources for socio-economic development in areas such as hydropower development, agricultural production, mining, tourism, and so forth. Rubber plantation has expanded significantly.

During the 1980s reform, Laos saw rapid economic growth. The GDP growth was at 7 percent during the reform period, and it slowly increased to an average of 7.9 percent over the five-year period 2011-2015. The GDP per capita increased from US$1,217 in 2010-2011 to US$1,970 in 2014-2015, which exceeded the

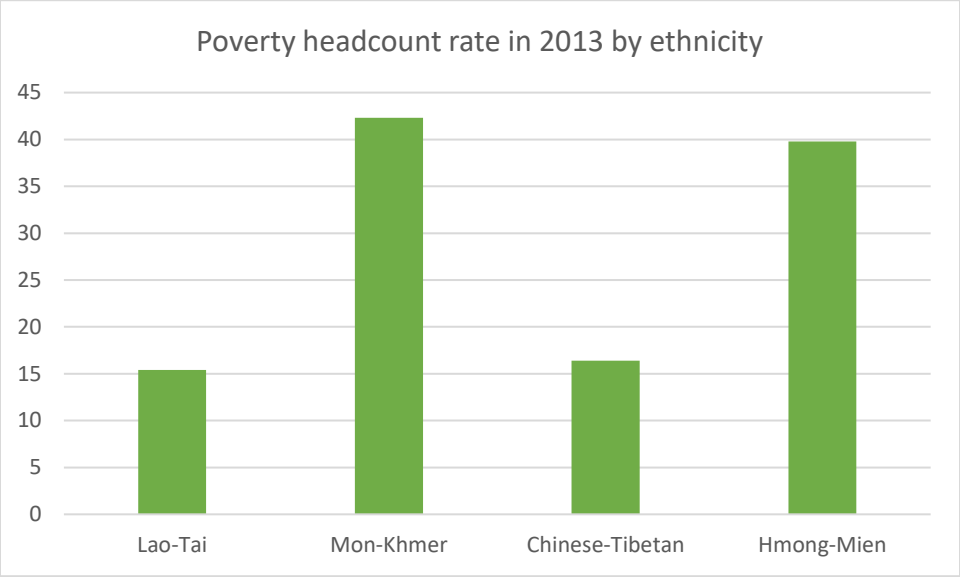
target of US$1,700 (Ministry of Planning and Investment Laos, 2016). However, benefits from economic growth have not been equally shared between rural and urban areas, due to geography and ethnic variety. In addition, there is a huge gender disparity in the employment sector. Women are more vulnerable than men since many of them work in the informal sector. Women made up 65 percent of unpaid family workers (UN Laos, 2017).

5.2.2 Ethnic Groups

Laos is a diverse ethnic country with 49 officially recognised ethnic groups across the country. The ethnic minorities are categorised under four main ethnolinguistic families: the Lao-Tai; the Mon-Khmer; the Hmong; and the Chinese-Tibetan (Ministry of Health Laos, 2015). The ethnic minorities are also classified by the topographic location where people live in the country: Lowland or Lao Loum (mainly the Lao-Tai); Upland or Lao Theung (mainly the Mon-Khmer); and Highland or Lao Soung (mainly the Hmong and Chinese-Tibetan). Each ethnic group has their own dialect, culture, and beliefs, which create difficulties for healthcare workers regarding communication and behaviour change. The non-Lao-Tai are the most disadvantaged, with the lowest education and highest poverty rates relative to the Lao-Tai.

Among all the ethnic groups, the Lao-Tai, which is the dominant ethnic group has the lowest poverty rate compared to the others. Notably, the Mon-Khmer (to which the Mangkong belong) has the highest poverty rate among other ethnic groups, at 40 percent as shown in Figure 5.2.

Figure 5.2: Poverty Headcount Rate by Ethnicity



Source: Lao Statistics Bureau, 2013

5.3 Family Planning in Laos

Lao PDR has been a signatory of the International Conference on Population and Development (ICPD) since 1994. Following the conference, the government endorsed the Birth Spacing Policy, 1995. Developing on this policy, Save Motherhood was adopted in 2002, followed by the National Reproductive Health Policy (RH) in 2005. The RH policy has been the main instrument providing overall guidance for the implementation of SRH/FP. Laos also promotes the Convention on Eliminating All Forms of Discrimination Against Women (CEDAW) through the Lao Women's Union (LWU) as a leading unit to ensure gender-mainstreaming in all sectors.

As outlined in the RH policy, 2005, the government adopted the human-rights-based and quality of care approach to ensure:

> good interpersonal relations and client satisfaction; freedom of choice; the right to information; technical competence of the service provider; integration of RH services and improvement of

> knowledge/motivation for positive behavior towards SRH; and ensure continuity of services through appropriate referral and networking (Section IV, p. 28).

5.3.1 Policies, Strategy and Action Plan

Under the RH Policy 2005, the Lao government endorsed the National Strategy and Action Plan for Integrated Services on Reproductive, Maternal, Newborn and Child Health (RMNCH) 2016-2025. The RMNCH aims to ensure equity and the rights of women and children and provides a vision and framework for improving the RMNCH outcome in the country. The RMNCH was built on the previous strategy MNCH 2009-2015. The previous strategy saw significant progress in the health sector, despite geographical and financial barriers. Progress was made on the Essential service package, which includes FP, vaccinations, antenatal care (ANC), and delivery. The government made significant progress on the Midwifery Development Programme 2012, which trained and deployed 1784 community midwives by 2015, which was a significant increase from 88 in 2010. The government also adopted a free MCH Policy in 2013 to provide free deliveries and child care.

Under the RMNCH, the government provides an essential service Package for RH, targeting all women of reproductive age, including adolescents. The package includes: RH/FP information and contraception counselling; SRH contraception and education for young people and adolescents, condoms; oral contraceptives; injectable contraceptives, implants; Intra Uterine Devices (IUDs); vasectomies; and tubal ligations. However, implants, IUDs, vasectomies and tubal ligations are not available through outreach or Village Health Volunteers (VHVs) and Village Health workers (VHWs).

In 2016, the Lao government made its commitment to Family Planning (FP) 2020:

> [to]increase contraceptive prevalence rate (CPR) from 42 percent to 65 percent; reduce the unmet need to 13 percent, and

> expand coverage and method mix for FP service focusing on long-acting methods such as implants and IUDs" (FP2020, 2018).

The SRH, including FP information and services, are also integrated into the 8th Five-Year National Socio-Economic Development Plan (2016-2020) under outcome 2, Output 4 – Universal access to quality health care services.

Currently, the government is implementing the FP interventions as outlined in the RMNCH strategy and action plan. Notably, the

> Strategic Objective 1 – RH: Increase utility and acceptance of quality RH information and services among all women and men of reproductive age, including adolescents, young people, and those living in poor and rural areas, regardless of marital status (Ministry of Health Laos, 2016, p. 9).

Community-based interventions are implemented in an integrated manner within the context of primary health care; the interventions include an integrated outreach service, model healthy village, VHVs, and VHWs. Table 5.1 shows the detailed action plan of the SO 1.1.

Table 5.1: The RMNCH Action Plan SO 1.1

SO1.1: By 2020, increase the contraceptive prevalence rate (CPR) for all women of reproductive age (all methods) to 65% and reduce the unmet need for contraception to 13%		
Key activities	**Responsible Department**	**Action level**
Policies/Strategies/Guidelines		
1. Revise RH Policy and design services to ensure the environment supports reproductive rights, and to improve the SRH of men, women, and adolescents.	DHHP	Central, Provincial, District

2. Develop/adopts supportive policies for the full delivery of FP services in the private sector, including IUD and implants services in private clinics.	DHC	Central
3. Develop a national IEC/BCC strategy on FP (based on National Communication for Health Strategy) with concrete implementation plans at field level.	CIEH	Central, Provincial, District
4. Develop IEC materials and training for ethnic groups (with the participation of each ethnic group).	CIEH	Central, Provincial, District
5. Revise national clinical guidelines on FP including 1) task-sharing/shifting on IUD and injectables, and 2) adaptation and integration of international clinical guidelines on implants.	DTR/MCHC	Central
6. Develop RH related book/BCC materials and disseminate across the country, including the RH Policy.	CIEH/MCHC	Central
Management, Monitoring, and Supervision		
1. Establish national supportive supervision system to ensure regular monitoring and supervision to RH/FP staff at all levels across the country.	DHC/DHP	Central
2. Include RH/FP in regular monitoring and supportive supervision	DHC	Central, Provincial, District, HC, Community
Training		
1. Conduct refresher training for existing staff in RH consultation and FP counseling and procedures including: - IUD training for provincial and district and HC. - IUD training for health officials in private clinics and NPA/NGO (youth center). - New injectables training for CBDs. - Implants training (public and private sectors).	MCHC	Central, Provincial, District, HC, Community

2. Extend the training of existing community midwife students by a month to become proficient in FP counseling and procedures (IUDs, implants, emergency contraception).	DTR/MCHC	Central, Provincial, District
Services		
1. Expand coverage and method mix for FP services in health facilities by: - Expand IUD and implant services - Establish separate private, friendly FP room (separate from MCHC room) in selected district hospitals - Ensure contraceptives are available in health facilities at all levels (including emergency pill). - Increase the coverage of FP/MNCH services at the community level through scaling up existing, successful community-based interventions such as integrated FP into every outreach service; CBDs, VHWs, VHVs. - Map and target high-burden districts and villages (high total fertility rate and high unmet need).	MCHC, DHHP (MCHC)/DHC, MPSC, FDD,	Central, Provincial, District, HC, Community
Demand-side		
1. Scale up FP advocacy activities and engage women's village groups, men, community leaders and elders in high-burden areas.	MCHC/CIEH	Provincial, District
2. Scale up existing promising practices to generate demand at community levels such as those from the CIEH or other partners.	CIEH	Provincial, District, HC
3. Conduct formative research to inform the development/adaptation and field-testing IEC materials in local ethnic languages.	MCHC/CIEH	Central

Source: The RMNCH Strategy and Action Plan 2016-2025, Ministry of Health, Laos.

5.3.2 Men's Involvement Strategies

Men's involvement in FP is incorporated into community-based interventions through Information, Education, and Communication (IEC) and Behaviour Change Communication (BCC) strategies. Guided by the RH policy, particular emphasis is given to involving men in the community. This is to increase the awareness among men and promote behaviour changes, so the men become supportive of their wife's reproductive rights, as well as decision-making regarding FP. The policy explicitly spells out the men's role in RH as follows:

> Special efforts should be made to emphasise men's, especially father's, shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including FP; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Benefits in achieving better RH should be highlighted to motivate men to participate in promoting RH actively. (Ministry of Health, 2005, p. 21).

This policy statement shows that the government places a strong emphasis on the role of men as a crucial contributor to women's RH, including maternal and child health through responsible fatherhood. However, the government seems to view men within the context of dominant Lao-Tai masculinity. Most policymakers are dominant Laos with little involvement with ethnic groups. Importantly, the policy mentions the role of men as a supportive partner and responsible parenthood, rather than including men as individuals who have their own rights and needs for RH.

According to the health official from MCHC, men's involvement has been integrated into FP counselling at the health centre, where both men and women are encouraged to participate together as a couple. However, the men's

involvement strategy was not translated into the concrete action plan shown in Table 5.1.

Community-based interventions

The community-based interventions aim to promote RH, such as maternal and child health including FP at community levels. The interventions include the village health committee, which comprises the village chief, youth union, women's trade union, and the village health volunteers. Not only does the committee serve as the health promoter, but also as the focal point gathering the people to attend the integrated outreach service.

The integrated outreach service is implemented in the villages in remote areas. The outreach combines FP and antenatal care, with vaccinations implemented quarterly by the outreach team. The team includes health staff from the District Health Office, midwives or health providers from the health centre, the village chief, and the village health volunteers or village health workers.

Another FP service delivered at the community level was the community-based distributor (CBDs) programme. The government has seen the effectiveness of this programme, which increased contraceptive use among women in remote areas. The people who become CBDs were usually from the same ethnic community where they served. Thus, the CBDs saw positive results by gaining trust and increasing access among ethnic women in hard-to-reach areas. However, the programme has ended, since the United Nations Population Fund no longer supports this work. During the phase-out of this programme, the government initiated training for the VHWs in replacement of the CBDs.

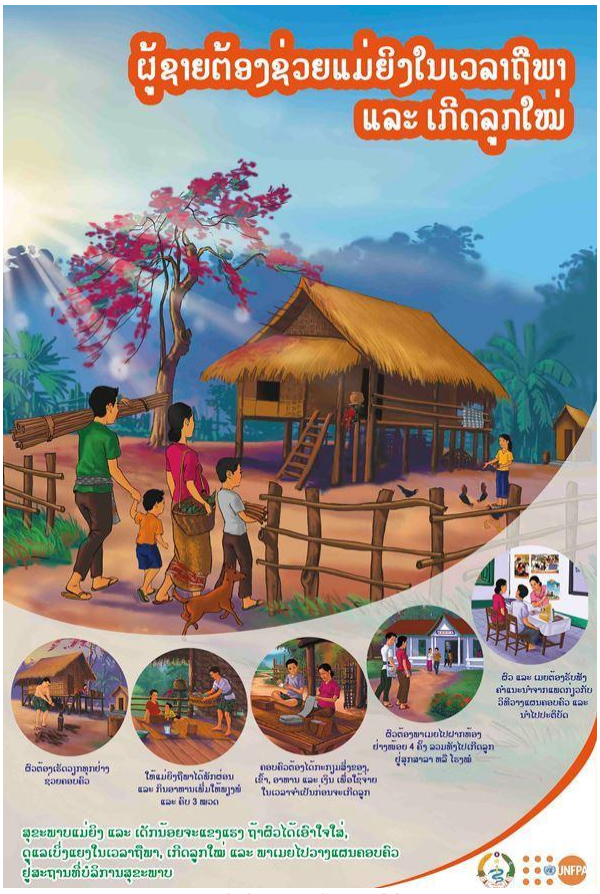
Information, Education, and Communication (IEC) and Behaviour Change Communication (BCC) strategies

In line with the RH Policy, the strategies for men's involvement in RH and FP, is through the IEC/BCC. The Centre of Information, Education for Health (CIEH)

takes the lead on designing, planning and implementing the IEC/BCC strategies for men's involvement at the community level.

Figure 5.3 shows one of the IEC materials developed by the CIEH to raise awareness and promote active participation of men. The poster is titled: "Men should help women during pregnancy and childbirth". The small images in the circles at the bottom covey messages about men's involvement, from left to right: "men should help family with everything"; "women should take enough rest and eat well"; "the family should be well-prepared before delivery"; "the husband should take his wife to get ANC service at least four times and take wife to give birth in the health centre or the hospital";and "husband and wife should listen to the health provider about FP and practice together".

Figure 5.3: Poster titled men should help women during pregnancy and childbirth



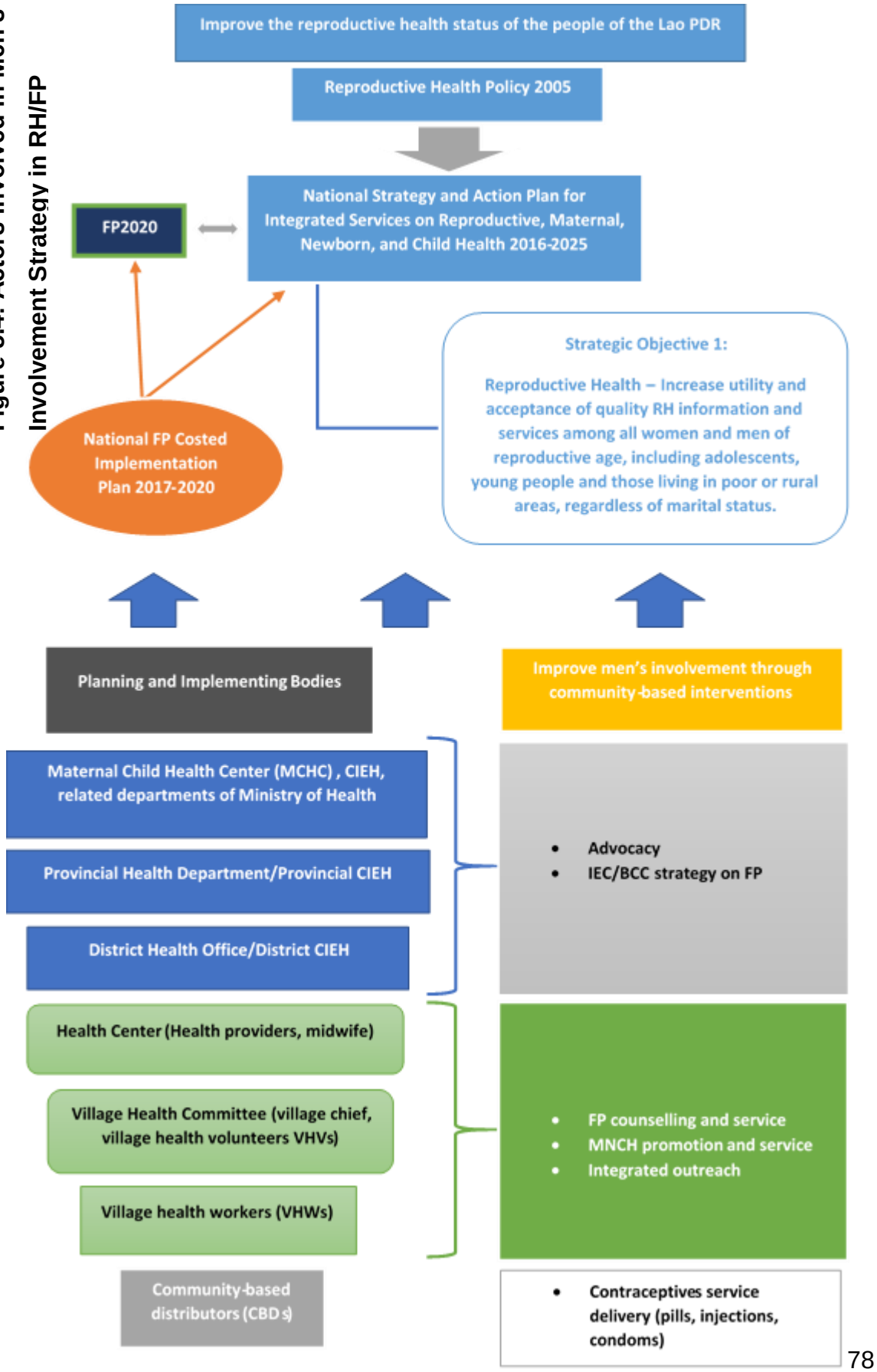
Source: CIEH, Ministry of Health Lao PDR

The message on the poster shows the government understanding of masculinity in a way that represents men in general. Men are seen to be a homogenous group having the same behaviour, which needs to be changed to support women. Given that Laos is a ethnically diverse country, it is essential to recognise that masculinity might differ between the 49 ethnic groups.

The planning and implementing bodies follow a hierarchical order from central to village levels. Figure 5.4[19] shows that while community-based interventions are considered essential, planning was carried out at the higher, central levels where the majority of officials are Lao-Tai.

[19] Adapted from the RMNCH Strategy and Action Plans 2016-2025, Ministry of Health, Laos.

Figure 5.4: Actors Involved in Men's Involvement Strategy in RH/FP



5.3.3 Reproductive Health and Family Planning Context

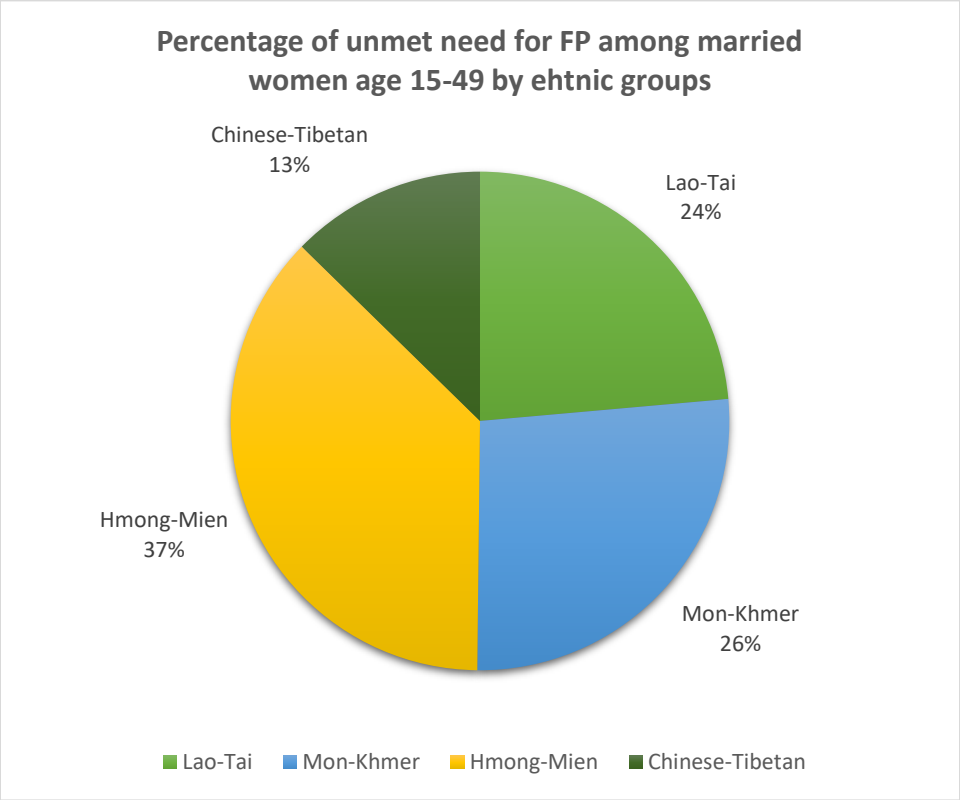
Although progress has been made on SRH, including FP, in the past decades, significant challenges still remain. There is a huge disparity between urban and rural and among the ethnic groups. Early marriage and early pregnancy are still common, especially among ethnic groups in remote areas. Lao PDR has one of the highest early pregnancy rates in the Southeast Asian region at 94/1,000 (Lao Statistics Bureau, 2015)[20].

According to the UN Laos report (2017), Laos has made progress on the Millennium Development Goals (MDGs) especially MDG 5 – improve maternal health. The maternal mortality rate (MMR) gradually dropped from 650/100,000 live births in 1995 to 339/100,000 live births in 2008, and it has reduced further to 206/100,000 live births in 2015 (Lao Statistics Bureau, 2015). However, the rate remains the highest in the ASEAN region, due to factors such as low coverage and inadequate quality of services. The rate is notably higher among the poor women with no education and ethnic women in remote areas where there are greater barriers to accessing health services.

In 2015, the Lao government adopted and localised the Sustainable Development Goals (SDGs). In particular, the SDG 3 encompasses MDG 4, 5, 6 and includes other issues, such as universal health coverage. Among other targets under SDG 3, the specific target for FP is spelled out[21]. Laos has made progress on FP. The use of modern method contraceptives for married women aged 15-49 increased slowly from 42 percent in 2011 to 49 percent in 2017. Meanwhile, the total unmet need declined from 20 percent in 2011 to 14.3 percent in 2017. The unmet need is higher among the ethnic groups as shown in Figure 5.5.:

[20] Mangkong specific data is not available, at least not at the time of this study.
[21] "By 2030, ensure universal access to SRH care services, including for FP, information and education, and the integration of RH into national strategies and programmes." (UN Laos, 2018).

Figure 5.5: Percentage of unmet need for FP among married women of reproductive age by ethnic groups



Source: Lao Statistics Bureau, 2017

5.3.4 Challenges

Despite the improvement in the health sector, universal access to health care services remains challenging due to mountainous geography and remote areas without a road, especially during the rainy season. Other barriers, such as socio-cultural, a lack of ethnic health staff, and communication and language problems are common, which makes it more difficult to provide health care among the poor with limited or no education, and for women, particularly ethnic women in hard-to-reach areas. Also, most ethnic people in remote areas still rely on traditional healers in the community, using herbal remedies and spirit worship as part of healthcare. People usually also consult with the spirit man before seeking healthcare service at the health centres. (MoH & ADB Laos, 2015).

The overall quality of health service delivery remains low. The referral system is inadequate, and the support system is insufficient. There has been an improvement of health services with better quality, but the needs have not yet been met. There is a lack of ethnically disaggregated data within the health sector that support planning and implementing programmes that target each ethnic group. Moreover, the government expenditure remains low, as it relies on external funding[22].

5.4 The Study Site

This study took place in Nong District, Savannakhet province. Savannakhet is the largest and most populated province with 15% (969,697) of the total Laos population residing in this province. There are 15 districts, and Kaisone is the provincial capital city. Savannakhet is situated in the southern part of Laos bordering with Vietnam to the east and Thailand to the west.

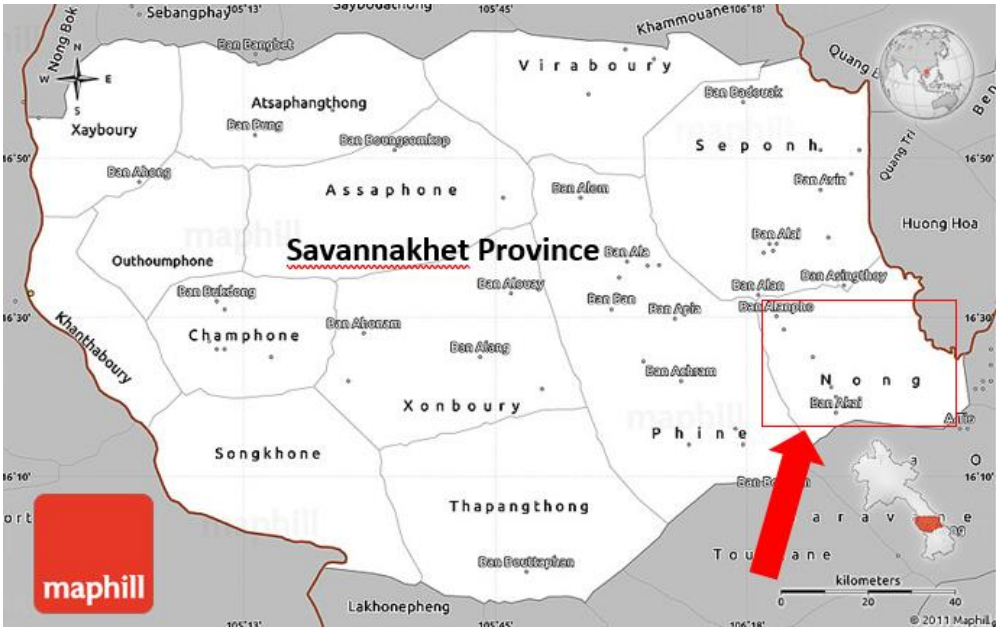
A FP programme began to be implemented in Savannakhet province from 2000[23]. In the beginning, only contraceptive pills were available. Now there are seven forms of contraception available in total, namely pills, injections, IUDs, implants, condoms, female sterilisation and male sterilisation. Some of the methods are not available at the health centre; particularly the permanent methods are available only in Sepon district, which is approximately 50km away. According to the Lao National Family Planning Costed Implementation Plan (CIP) 2017, among other provinces, Savannakhet continues to have the highest gap in funding regarding the FP programme.

[22] Particularly at the health centre level, external resources cover 58% of the costs, while 20% comes from the health centre revenue and the remainder relies on a service charge (WB Laos, 2016).
[23] Based on information obtained from informal discussion with the District Health Staff during the fieldwork.

5.4.1 Nong District[24]

Nong district is one of the poorest districts in the country. It is approximately six hours by bus from Kaisone district. Nong borders with Vietnam, and there are growing Vietnamese rubber plantations in Nong creating job opportunities for the people. There are seven ethnic groups in Nong, namely: Lao (Lao-Loum); Phu-Tai; Mangkong; Ta-Oi; Pah-Koh; Tri; and Ka-Tang. The Mangkong make up the majority of the residents. There are 70 villages and eight health centres. The villages are divided into nine cover zones, which means that each health centre covers up to ten villages.

Figure 5.6 Map of Savannakhet Province



Sources: http://www.maphill.com/laos/savannakhet/simple-maps/silver-style-map/free/

[24] Based on the information obtained from the Savannakhet Provincial Statistics Report 2017 and informal discussions with the District Health Staff during the fieldwork.

5.4.2 The Mangkong

The Mangkong or Makong[25] (Lao Theung as based on topography or Mon-Khmer as based on ethnolinguistic family) comprise the majority of the population in the district. The total population is slightly over 30,000[26] people. The Mangkong are animists (Ovesen, 2002). They believe in spirits, and that natural phenomena, such as mountains, forests, and rivers, have spirits. For example, people sacrifice animals to worship the spirits before growing rice.

The majority of the Mangkong ethnic group engage in farming. They rely heavily on rainfall for their slash-and-burn farming or shifting cultivation (known in Mangkong term as 'Sak Hai'). According to the translator, people grow rice in the rainy season between May and June and harvest in September-October. Despite the government's policies to end slash-and-burn agriculture, people are still practicing farming in this way as there is no alternative livelihood. The forest is the main source of food production for bamboo and wild animals. Most Mangkong also own domestic animals, for instance chickens, cows, buffalos, pigs, and goats. Observations during the fieldwork found that the Vietnam-owned rubber plantations located in Nong have offered employment opportunities for men, hence, some men are shifting from farmers to paid workers.

Gender

According to an informal discussion with the translator and the district health staff, the custom among the Mangkong is a patriarchal and patrilocal marriage system. Men are the head of the household and make every decision in the family. Women move to reside with their husband's family after marriage and become one of the family members. Given that men are the decision makers coupled with being an influential elder member, women experience a relatively low status and are subordinate within the household (Khouangvichit, 2010). In the Mangkong

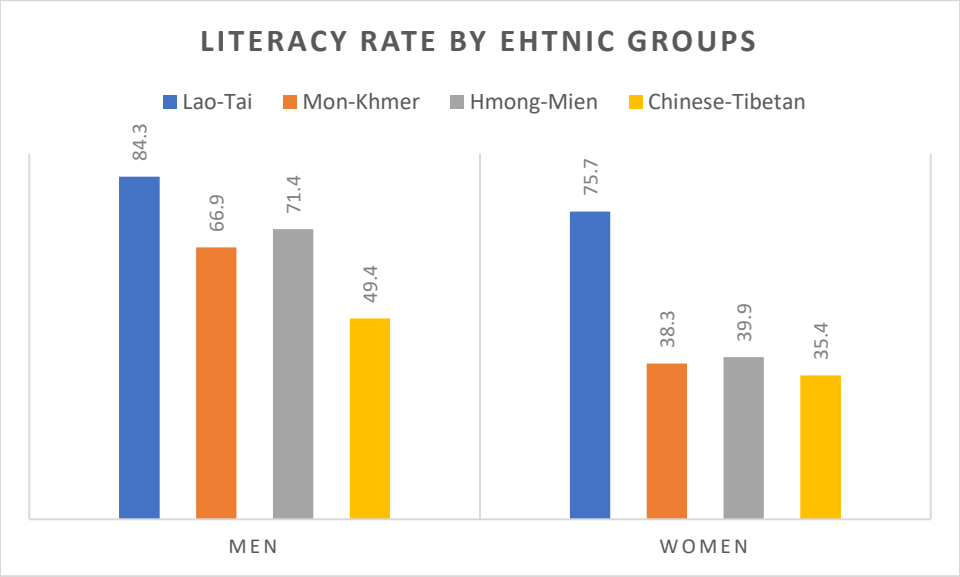
[25] The names Mangkong and Makong are used interchangeably. However, Mangkong is used throughout this thesis.
[26] According to Savannakhet Provincial Statistics Report 2017.

community, women are responsible for reproduction including childcare and household work, while men are responsible for production, particularly in farming and income-generating activities. Also, men can ride a motorbike, whereas most women cannot. When a family member gets sick, especially if women get sick or pregnant, men take them to the health centre.

Due to the culture that values boys over girls regarding education, most men can speak and read the Lao language because they went to school, while women cannot. Other constraints to attending school are because of the long distance (Ovesen, 2002). According to one of the primary participants, the school is far away from her village. Thus, her children stopped going to school because they cannot walk that long distance.

According to LSIS II 2017, the literacy rate is relatively low among women compared with that of men. The rate is lower in the Southern part of Laos and remote areas without road access, particularly among the poorest and ethnic groups. Notably the Mon-Khmer (who the Mangkong belong to) has the second lowest literacy rate at 38 percent for women, and 67 percent for men. Lack of decision-making power among the Mangkong women, coupled with gender inequality regarding literacy, shows the vulnerability of women.

Figure 5.7: Literacy rate by ethnic groups



Source: Lao Statistics Bureau, 2017

Reproductive Health and Family Planning

According to an informal discussion with the district health staff during the fieldwork, women often give birth in the forest without assistance from the health centre's skilled birth attendants. The reason why women give birth in the forest is due to the belief that delivery inside the home would bring misfortune to the family, and blood is believed to be an 'impurity' (Alvesson, Lindelow, Khanthapat, & Laflamme, 2013). The health staff said that due to a lack of knowledge concerning reproductive, maternal and child health, women still work hard with the normal workload and multitask during pregnancy, which often causes a miscarriage, stillbirth and maternal death. Moreover, men are not allowed to get involved during childbirth, as it is seen to be inappropriate. Instead, men build a hut outside the home for women to deliver. Older female family members such as a grandmother or mother, and female siblings and relatives often help women during delivery.

There has been increased utilisation of health centre for ANC, delivery and FP. According to the health staff, with the increased awareness among the Mangkong

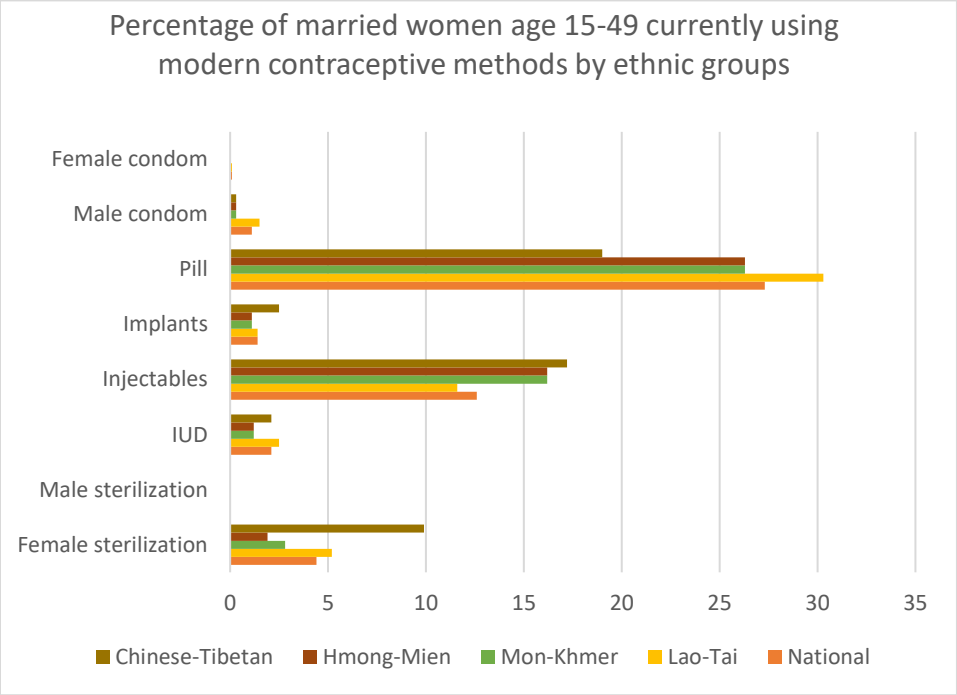
community, women have started to visit the health centre with support from their husbands. Women who cannot make it to the health centre still give birth at home with the help from a trained traditional birth attendant. The health staff said that there is one trained traditional birth attendant in each village. With the increased availability of FP information and services, people have access to this information and service, so they usually have 3 – 4[27] children in each family.

Despite such a positive transition, women, particularly those in remote areas, still face constraints that hamper them accessing the health centre. These barriers include long distance, lack of vehicles, lack of money and so forth (Alvesson et al., 2013). The district health staff said that people in hard-to-reach areas still believe in applying spiritual practices, such as getting cured by 'Pao' – by shaman, before they go to visit the hospital.

The gender expectation that reproduction is the women's responsibility places more burden on women. As a head of the family, men often make a decision on behalf of their wife regarding RH including FP (UNFPA Laos, 2015). Thus, men are a key determinant in the health-seeking behaviour and the RH outcome of both men and women. The cultural perception also has an impact on the use of contraceptives among the ethnic groups. Both men and women perceive that women are the contraceptive users due to their reproductive role. The figure below shows the very low use of condoms, notably among the Mon-Khmer whom the Mangkong belong to. There is no male sterilisation among men of all ethnic groups.

[27] Specific fertility rate among the Mangkong is not available.

Figure 5.8: Percentage of current modern contraceptive users by ethnic groups



Source: LSIS II (Lao Statistics Bureau, 2017)

Gender Division of Labour

The observation from the fieldwork found that men and women bear an equal workload in the rice field. They go to the field every day from early morning until evening. In the rice field, there is a clear task division between men and women. While men do the tough work, such as 'Sak', which requires more energy and muscle to make a small hole in the ground, the women do relatively lighter work such as 'Thom', where the rice seeds are sown in the hole[28].

[28] While the parents are working in the field, children stay at home with their grandparents and their older siblings. Following the traditional gender role; an elder sister takes care of their younger siblings, and undertakes household work, such as pounding the rice, cooking, washing clothes and collecting water and firewood. There is a water pump located in the centre of the village where people can go to collect water, wash their clothes and take a bath. The elder brother's role is to graze cattle along the road and in the field.

Figure 5.9: Pictures from the Field I

Men 'Sak' (using a long wood to pound on the soil to make a hole)

Women 'Thom' (sowing the seeds)

Source: The Author, 2018

Most Mangkong women have weaving skills. Fieldwork observation found that women in every household visited (including those just passed by) owned a weaving loom, which is often built by their husband. Women make their own 'Sin', the Lao skirt and clothing for their family during their spare time; some of them make Sin for commercial reasons also. According to an informal conversation with Mankong women, they occasionally sell Sin when tourists visit. However, there are few formal channels for them to turn weaving into an income-generating activity. Women need to access skilled training and markets in order to sustain their weaving for commercial purposes (McIntosh, 2013).

As already discussed, the transition from farming to employment in Nong allows men access to income generation, while women remain in their traditional role. Therefore, women become more subordinate with respect to the family economy, as they do not have control over the finances. Given that women take care of the children and other family members' health, this lack of control over such resources may have negative impacts on the health of themselves and their children.

5.5 Chapter Summary

This chapter provides an overview of FP in the context of Laos with a focus on the Mangkong ethnic group in Nong District, Savannakhet Province. Laos has supportive policies and a strong commitment to improving the SRH outcome of the people, which is seen in the integration of SRH into the national development plans. However, Laos still faces challenges in ensuring universal access to FP information and services, particularly among ethnic groups in rural areas. There are various barriers that constrain women and men in terms of access to FP among the Mangkong, which range from cultural to structural issues.

CHAPTER 6: FINDINGS

6.1 Introduction

This chapter presents the findings from the fieldwork and explores whether and in what ways men's involvement increased women's empowerment in FP.

Pseudonyms are used to identify three key informants – the CBD in village 7, the primary health provider in village 4 (belonging to health centre B), and the village chief in village 6; and the three couples in the stories. The rest are identified by number, e.g., Couple (CP) 1, 2, 3. Titles are used to identify other key informants. Alphabet letters are used to identify the villages. Quotes from the interviews are used throughout the chapter to present the voices of the participants. The quotes have been translated from Mangkong to Lao to English, and brackets in some quotes are used to clarify a point.

The chapter commences with a presentation of the results of the interviews with key informants and the primary participants, which are divided into two categories of men's involvement in RH/FP. This explores the way men are involved and participate in RH/FP, the levels of such participation and the barriers to the active participation of the Mangkong men. The last section discusses women's empowerment, focusing on their self-confidence, autonomy, ability to discuss and negotiate, and decision-making power in FP.

6.2 Men's Involvement in Reproductive Health and Family Planning (RH/FP)

The results from the interviews with the primary participants and the key informants revealed two categories of men's involvement in FP: 1) men's involvement in RH/FP as a promoter/service provider – the village chief, the primary health provider, and the CBDs; 2) men's involvement among the target group – the Mangkong men. The first category plays a crucial role in promoting men's involvement in RH/FP in the community by raising awareness among the

Mangkong men and women in the community. As a result of this first category of involvement, the Mangkong men improved and increased their participation in FP counselling, integrated outreach, and during their wife's pregnancy and childbirth.

6.2.1 Category 1 – Men's Involvement in RH/FP as a Promoter/Service Provider

Three actors in this category exemplified the men's role in promoting men's involvement in RH/FP. They were the CBD in village 7, the primary health provider in the health centre in village 4, and the village chief in village 6. These three actors show the positive role of men in promoting and raising awareness among men in the community in relations to RH/FP. The following sections present their stories.

The CBDs

The CBDs visited villages in hard-to-reach areas. They provided information and service on contraceptive methods such as the pill, condoms, and injections. The government delivered training for the CBDs and also provided a salary, vehicle, and equipment to facilitate their work on a monthly basis. According to the Health Official at the Maternal and Child Health Centre (MCHC), although the government recognised the effectiveness of the CBDs as the primary service provider who reaches out to the most marginalised people, the programme recently ended. She explained:

> The assessment shows the effectiveness of the CBD programme. However, the expenditure for the programme is too high, because we have to pay a salary to the CBDs. The other reason is that the number of the health centres is increasing, and we also train the 'PhaedBaan' (Village Health Workers - VHWs). Thus, we ended the CBD programme. (Health Official, MCHC, Vientiane Capital).

She said that the government provides six months' training for VHWs to replace the CBDs to provide FP service in the villages.

Although the CBDs programme was phased out, some CBDs in some villages are still operating under the budget of the district hospital in Nong district. For instance, Mr. Kong (pseudonym), who has been working as the CBD in village 7 for seven years, is now providing FP service to the people in his village and other villages nearby:

> The CBDs programme ended two years ago now. However, the health centre and the District Hospital continue to support CBDs under the budget of the hospital. (Kong, CBD).

Mr. Kong has been quite a role model in his village. He is aware of FP and supports his wife to use contraceptive methods. He and his wife do not want to have any more children, so his wife has been on the injection. In his words:

> If we did not use any contraceptives, we might have had two more children now. However, we can avoid pregnancy. So, when people saw us like this, they wanted me to work as a CBD.

Like other CBDs, Mr. Kong attended a two-week training course in Savannakhet province before commencing his work in the villages. According to Mr. Kong, there are two CBDs who continue working in the area, and each of them covers several villages. He travels to get the contraceptives in the district hospital by motorbike:

> I go to get the contraceptives by myself (at the hospital). I go to send a report (users' record) and get the contraceptives.

Since Mr. Kong gets the contraceptives at the hospital by himself, he charges a contraceptive fee to cover his transportation and fuel. He said that he charges a small amount of 5,000 LAK (0.90NZD) for a contraceptive injection fee. He added that most women in his village prefer the injection because it is more convenient for them.

During the interview, Mr. Kong said that he had seen some positive changes since he started working in the villages, especially in men's attitude becoming supportive of their wives. He explained:

> Before the CBDs programme started, people usually had about ten children, and it is difficult for them to go to the rice field and work, and there is not enough food to feed everyone. But now families are reduced to 3-4 children. Men have been increasingly involved and have a better understanding, so they allow their wife to access the FP service.

Mr. Kong said that people work in the rice field every day from early morning to the evening, so his service hours must be flexible. He said that people often come in the morning or evening after returning from their rice field.

Regarding men's involvement, Mr. Kong said that men and women should work together and share responsibility and make a joint decision on FP:

> Men help women with heavy work, such as carrying firewood. Women pound the rice and men feed the pigs. Men and women make a joint decision on FP. We should be like this, and we can have good health.

Mr. Kong uses a FP poster to provide information to both men and women in the villages. However, he said that the men are shy, so they do not want to use condoms, and they often laugh when he demonstrates how to use condoms.

According to Mr. Kong, women do not read, so they usually forget the expiry date of the injection, so he often reminds the women before the expiry date, as he explained that:

> The injection is valid for 90 days, but they usually go to the health centre on the 95th day. However, in my village, I inform the people on the 88th day, so as to remind them.

Mr. Kong seemed to enjoy his work as a CBD, and he will continue to provide the service to the people, as long as there is support from the district hospital. For him, there are no challenges for providing the service to people. When asked about challenges, he replied:

> No, nothing. It depends on the people, as it is based on voluntary choice if they want to use FP for birth spacing. We cannot force them to use contraceptives. I only provide the service.

It is noteworthy that Mr. Kong mentioned 'voluntarism' as the reason why he did not face any challenges in providing a FP service to the people in the villages. This suggests that Mr. Kong is not trying to get many clients in order to increase the number of users.

The Primary Health Provider

Mr. Phan, who is from another ethnic group, has been working as a primary health provider in health centre B (in village #4) for 15 years. He has built a good relationship and strong trust with the people in the village. Mr. Phan is part of the integrated outreach service, which is conducted quarterly in remote areas. However, due to adverse infrastructure and weather conditions, Mr. Phan said that they are not able to visit every village in remote areas, especially during the rainy season. Therefore, they usually reach out to the hard-to-reach areas in the dry season, when it is accessible.

Mr. Phan and his family moved to live next to the health centre so that he can be on stand-by and be ready to serve the people whenever they need him. He provides information to both men and women in his village, as he explained:

> I provide health education to the people. I say that a couple should make the decision together and if the husband or the wife wants to have children, then they should discuss with each other and plan together.

He also provides information and FP services at the health centre by using a FP poster to explain to the people in the Mangkong language:

> I explain the usage of contraceptives. For example, if they get the injection, they should avoid having sex for one week. I also explain about condoms and information about STI.

Moreover, Mr. Phan provides information to newlywed couples and encourages them to discuss with each other about whether and when to have children before coming to obtain FP services.

During his 15 years of work as the health provider, Mr. Phan has seen positive progress regarding men's involvement; in particular, he has found increased awareness among men and they allow their wife to access FP. He said:

> Men let their wife use the contraceptives, and they support them regarding transportation. So, they take their wife to get FP services.

He added that it is now unlike in the past, when people did not know what to do if they did not want to have children, and they had to rely on traditional methods. Thus, there has been quite a substantial positive change in the community.

In Mr. Phan's opinion, access to information remains limited particularly among those who live in remote areas. For him, gaining trust from the people is difficult and takes time. During the interview, Mr. Phan seemed to be proud of himself for having developed a strong bond of trust with the people in his village, as he said that more and more women come to see and talk to him about RH/FP, which was not the case in the past. During the fieldwork, I observed this good relationship between Mr. Phan and the community. He assisted the research team as we walked around the village and interviewed two couples in his village without interference.

The Village Chief

The village chief is a member of the village health committee (VHC) and the integrated outreach service. The role of the village chief is vital as he controls admittance to reach the people in the village and serves as an instigator to gather the people to attend the outreach and other community meetings and events. Mr. Vong, the village chief in village #6, sets an excellent example of the village chief participating and promoting RH/FP in the community. Over ten years of involvement in VHC, he has participated in many RH/FP related training sessions; he is well-aware of RH/FP.

According to Mr. Vong, both men and women in his village attended the outreach. He said that there is no case where the people do not want to attend. He said that during the outreach, the team provides information about men's involvement:

> The health education also talks about men's involvement, like using condoms. Also, when men want to have affairs with other women, they have to use condoms.

Interestingly, Mr. Vong mentioned 'extramarital affairs' as the reason for men to use condoms. His interview included that the team also raises awareness among the Mangkong men to be supportive of their wife during pregnancy and childbirth:

> When women get pregnant, the men should take them to the health centre for ANC, until their due date. When women give birth, men have to take care of them and help them by making the fire, collecting water, cooking and doing tough physical work.

Mr. Vong said that in the Mangkong society, the men are the head of the family and it is the men who usually plan and make decisions, but they also discuss issues with their wives. Although men are the decision-makers, he said that women usually make a decision on using FP methods and the husband supports them:

> They let their wife use contraceptives. They do not tell their wife to use specific methods; it depends on their wife.

From the observation during the interview, Mr. Vong seemed to be passionate about working for the well-being of his people in the village. He expressed his compassion for his people that:

> I empathise with the people. I think outreach is essential, so the people must attend.

He said that not everyone attends the outreach, due to work in the field. In such cases, he would visit them when they return from work and explain the outreach information to them:

> If those who work cannot attend, I visit them at home and explain to them when they come back. I am worried that it is going to be difficult for them if they do not know about birth spacing.

Similar to Mr. Phan, Mr. Vong has developed a strong trust from the people. Because of such trust, the women in his village come to talk to him about FP, and they talk to him about implants:

> Women often come to talk to me when they want to get an implant. When they come to talk about FP, I always explain and try to be a role model.

Regarding men's involvement, Mr. Vong seems to promote condoms in the context of outside marriage, as he mentioned earlier and again when he noted: "I also explain to the men who go outside (stay at the hotel)".

Besides FP, the people also come to talk to him about their health problems:

> The people often come to talk to me when they get sick or have any problem including illness and vaccination; I always refer them to see the health provider at the health centre.

These quotes from his interview show that Mr. Vong has actively promoted RH/FP through setting himself as a role model and building a good relationship with the people. Such participation has resulted in improved communication

between the people and Mr. Vong, which in turn facilitates his work in further promoting RH/FP in his village.

As demonstrated above, the interviews with these key informants show a high level of participation and involvement in RH/FP promotion in the community. Regardless of other structural issues that have an impact on their performances, the role of promoting and providing information to the people is already a kind of participation itself.

The interviews with Mr. Kong, Mr. Phan, and Mr. Vong suggest that men's involvement in RH/FP, through awareness raising alongside the integrated outreach and FP counselling, has resulted in increased awareness among both Mangkong men and women. Each of these three men promote the man's role to be positive and supportive of their wife during pregnancy and childbirth and especially allow their wife to use contraceptive methods. Furthermore, they also promote spousal communication and decision-making on RH/FP among the couples in their village as demonstrated from the interviews already mentioned.

Their stories show that to achieve the behaviour change through such community-based intervention is difficult, and this change requires a long-term strategic plan. Building trust and maintaining a good relationship with the community is vital. Communication is also essential. All three men (Mr. Vong and Mr. Kong are Mangkong, whereas Mr. Phan is from another ethnic group) speak the Mangkong language, thus the language serves as the first step to paving the way to reach out to the people in the community. Information including IEC/BCC tools in the ethnic language is essential to raise awareness and understanding among the Mangkong community.

6.2.2 Barriers

According to the interviews, barriers still remain regarding men's involvement in FP, at the promotion and service delivery level. These include structural barriers where the intervention is implemented, for example, infrastructure and budget

availability. Also, a cultural barrier persists with the perception that RH/FP is a women's issue, which often results in a reluctance to engage with the Mangkong men in the community. The personal commitment of these actors also affects the levels their role is involved in RH/FP intervention.

Structural Barriers

Structural barriers are created by the implementation of the community-based intervention, which seems to be inconsistent and often depends on resource availability. For example, according to the district health staff, reaching out to the most marginalised group is essential. Moreover, Mr. Phan said that outreach is planned to be conducted quarterly and targeting the most remote areas. However, due to poor infrastructure and weather conditions, the access to people in these hard-to-reach areas becomes discretionary.

Indeed, the infrastructure presents a significant issue for access to the people and vice versa. To illustrate, Figure 6.1 shows the road to village 7 where Mr. Kong resides. The road to the village is narrow, bumpy and it becomes muddy and slippery during the rainy season. According to the key informants, the road to village 7 is not the worst one, as there are many more villages that are cut off and inaccessible in any particular rainy season.

Figure 6.1 Pictures from the Field II

Source: Author, 2018

In addition, resource availability has also been an issue for implementing timely and consistent community-based interventions. A prime example is the phasing out of the CBDs programme. Although the case of Mr. Kong shows the strong commitment of the district health office, the programme is not sustainable as it depends on the limited resource.

There are limited IEC materials for the health promoter and service providers, as only a few IEC materials such as posters were developed (see chapter 5). Thus, the use of IEC materials is limited. At the time of the field work, there were no such posters showcased in the health centre. Also, the written message may not be useful as most people do not read.

Cultural Barriers

The perception of the health providers of RH/FP as a women's issue remains, which results in overly targeting women. Mr. Kong, Mr. Phan, and Mr. Vong all show positive role models of their own behaviour. However, information on how they engage with the Mangkong men remains insufficient. For example, they said that most men are shy, especially when talking about condoms. However, they did not provide further insights on how they address the reaction of the Mangkong men and improve their participation.

Personal Factors

During the interviews, the three actors showed their compassion for the people and their commitment to raise awareness among the people. However, such a commitment might be under the guise of doing business. For example, Mr. Kong was eager to visit women to remind them of the expiry dates of the injection; he might do so to increase the service and, hence, his income.

Although Mr.Vong, Mr. Phan and Mr. Kong demonstrated the positive role of men in RH/FP, it is important not to generalise or consider this to be representative. These three actors are working in FP and were willing to discuss FP, as others

might not be. For example, the village chief in village 2 was not included in this finding, as he refused to participate in the interview and reluctantly said that he did not know much detail about FP and men's involvement. Although he said that he occasionally displays the MCH/FP film to his people in the village, he seemed very reluctant to talk further about FP.

6.2.3 Category 2 – the Target Group (the Mangkong men)

The Mangkong men's involvement in FP counselling, the integrated outreach, the use of contraceptives, and support during women's pregnancy and childbirth is varied ranging from partial participation to active participation. In addition, various factors such as personal, structural and cultural aspects also have impacts on the level of men's participation among the Mangkong men.

Family Planning Counselling and Service

The findings revealed diverse factors, such as personal, structural and cultural aspects, that impact on the level of men's participation in FP counselling together with their wife. It is vital that the health providers initiate and encourage both men and women to engage in the counselling together as a couple, rather than engaging women in isolation and excluded men from the process.

No Participation

Many women referred to the close distance (within walking distance) of the health centre as the reason why they get the counselling alone without their husband accompanying them. According to the interviews with couples who live near the health centre, women usually get the FP counselling and service by themselves. To illustrate, the wives CP1, CP3, CP4, CP5 and woman 2 from village 1, and the wife CP9 from village 4 said that they walk to the health centre alone. For example, the wife CP9, who started to get the injection after she gave birth to her

third child, went to obtain the service at the health centre by herself. Her house is located opposite the health centre, so she can walk in less than a minute:

> I went to get the injection alone because the health centre is just nearby my house. (Wife, CP9).

Similarly, the wife CP5 who lives in village 1 near the health centre A also went to the health centre by herself. Her husband said his wife goes to obtain the pills alone.

In the cases above, the husbands are wholly absent, resulting in no participation in the counselling and service together as a couple at all. There are two points that emerged from the interviews above. First, a close distance to the health centre provides easy access for women to receive information and service. However, as evidenced in the examples, a close distance to the health centre can also prevent men's participation because of its easy access. In this context, neither men nor women feel the need to participate together as a couple. Notably, men do not feel the responsibility to participate, hence, fail to gain the vital information, which is essential for a couple's decision-making back in the home.

Partial Participation

Partial participation refers to men who are sometimes physically present at the health centre with their wife, but not necessarily engaged in the counselling. Such participation was found among the interviews with three couples (CP10, CP11, CP12) and one woman (woman 1). For example, the wife CP10 is currently on the contraceptive injection. Since she lives in village 5, she got the service from the district hospital, as village 5 is covered by the district hospital. Since she did not know how to ride a motorbike, her husband took her to the hospital but was not necessarily involved in the conversation with the providers:

> I have got the injection 3 times now. My husband took me to the hospital. (Wife, CP10).

The wife CP11 used to take the pill but has since got the injection. Her husband is the chief of village 6. She has been on the injection for two years now. She said that her husband takes her to the health centre when he is home, and when he is not, then she usually goes with her friends.

The interviews with these couples show the men's partial participation. This can be interpreted that they might be just physically present as a companion or support regarding transportation. This is because, in the Mangkong society, women stay at home while their husband often travels to work outside their village. Thus, men know how to ride a motorbike, whereas women do not. Mr. Phan mentioned that men usually take their wife to the health centre.

Participation might also come in the form of support with regards to reading the appointment card for their wives, since men are more likely to be literate than women (see Chapter 5). Most Mangkong men can read and speak the Lao language, but women do not. Although some women can speak a little, they tend to be shy to speak, as they fear that they might say it wrong.

Active Participation

Active participation is beyond a mere physical presence, as it involves the attention paid to the information given by the health provider and the interaction during the counselling. There are a few men who seemed to participate in the counselling and service actively. The husband CP12 from village 6 and CP13 from village 1 exemplify such active participation. For example, the wife of CP13 from village 1 is currently on the injection. They both know about the contraceptive methods from the health providers. The husband took his wife to get the service at the health centre. According to the interviews, these husbands seemed to participate in the counselling process:

> She has been on the implant for three years now. We went to get the implant together. We remember the expiry date (implant) together. (Husband, CP12).

> We went to the health centre together. The provider said that she (his wife) should get an injection every 3 months. (Husband, CP13).

In the cases above, the husband shows his intention to participate in counselling together with his wife as a couple, which is demonstrated by his willingness to listening to the providers. The midwife confirmed that some men ask some questions during the counselling.

Exclusion

Although the husband CP13 expressed his interest in participating in the counselling together with his wife, he was usually excluded, hence hampering him from active participation. Due to the attitude of the health providers, some husbands felt excluded from the counselling process. The husband CP13 added that the provider did not provide any information about condoms to him and his wife, as they only provided the injection service to his wife. He said:

> I went there with my wife to get the injection. The provider did not provide any information about condoms. (Husband, CP13).

Similarly, the husband CP6 from village 2 also took his wife to get the injection at the health centre. He expressed his interest in participating in counselling, but he felt excluded as the provider did not talk to him:

> When I took my wife to the health centre, they (the providers) did not say anything. They only talk to women. (Husband, CP6).

The two quotes above highlight the reluctance of the health providers, who are supposed to engage men during the counselling actively.

Cultural Perception

The interviews confirm that RH/FP is still considered to be a women's issue. The wife CP1 also mentioned that this cultural aspect limits men's participation as she indicated that men, in general, are not interested in contraceptives:

> I am the only one who listens to the provider, although the provider gives information to both of us, he is not interested. (Wife, CP1).

Since both men and women, including the health providers, perceive RH/FP as women's work, women are overwhelmingly targeted, while men are often excluded.

Personal Factors

Personal factors also impact the level of men's participation. Men do not want to participate due to a lack of interest. For instance, the husband CP1 said that although sometimes he accompanies his wife to the health centre, he did not listen to the provider:

> When I took my wife to the health centre (to get an injection), I did not pay attention to listen to the provider. (Husband, CP1).

The observations during the interviews with the couples also showed that women are more willing to talk about FP than their husband. Thus, the lack of attention to FP among men might be part of the reason why women were more engaged in the interview process.

Integrated Outreach Service

According to the interview with the midwife working in health centre A, the outreach is an integrated service comprising of FP, antenatal care (ANC), immunisation, and nutrition. The outreach team coordinates with the village chiefs to conduct the outreach. The chiefs gather the people, especially encourage

pregnant women and children to attend. Two situations arose regarding the Mangkong men's participation in such outreach – couples attended together and couples where the wife attended alone.

Couples Attended the Outreach Together

Based on the interviews with the primary participants, all couples have heard about the integrated outreach. Five couples (CP4, CP8, CP10, CP11, CP13) said that they attended the outreach together as a couple. However, their participation is partial. For example, the wife CP4 is currently on the injection, and she got the service from the health centre A in village 1. Her husband also attended the outreach with her. However, he seemed to be not interested in the information given by the outreach team as he said that he did not remember what the team talked about.

In the case of CP4, the husband did not fully participate in the outreach; his reason was lack of interest in the outreach. He further added, which confirms his lack of attention, that he did not know whether there is a free condom at the health centre. His response was:

> Is there a free condom? I do not know. (Husband CP4).

In addition, partial participation was demonstrated by CP13. The wife has been on the injection for four times now, and she got the service at the health centre. Both the husband and the wife attended the outreach together, but sometimes the wife attended alone, the wife CP13 said:

> When there is the outreach, both my husband and I attend together, or sometimes I attended alone. (Wife, CP13).

When he did not attend the outreach, his wife would tell him about the information provided by the outreach team. He said:

> My wife said that they provide information about birth spacing by getting an injection, and if it is not available at the health centre, we can get it in the district hospital. (Husband, CP13).

This response shows the husband is aware of the outreach, even though he was only partially involved and sometimes he was absent. Such involvement is more meaningful than the mere physical presence without paying attention to the information during the outreach, as was the case of the husband CP4.

The couple CP8 in village 4 demonstrated active participation. The wife CP8 used to take the contraceptive pill and the injection, but due to side-effects such as fatigue, she decided to get an implant. The wife said that she did not remember all the information given by the providers during the outreach; in her words:

> I do not remember everything that the provider said (laughed). I remember there are injections and implants. (Wife, CP8).

Meanwhile, her husband added:

> They also talked about birth spacing and the pills. (Husband, CP8).

This couple shows the man's active participation illustrated by the attention that the husband paid, as he listened to the information during the outreach. However, it is noteworthy to consider that the husband CP8 used to be a village volunteer for an NGOs. Thus, his experience has a particular impact on his awareness and behaviour as he has become more active when it comes to community activities.

Women Attended the Outreach Alone

Among other interview participants, three couples (the wife CP1, CP5, CP12) and two women (the woman 1, 2) attended the outreach alone, without the participation of their husband. For example, the wife CP1 attended the outreach alone, and as already cited previously, her husband was not interested, though he supports his wife's use of the FP service.

The wife CP5 in village 1 is currently taking the contraceptive pill. She received information about FP from various channels, such as the district hospital, the health centre, and the outreach. She attended the outreach, while her husband did not. Her husband admitted that he was not there with his wife.

Both woman 1 and 2 (whose husbands did not participate in the interviews) said that their husband did not attend the outreach with them. Woman 1 in village 5 received the injection service at the district hospital and said that:

> The health education outreach came down here (to talk about condoms). My husband did not attend. (Woman 1).

These comments show men's absence during the outreach, whereas women seemed to have an obligation to attend.

6.2.4 Barriers

Similar with FP counselling service, cultural and structural factors also emerged from the interviews with regards to why men do not attend the outreach together with their wife.

Cultural Aspect

As mentioned above, the cultural perspective of the Mangkong community perceives MCH/FP as the women's responsibility. The following quote from the husband CP5 demonstrates the perception of the Mangkong community:

> I was not there; my wife attended, we (Mangkong men) don't know about this, as they usually ask women, not men. (Husband, CP5).

This statement indicates not only the perception of the Mangkong community, but also the perception of the health providers, as "they usually ask women, not men."

Thus, the cultural perception is a vital factor that has an impact on men's involvement in RH/FP.

Structural Factor

Another factor which also impacts men's participation involves the structure of the outreach and how it is achieved. According to Mr. Vong, the health education outreach used to be conducted in his village, but now is conducted in the health centre, as he explained:

> The health education outreach was conducted in villages every year. Now, they conduct the outreach at the health centre. We do not do the outreach in the villages anymore. (Vong, Village 6).

In contrast, the midwife at the DNS health centre said that they perform the outreach in the villages in remote areas. She added that the outreach is conducted at a time that fits the people's schedule, such as in early morning before they set off to the rice field or in the evening when they return from the rice field. She also corroborates the point that outreach only targets villages in remote areas beyond the zone covered by the health centre, and it is conducted quarterly. She said:

> We conduct the outreach in other villages, far away from the health centre. For those who are living nearby or in areas covered by the health centre, they usually come to get the FP service in the health centre. (Midwife, Health Centre A).

With such contradictory information provided by Mr. Vong and the midwife, it suggests that the implementation of the outreach is inconsistent. Furthermore, as presented above, the interviews with the key informants indicate the inconsistency in coordination and implementation of the health education outreach.

Use of Contraceptive Methods

The findings revealed that none of the participating couples have used or wanted to use a condom or undergo vasectomy. However, the interviews from the key informants indicated that there are a few men who use condoms and have undergone the vasectomy. Unfortunately, there was no opportunity to interview those men, because they do not want to be exposed. Misconceptions, as well as personal, cultural and structural aspects, are reasons why both men and women are reluctant to use a condom or even talk about it.

According to the key informants, there are a few men who use condoms. For example, the midwife in health centre A said that there are a few who came to get the free condoms from her:

> In my records, three men are using condoms. They come to get five condoms each time. (Midwife, Health Centre A).

She added that each of these men decided to use condoms because their wife suffers from side-effects of other contraceptive methods.

Mr. Kong also agreed that a few men in his village came to get free condoms from him:

> Ten men are using condoms. (Kong, village 7).

He added that there are five men who started to use condoms because their wife experienced side-effects from other contraceptive methods. He also stated that there is a man who came to get condoms from him secretly:

> This month, there was a man came to me to get condoms, He came secretly because he does not want other people to know about this.

It is important to note that he mentioned ‘secretly,’ which might concern the rumour of extramarital affairs as discussed above.

A few men also underwent vasectomy. According to Mr. Vong, some men underwent the sterilisation during a past free sterilisation project:

> In 2008-2009, there was a free sterilisation project, so there were some men who did it because they decided not to have any more children. (Vong, Village #6).

Misconceptions

The midwife said that talking about condoms is what the Mangkong society call 'Leung Peuh' or 'dirty topic,' thus, the people like to make jokes and laugh about it. There is a rumour that men who use condoms infer that they might have extramarital affairs. This concept prevents men from sharing the responsibility with regards to using contraceptive methods. For example, the husband CP6 knew that there is a free condom at the health centre but has never used any and does not want to use any. He said:

> If we go outside and stay at a hotel, then we have to use condoms to prevent HIV/AIDs and STIs (Husband, CP6).

Similarly, Mr. Vong also confirmed such beliefs, as he explained:

> When men want to have affairs with other women, they have to use condoms.

Therefore, there is no doubt that neither men nor women are willing to use a condom. The concern associated with the faithfulness of marriage prevents them from understanding the use of condoms as dual protection and one of the FP methods. The way the health providers promote condoms also influences the understanding of the people. As the quotes above show, the information about condoms is often provided within the context of HIV/AIDs and STIs but to a much less extent within the FP context.

The misconception about sterilisation also persists. For example, the husband CP2 heard from his peers that sterilisation causes inability to work in the field. He said:

> I heard from other men who underwent sterilisation said that they could not work hard in the field for years. (Husband, CP2).

He expressed his willingness to undergo sterilisation if he can still work hard in the field after the surgery, as he continued:

> If we can work hard like usual, then I might consider doing it. (Husband, CP2)

The midwife in health centre A confirms such misconceptions. She said that men do not want to undergo sterilisation because they fear that something might go wrong.

Similarly, Mr. Vong said that:

> Sterilisation is difficult because if they undergo sterilisation, they will not be able to work in the field anymore, that is why they do not want to do it. (Vong, Village 6).

Interestingly, the misconception also exists at the level of practitioners, as a role model in promoting FP, Mr. Vong seemed to have such a misconception and fear himself. As such, he does not want to undergo the surgery. Instead, he told his wife to submit to the previous free sterilisation project:

> I used to tell my wife to undergo sterilisation when there was a free sterilisation project many years ago. (Vong, Village 6).

His wife did not undergo the sterilisation due to fear, and she got the injection instead.

Personal Reasons

Apart from the misconceptions of condom use, in the case of CP8 (who have three children and the wife is on an implant) both the husband and the wife said that they do not want to use a condom because it is uncomfortable. The wife said:

> He never used a condom as he fears that it might slip out (laughed). (Wife, CP8).

Her husband added that using condoms may result in less pleasure. He said:

> I know there are free condoms, but I do not want to use one because it might make me feel uncomfortable and not fun (laughed). (Husband, CP8).

The wife confidently said that she does not want her husband to use a condom:

> I never wanted my husband to use a condom (laughed). (Wife, CP8).

Thus, this couple shows that neither of them feel comfortable using a condom and they do not want to use one. The wife said that she would continue to get an implant after the current one expired.

Cultural Perceptions

The interviews also revealed a cultural perspective regarding the use of male contraceptive methods. For instance, both CP6 and CP7 referred to 'the Mangkong men' as the reason why they never use and do not want to use a condom. The CP6 husband took the wife to get an injection at the health centre. She had suffered from side-effects, such as stomach ache, headache and sickness. However, she never switched to other methods. Even so, her husband does not want to use any male contraceptive methods. He said:

> I know there are free condoms at the health centre, but I never used them. We (the Mangkong men) do not use condoms. (Husband, CP6).

The CP7 husband in village 3 took his wife to get the injection at the health centre and said that he does not want to use a condom, even if his wife did not use contraceptives. He said:

> I do not want to use a condom because my wife has already had an injection. If my wife did not get the injection, I still wouldn't want to use a condom because we (the Mangkong men) never use a condom. (Husband, CP7).

Interestingly, both the CP6 and CP7 husbands mentioned 'we' when referring to Mangkong men. The CP7 husband added the difference between the Mangkong men and the Lao men in general, he said:

> We do not use a condom unlike the Lao men (Lowland Lao).

These quotes illustrate the perception of the Mangkong men that it is not common among Mangkong men to use condoms.

In addition, many couples (CP1, CP4, CP5, CP8, CP9, Cp10, CP11, CP12, Woman 1) perceive that using FP is the work of women. Thus, women have the responsibility to use contraceptive methods. The following interviews exemplify this perception. The CP1 wife confidently said that she is responsible for using the contraceptive methods, not her husband:

> I think women should be the one who uses contraceptives because it is our responsibility. Men do not have to take it. (Wife, CP1).

The CP8 husband referred to the women's reproductive role as the reason why using contraceptive methods is the women's responsibility:

> Using contraceptive methods is the work of women because they take care of children. (Husband, CP8).

His wife also agreed with him, she smiled and said:

> Yes, it is my work, and I am not shy to talk about it. (Wife, CP8).

The CP13 husband said that he supports his wife to use contraceptive methods:

> Women are responsible for using contraceptives, and I support that. (Husband, CP13).

The cultural factor is vital as it influenced the perception of both men and women about FP, especially the use of contraceptive methods. As a result, there is little shared responsibility regarding the use of contraceptives among couples, which continues to place a burden on women.

Affordability

Although the interviews above show various factors that prevent men from using the male contraceptive methods, the interviews with CP4 and CP5 found that there is also an economic factor. For example, CP5 husband expressed his willingness to share responsibility in the use of contraceptive methods, and his wife is currently taking the pills. He said that he would use condoms if they cannot afford the pills anymore:

> If we do not have money to buy the pills, then we might consider using condoms. (Husband, CP5).

CP4 also referred to such a financial problem, as the wife explained:

> We cannot afford the male sterilisation; it costs about 4 million LAK (718NZD). We do not have enough money. (Wife, CP4).

Mr. Vong affirmed that the people could not afford the sterilisation because of its high costs. He reported that sterilisation costs around 3 million LAK (539NZD).

Not only does poverty prevent men accessing contraceptive methods, but also women. Often, women cannot afford the contraceptives of their choice. Mr. Vong also witnessed such barriers, as he mentioned that affordability was an issue which hampers women from getting an implant which costs 50,000LAK (8.60NZD). He said that some women come to talk to him as they want to get an implant, but he had to inform them that there is no free implant service anymore. He explained:

> The staff said that there is no project providing free implants anymore, because of the lack of budget. So, only those women who have money can afford it.

Accessibility

Indeed, sterilisation seems to be the least favourite method due to misconception, affordability, and access. According to the midwife at the health centre A, sterilisation is not available in Nong district hospital; as it is only available at Sepon district hospital, which is around 50km away from Nong. Travel to Sepon is either by motorbike or by bus. However, fuel costs or the bus fee plus the sterilisation costs are beyond what people can afford. Thus, the people would not consider it as an option unless it is provided free of charge.

Pregnancy and Childbirth

Support During Pregnancy

All male participants said that they supported their wife during pregnancy. According to Mr. Vong and the district health staff, men have increased awareness of supporting pregnant women:

> In the past, men did not help women during pregnancy, so pregnant women had to multitask, like carrying their baby while cooking and collecting water. They worked hard and that caused maternal death. It was such a pity! (Village Chief, Village 6).

Similarly, Mr. Phan reinforced the point above:

> In the past, they sometimes left their pregnant wife in the house, and they went to the rice field without taking care of their wife. (Health provider, Health Centre B).

The interviews with the couples show the women now receive support from their husband during pregnancy. For instance, the CP11 wife said that she is happy that her husband helps her during pregnancy:

> Men help women during pregnancy. I am happy that my husband helps. He helps with some heavy work. He also helps until now. (Wife, CP11).

The CP12 husband helped his wife during her pregnancy by cooking, collecting firewood and water.

The CP13 husband said that he understands that women should not work hard during pregnancy, so he supported his wife during her pregnancy:

> When my wife got pregnant, I helped her with collecting water and firewood because she was pregnant, so she cannot work hard, so I helped her. (Husband, CP13).

Support During Childbirth

The couples also see the importance of help from skilled birth attendants when giving birth. According to the interviews, men take their wife to deliver at the health centre. They also take care of and support their wife during childbirth:

> I gave birth at the health centre. My husband took me there. He helped with holding the Dextrose/IV and carrying my baby back home. (Wife, CP14).

The CP13 husband said that he supported his wife throughout the delivery process:

> My wife gave birth at the health centre, and I accompanied her. I helped her in preparing diapers and 'Sin' – Lao skirt, I know that men should help women. (Husband, CP13).

The above quotes show a shift in men's perception and behaviour, as men have now become aware of their role and responsibility as a husband and a father. Mr. Phan witnessed such changes. He said that now men take their wife to give birth at the health centre.

According to Mr. Vong and the district health staff, the people not only have an increased awareness of FP but they also the understand the importance of giving birth with assistance from the midwife:

> Giving birth is more convenient now because there are midwives and nurses to assist and take care of the women. The health staff always say to the people that FP can prevent maternal death. (Vong, village 6).

The findings above indicate a positive shift in men's perception and attitudes about maternal and child health, which was once seen as the women's sole responsibility. Men have started to see their role as a husband who should support his wife during pregnancy, and childbirth and have started to help with household work to reduce the women's burden.

6.3 Men's Involvement in Productive Work

Gendered productive work is essential, as it is one of the determinants for both men and women's RH. The productive work in this section refers to income generation, and shared responsibility in household work. With an increasing number of job opportunities created by foreign companies, such as the Vietnamese Rubber Plantation, men have access to such opportunities, but it is not equally accessible to women. This employment creates an income for men, which might translate into men having control over a financial resource that, in

turn, might have an impact on the spending on FP services. Women might become even more dependent on their husbands regarding access to FP.

The interview with CP4 revealed the changing livelihood, as the result of increasing direct foreign investment, especially in Nong district. The gradual shift from farming to employment in the industry has a specific impact on the gender roles and RH/FP of the couples. The interview with this couple suggested that while men have opportunities to work and generate income, the women's role as the primary caregiver remains unchanged. It also indicates the gender inequality regarding employment opportunity. However, there was a positive finding with regards to shared responsibility in household work. It was once rare for men to take such a role, due to the predominant perception that such work is the responsibility of women.

6.3.1 Income Generation

Based on the observations in the field, there is an increasing employment opportunity for men to work in foreign companies. Since Nong district shares a border with Vietnam, many Vietnamese rubber plantations have been built in the district providing job opportunities for the Mangkong men. The shift from farming to working in the plantations is significant, as it has impacts on the traditional livelihoods of the Mangkong people, and the RH/FP of the people as well. The context of the following Story 1 from CP4 exemplifies such a shift.

Story 1: *Mrs Lee and Mr Souk (CP4) are distinct from other couples, as the husband is currently employed and working for the Vietnamese rubber plantation. Lee and Souk live in village1 situated mid-way between health centre A and the district hospital. The village is a little closer to the hospital, hence covered by the hospital. Lee and Souk are a young couple at their mid-20s. They have three children and they want to have one more child, but Lee said that they plan to have another child in the next three years. Thus, Lee is now on the injection, which she got from the service at the health centre A.*

Lee seemed to be well-informed about FP and contraceptive methods, as she explained during the interview that she used to take pills but due to side-effects of nausea and vomiting she switched to the injection. Unlike other women, Lee consulted with the health provider and received advice that if she suffered from the side-effects she should switch to other methods – injections and implants. Although Lee switched from the pills to the injection, she still feels weak and tired. However, Lee does not want to switch to implant as it lasts for three years and it would be more difficult for her if she experiences side-effects, as she would have to wait for three years to remove it.

Lee discussed FP with Souk and Souk took her to the health centre. She said that if she did not use contraceptives then she would become pregnant every year, so she talked to Souk and they made the decision together:

> *So, I discussed with my husband about birth-spacing and talked to the health provider. (Lee, CP4).*

Souk also said that he took Lee to the health centre to get the service:

> *We talked with each other and decided that we don't want to have children now. I took her to get the injection at the health centre. (Souk, CP4).*

Lee said that Souk has been supportive of her using contraceptive methods:

> *My husband told me to get the service and he said that I should use the method that is suitable for me. (Lee, CP4).*

Due to their age, both Lee and Souk appeared to be a little bit shy but that did not affect their talking during the interview. They both smiled, chuckled and sometimes laughed throughout the interview. It is noteworthy to look at the shift from famer to employee.

Although the interview with Lee and Souk does not explicitly demonstrate how shifting livihoods impacts their RH/FP, it is worth considering changing conditions as a possible influential factor.

6.3.2 Household Work and Childrearing

All participants showed they shared responsibility regarding household work, which was once traditionally viewed as women's work alone. The men's involvement strategy adopted through FP community-based interventions, such as the outreach, has promoted the men's role in reducing the burden on women, especially during pregnancy and childbirth. All male participants said that they help their wife in taking care of children, cooking, and collecting firewood and water. As already discussed above, most of them also give support by doing housework during their wife's pregnancy and childbirth, which is considered to be a positive change.

6.4 Women's Empowerment

As specified by the Family Planning Situation Analysis report (FPSA) 2015, women, and especially ethnic women in rural areas, have limited or no decision-

making power regarding whether and when to have children and how many children to have. This lack of decision-making power includes the use of contraceptive methods. According to the Lao Reproductive Health Survey 2005, married women of reproductive age (15-49) do not use contraceptives because of opposition from their husbands. At approximately 9.7 percent, this reason was the third highest ranked factor.

In the Mangkong society, the marriage pattern is patrilocal, so women move to live with their husband after marriage. Hence, although women have increased access to information on FP, they may not be able to translate this into practice because of their husband and other influential actors within the family. The findings revealed women's empowerment in RH/FP was based on four indicators: self-confidence; ability to negotiate and discuss with their spouse; autonomy to choose their preferred methods; and decision-making power.

6.4.1 Self-Confidence

The interviews with all 13 couples and the two women showed the women's self-confidence in several ways. Firstly, the women showed high self-confidence during the interview. For example, the way the women engaged in the interview somehow refuted the assumption that ethnic women are shy. Observations and interactions with the women during the interviews, revealed that the women appeared to be outspoken and more willing to participate in the interview compared to their husband. Although women do not speak the Lao language, they seemed to talk confidently in their ethnic language. The atmosphere during the interviews was comfortable and filled with laughter that enabled the women to talk at ease, even with their husband's participation.

Secondly, all women showed their knowledge of FP information and contraceptive methods, although within limited choices, as well as where to receive the service. Thirdly, the women are aware that FP involves spousal communication, so couples should discuss and plan together. As such, women

demonstrated their confidence to initiate a conversation about FP with their husband. Further discussion of this concept is in the section 6.5.3.

The perception of women as the one is who responsible for using FP methods also indicates their high self-confidence. All of them confidently said that FP is their responsibility. Thus, they decide on the contraceptive choices. Two women illustrate exceptional cases of women's self-esteem, as presented in Story 2 and Story 3. However, what distinguishes them from the rest is that their socio-economic and educational background, and the individual personality, respectively.

However, the interviews with two women (woman 1 and woman 2), whose husbands did not participate in the interview, expressed their fear when talking about condoms with their husband. Thus, they seemed to have less self-confidence when it comes to spousal communication about FP. Also, women expressed low self-confidence about consulting with the providers about the side-effects of some FP methods.

6.4.2 Autonomy

Based on the interviews, the husbands support their wife and let their wife choose contraceptive methods. Many women said that they prefer long-acting reversible contraceptive methods (LARCs), for example, a contraceptive injection or implant. Most of them had a tendency to forget to take the pills, and they must remember to take the pills on time for them to be effective. Thus, women usually choose to get the contraceptive injection or implant, so they do not have to worry about remembering the time. They said that the contraceptive injection and implant allow them more time to work and raise their children:

> I prefer implants because it lasts longer, so I can work as usual.
> (Wife, CP8).

> The injection makes our life more comfortable and allows more time to raise our children and also have time to go to work. (Husband and wife, CP9).

Women prefer the injection because the length of time for the injection is acceptable for most women; unlike pills, they do not have to worry about remembering the time.

Poverty

Poverty seemed to be an issue that prevents women from getting their preferred methods. The findings revealed that some women wanted to get an implant but chose to get the injection due to the expense of implants. Compared to the implants, the injection is relatively affordable – the injection costs 5,000LAK (0.90NZD) (although some women paid as much as 10,000LAK (1.80NZD)), whereas the implant costs 50,000LAK (8.98NZD). As discussed earlier in this chapter, the midwife charges a registration fee at different costs, depending on the financial situation of women.

The CP6 complained about the high cost of the implant service. The CP6 wife has received the injection twice and has been suffering from side-effects, such as feeling tired and having headaches, and so forth. She does not want to take the pills and cannot afford the implant. Thus, she continues to tolerate these side-effects. Her husband complains about the service provider:

> They did not accept 50,000LAK (8.98NZD) as they want 100,000LAK (17.93NZD). I asked other people in the village; they said that it costs 100,000LAK. If you do not have money, they will not take care of you. (Husband, CP6).

The quote shows dissatisfaction regarding the attitude of the health provider. However, the cost of an implant appears to contradict that given by the midwife in health centre A. The midwife said that she charges a small fee, which they called a ‘registration’ fee. She explained:

> We charge a 5,000LAK (0.9NZD) registration fee for the injection and 50,000LAK (8.98NZD) for the implant. (Midwife, Health centre A).

However, none of the women agreed with these details during the interviews. Many of them said that they paid 10,000LAK (1.80NZD) for the injection:

> After I got an injection, I always feel cold at night. The provider did not say anything like this. I paid 10,000LAK (1.80NZD) for the injection. (Wife, CP10).

Some women want to get an implant, but they cannot afford it due to the high cost:

> I want to get an implant, but I do not have enough money yet. Implants cost 50,000LAK. They (health provider) said that if I am allergic to the injection then get the implant or take pills. (Wife, CP13).

The interviews above reflect that poverty coupled with the uncertainty over the price are barriers that prevent women having access to a wide range of FP methods and indeed to their preferred choice of method.

Power Relationship

Another issue to emerge from the findings was the power relationship between the health providers and the people. The interviews with some couples (CP3, CP6, CP7, CP10) found that some women suffer from FP side-effects and yet they tolerated these side-effects rather than consult with the providers. For example, the CP3 wife is currently on the implant and she said that she got the FP information and service from the health centre. She explained that the provider gave her three choices: injections which last for three months, implants which last for three years, and the pills which she has to take monthly. Since she and her husband decided not to have any more children, and the implants last

the longest, she decided to get an implant. Like many other women, she experiences the side-effects, but she did not consult with the provider, although the provider told her that she could switch to other methods if the implant is not suitable for her. She explained:

> I know (that I can consult with the provider), but I do not want to. (Wife, CP3).

Her husband added that many women in the village experience the same side-effects, but they do not consult with the provider either:

> Many people experience the same, but they do not go to see the provider. That is why we do not go. (Husband, CP3).

Similarly, CP6 who complained about the high cost of implants said that the provider did not provide them with any information, and they did not ask either:

> They did not check the health condition before providing the service. We did not ask details. They did not say anything. (Husband, CP6).

Interestingly, the CP7 wife got the injection from the health centre, and she also experiences the side-effects. The wife explained her symptoms:

> After the injection, I felt tired and did not eat well. I did not talk to the provider about this. (Wife, CP7).

Her husband jumped in and expressed his frustration that:

> Even if we consult with the provider; they do not give more information. (Husband, CP7).

The quotes above show that the couples are uncomfortable to talk to the health providers regarding their problems. This might be due to the power that is displayed in the relationship between the health providers and the clients.

Peer to Peer Communication

Based on the interviews with both the key informants and the primary participants, peer to peer communication appeared to be predominant. Many couples referred to their peers in regard to their preferred choices, including issues related to the side-effects and the consultation with the health providers. As the CP3 husband stated, the reason why they do not consult with the provider about side-effects is frequently that many other women in their village do not do so. His wife decided to get an implant because she heard other women say that the implant is good.

Similarly, the CP6 husband said that:

> We heard other women in the village talk about the injection, so we decided to get it. (Husband, CP6).

In addition, the CP7 wife also referred to her peers, as she said that she decided to get an injection because her friend also got one:

> I knew about the injection from my friends who got the injection and that it allows them to space their births, so I decided to get it. (Wife, CP7).

Peer to peer communication is quite common in the Mangkong community, as evidenced in these comments. Women usually talk to each other about contraceptive methods. Such communication also reflects the trust and good relationships between women in the Mangkong community.

6.4.3 Spousal Communications

The interviews indicate that both men and women have good spousal communication concerning FP. All of the participants said that they discuss with their spouse whether and when to have children, and how many children they want to have, including which contraceptive methods they want to use for either spacing births or limiting birth. Based on the interviews, women usually initiate

such conversations with their husband and discuss the situation with their husband first. The following quotes are from wife 4 and woman 2:

> I discussed FP with my husband and went to the health centre with him. If I do not use contraceptives, I will get pregnant every year. So, I discussed birth spacing with him and talked to the health provider. (Wife, CP4).

> I talked to my husband about when I want to have children. I said to him that if our child grows up a bit do you want to have another? He said yes…but we did not talk about how many children we plan to have yet. I talk to him first. (Woman 2).

The interviews also revelated that while women initiate conversations and negotiate with their husbands, as shown above, they do so as a means to seek approval, because their husband is the head of the family. According to the district health staff, due to lack of awareness in the past, men did not 'allow' their wife to access the FP service, as they fear that they will not be able to have any more children.

However, fear is not the only reason, as there are many other socio-cultural and economic factors involved, which are partly mentioned elsewhere (Lao Reproductive Health Survey 2005). The interviews found that due to increased awareness and access to information, men 'allow' their wife to use the service. The husband will 'tell,' 'let,' 'agree,' or 'allow' his wife to use contraceptive methods as demonstrated below:

> I told her to get the injection. I decided whether we want to have children or not…I do not want to have any more children now. (Husband, CP13).

> I agreed (the injection), I used to tell her to undergo sterilisation when there was a free sterilisation project, but my wife was too afraid, so she rejected that. (Husband, CP12).

It is noteworthy that the words ‘let,’ ‘agree,’ and ‘allow’ illustrate that men are the final decision-maker in the family. As such, women depend on their husband regarding whether and when to have children and how many children to have and this includes the permission to use of contraceptive methods.

The village chief in village 6, Mr. Vong and his wife illustrate negotiation between husband and wife. Mr. Vong said that when there was a free sterilisation project in the village many years ago, he told his wife to undergo the sterilisation. However, his wife rejected this idea, as she was afraid of the surgery:

> I used to tell her to undergo sterilisation during the free sterilisation project, but my wife was afraid, so she did not do it. (Vong, CP11).

His wife’s rejection seemed to be a form of negotiation, instead of deferring to her husband, the wife showed her power to reject her husband’s idea.

6.4.4 Decision-Making

While women have limited autonomy to choose their preferred methods within limited choices, and also the ability to discuss and negotiate with their husband, the men still hold the power to make the final decision.

According to the interviews, three patterns regarding decision-making emerged. Firstly, the men decide on whether to have children and how many children they want to have, whereas women decide on using particular contraceptive methods. Secondly, women defer to their husband for every decision. Thirdly, men and women make a joint decision.

The First Pattern: Men Decided on Having Children, Women Decide on Contraception Method

The interview results show that three couples (CP1, CP3, CP10) exemplified the first pattern:

> My husband decides on whether to have children or not, and I make a decision on which FP methods to use for birth spacing. (Wife, CP3).

> I make my own decision to use contraceptives…he does not prohibit me from using it. It is my own body, so I know which method is suitable for me. (Wife, CP1).

The quote shows that although women have a say in which contraceptive methods they want to use, it usually comes after their husband's decision on whether to have another child or not. As such, if their husband wants to have another child, they have to drop the contraceptives. As already discussed, the contraceptive is perceived to be the women's responsibility. Thus, men do not usually decide on behalf of their wife, but they 'let' their wife choose:

> I let my wife make the decision (about injection), I depend on her. (Husband, CP10).

Husband 10 said that he depends on his wife for using contraceptive methods. Because men show little attention to FP methods, and since women are the ones who use contraceptives, the husband provides space for his wife to make her own decision on which methods she wants to use.

The Second Pattern: Women Defer to Men

In the second pattern of decision-making, the women entirely defer to their husband, because they are the head of the family. Three couples (woman 1, woman 2, CP13) were found to fit this pattern:

> My husband is the head of the family, and I listen to him. (Woman 1).
>
> Both my husband and I are the head of household. My husband makes a decision. (Woman 2)
>
> I do not want to have another child yet…it depends on my husband. (Wife, CP13).

These quotes confirm the position and power of the husband in the family; the husband plans and decides FP.

The Third Pattern: Joint Decision

The last pattern is followed by eight couples (CP4, CP5, CP6, CP7, CP8, CP9, CP11, CP12) who made a joint decision:

> We made the decision together that my wife takes the pill because we want birth spacing. (Husband, CP5).
>
> We both made the decision together about FP. We talked about this. (Husband, CP12).

These eight couples demonstrated that they talked to each other and made a decision together on whether and when to have children, including contraceptive methods.

Mini Case Studies of Joint Spousal Communication and Decision-Making

Women were outspoken during the interviews, and many of them were willing to participate and tell their stories. During the observations and interviews two distinct and interesting stories were found in relation to women's empowerment in the decision-making process. Story 2 indicates socio-economic and educational background, and Story 3 shows the individual personality.

Story 2 below shows women's decision-making power. During the interview, the wife confidently explained that she discusses FP with her husband and they make the decision together. It is important to note that the socio-economic and educational background of this couple distinguishes them from others. Both are employed, and the wife is now pursuing higher education, thus they both have a clear plan for their future.

Story 2: *Mrs Nee (pseudonym) and Mr Boun (pseudonym) live in village 1 which is covered by the health centre A. From the interview, we learned Nee is a kindergarten teacher in village 1. She is now studying in the province to finish her degree. She moved to village 1 when she got married to Boun, who is a repairman. He goes to work outside the village and his brother is the village deputy chief of village 1. They have two children. Nee gets the contraceptive injection at the health centre A located right next to her school, so she can walk there after she finishes the class. When Nee went to see the provider, she said that the provider did not provide any information about side-effects, she said:*

> *No, the provider did not provide such information and I also did not ask. I know the side-effects when I actually used it. (Nee, CP1).*

Nee paid 1,000LAK (0.18NZD) for the pill, and 10,000LAK (1.77NZD) for the injection.

They want to have one more child, but they cannot have it now because Nee is still studying. Boun fully supports her and said that they will wait until Nee has graduated. Boun said:

> *My wife is studying now so it will be difficult for her to have another child. I stay at home looking after my children while she is studying. We will have more children when she finishes her study and my two kids have grown up a bit. (Boun, CP1).*

Both Boun and Nee said that they both discuss and make the decision together about FP. But for the contraceptive methods, Boun lets his wife make the decision on her own. With regards to participation in the health education outreach and FP counselling, Boun seemed to have less interest. Boun said that he did not participate in the outreach with Nee. Boun sometimes accompanies Nee to the health centre, but he did not pay attention to listen to the provider. They both chuckled, then Nee added that her husband does not know about contraceptives, and it is her responsibility to use contraceptives so she has knowledge about it. In her words:

> *It's only me who listens to the provider. Although the providers give information to us, men are not interested. It is women who know about contraceptives. (Nee, CP1).*

The observation confirmed that during the interview, Nee was very articulate and she was so proud of her study. Meanwhile, Boun did not talk much but quietly listened and supported his wife during the interview.

Interestingly, the individual personality also impacts on the women's decision-making power. The following Story 3 shows the wife somehow has the final say.

Story 3: *This story is about CP10 in village 1 located near the District Hospital. Mrs. Chan (pseudonym) and Mr. Sone (pseudonym) are farmers. Chan is currently on the injection. They have two children. Chan has had the injection three times now and she got the injection at the district hospital. She said that she discusses this with her husband before going to get the service and her husband agrees and allows her to do that. She said that her husband is the head of the family and they have talked with each other about if they have too many children then they will not have enough food to feed their children. Chan said that*

her husband supports her using the contraceptive methods and took her to get the service at the hospital. Sone said that he respects his wife's decision regarding the contraceptive methods:

> *I let my wife make decision. I depend on her. (Sone, CP10).*

Although they both attended the health education outreach and learned about how to use a condom, they have never use one and do not want to use one. Chan confidently said that she is responsible for using contraceptives. When I asked her if she wants her husband to use a condom, she smiled and did not say anything. Meanwhile, her husband was sitting quietly and barely looked up at everyone.

Similar to the other women, Chan paid 10,000LAK (1.77NZD) for an injection and experiences the side-effects from the injection, such as feeling cold at night, but she has never consulted with the provider. She said that the provider did not mentioned such symptoms when she was getting the service. She added that she did not consult with the provider, she just got the injection and the provider allowed her to go home after the service. Chan knows that there are contraceptive pills, but she does not want to take a pill nor does she want to give it a try. So, she continues to get the injection.

Observation during the interview with this couple found that Chan is more outspoken and lively compared to Sone, who was quietly sitting beside Chan while holding their child in his arms. Chan talked more than Sone, who seemed to be a little shy and did not talk much. The contrasting personality of this couple reflects the power relationship within the family. Chan said that Sone listens to her and does whatever she tells him to do. She said:

> *My husband listens to me for everything. He always does whatever I say, so like I tell him to go collect water and he does (chuckled). (Chan, CP10).*

She laughed and continued that sometimes she listens to her husband but not always. By this time, her husband was smiling and said nothing. They both help each other with shared responsibility regarding housework. Chan said when she pounds the rice then her husband cooks, and when her husband pounds the rice then she looks after their children.

What I found very interesting was that the personality of Chan is quite different from the other women I interviewed. Chan laughed a lot and this influenced the whole atmosphere of the interview as it was filled with lots of laughter. Although Chan said that her husband is the head of the family, interview data and my observation during the interview, it seems that Chan has a say within the household. She made her own decision on contraceptives and her husband supports her. Further to this, she discusses and negotiates with her husband about FP including shared responsibility within the household.

6.5 Chapter Summary

The findings suggest that there are two categories of men's involvement in RH/FP: namely men's involvement in the promotion and service delivery; and the target group – the Mangkong men as a husband and a father. The results highlight the Mangkong men's involvement in two areas. The first of these areas involves RH – FP counselling, integrated outreach, use of contraceptive methods, and support during pregnancy and childbirth. The second area of involvement is in productive work, such as shared responsibility in household work and child caring. The levels of such involvement and participation from the study subjects ranged from no participation to partial participation to active participation. In addition, the levels of such participation are influenced by various factors, such as personal, cultural and structural influences. The findings also revealed the positive outcome of men's involvement resulted in their increased awareness of FP, hence, their attitudes and behaviours altered to become supportive of their wife in the decision-making process regarding FP. Increased women's self-confidence was

demonstrated through their awareness on FP and their ability to initiate conversations, discuss and negotiate FP issues with their husband, as well as jointly decide on FP.

CHAPTER 7: DISCUSSION

7.1 Introduction

Men's involvement in FP programmes has not yet been effectively and meaningfully translated into practice. While the FP programmes support the idea of masculinities approach to sexual and reproductive health (SRH), various issues can be seen. For instance, the definition of masculinity remains narrowly focused on hegemonic masculinity, which neglects men's other roles and experiences. Also, the assumption that incorporating men leads to women's empowerment and gender equality in the context of SRH tends to be oversimplified. Past studies showed that men's involvement results in men becoming supportive of women in FP (Maharaj, 2000; Sternberg, 2004; Rosliza & Majdah, 2010; Bayray, 2012; MacDonald et al., 2013; Adango et al., 2013; Estrom et al., 2015; Ezeanolue et al., 2015). However, due to the lack of a nuanced understanding of the masculinity concept and in consideration of the intersectionality that shape men's experiences, men's involvement strategy tends to be problematic in practice.

In the light of existing literature, this chapter critically analyses and discusses the implications of the findings in the preceding chapter. The aim of this chapter is to answer the research question: Whether and in what way the role of men in FP impacts women's empowerment in FP? The findings in Chapter 6 show that even men's involvement in a FP programme at the community level tends to be problematic, due to various barriers that have impacts on the level of men's participation. The findings also provide evidence of the disempowerment among the Mangkong men, which supports the literature in Chapter 2. Despite these barriers, the conclusion is consistent with many studies regarding positive results from men's involvement in the areas of attitudinal and behavioural change among the Mangkong men. They have become supportive of their wife's choices and share responsibility regarding childrearing and household work. While the findings suggest that men's involvement partially results in women's

empowerment, which is demonstrated by the spousal communications, negotiation and joint decision-making in FP, other influential factors also have an impact on women's empowerment.

This chapter commences with a discussion of the positive outcomes and obstacles to men's involvement in FP in Section 7.2. This is followed by a discussion in Section 7.3 on women's empowerment, including the impacts men's involvement and other influential factors on the level of women's empowerment. These influential aspects include strategic gender needs, and practical gender needs and policies, which create the enabling environment for women's empowerment.

7.2 Men's Involvement in Family Planning

The results in the preceding chapter indicated the two ways men were involved in FP and their various levels of participation, ranging from partial to active participation. The first type of men's involvement was men who were involved in FP programmes as a promoter and service provider. Examples are the health providers, the community-based distributors (CBDs), the village chiefs, and the village health volunteers (VHVs). The second type is men's involvement as partners and clients.

Men's involvement in FP as a promoter/service provider tends to be active participation. This way of involvement seems to be aligned with the involving *men as agents of change* approach (Greene et al., 2006), as the FP programmes work with the community leaders to promote positive change in the community. However, it does not necessarily challenge unequal power relations. In addition, these actors faced structural and cultural challenges in promoting and providing FP information and services. These challenges included: the strong perception of women as the only contraceptive users; the poor existing health system and service, as well as poor quality of care; the limited capacity of health promoters and providers, especially their counselling skills; the funding gap for implementing

FP programmes, which impacts on the timely implementation of outreach activities; the attitudes of the health providers reinforcing the power relations between the providers and clients; and many other issues.

Regarding the second type of men's involvement, this study found that the Mangkong men's involvement was viewed as mere *supportive partners* to support their wife in using contraceptives. This finding is consistent with existing literature (Dudgeon & Inhorn, 2004; Sternberg & Hubley, 2004; Anderson, 2005; Hardee et al., 2017) arguing that a men's involvement strategy is often used as an instrument rather than an attempt to address men's needs, thus, men's own needs were not met. Even within the involvement of men as *supportive partners* approach, the level of involvement varied, due to cultural and structural barriers. However, it is important to acknowledge that there were some positive results due to men's involvement despite the many obstacles.

7.2.1 Positive Outcomes Regarding Involving Men as Supportive Partners

The positive outcome regarding men's supportive attitudes is consistent with other studies by Maharaj (2000); Sternberg (2004); Rosliza and Majdah(2010); Bayray (2012); MacDonald et al. (2013); Adango et al. (2013); Estrom et al. (2015); Ezeanolue et al. (2015). These studies concluded that involving men as *supportive partners* does lead to men supporting their wife to use contraceptive methods, as well as sharing responsibility regarding household work and child caring. All male participants allowed their wife to obtain FP service at the health centre and respected their wife's choices regarding contraceptive methods. They also helped reduce the burden on their wife, especially during pregnancy and childbirth. These attitudinal and behavioural changes imply that gender roles are evolving as men start to be involved in work that was traditionally perceived as purely the women's responsibility.

In addition, this study supports Sternberg and Hubley (2004); Groce-Galis and Gay (2017); and Koffi (2018), who all suggest that men are interested in being involved in FP counselling and services. Some Mangkong men expressed their

interest in learning about male contraceptive methods during counselling. Although they did not express directly that they want to be involved, their attitudes and tone of voice during the interviews conveyed such interest.

Despite the positive outcomes above, the levels of involvement of men as partners and clients are determined by cultural, structural, and other factors. Therefore, without addressing these barriers, it is difficult to achieve men's involvement in a meaningful way.

7.2.2 Barriers to Men's Involvement

The preceding chapter presents findings on the cultural barriers, such as the perception of RH/FP as a women's issue. Such a perception also influences the behaviour among the Mangkong men, especially regarding the use of contraceptive methods.

The Cultural Perception: Family Planning is a 'Woman's Issue.'

Culture shapes the perception of individuals in society. The cultural norms that perceive RH/FP as a women's responsibility and that women are the contraceptive users are not new. A number of studies over the past decades, such as Sen and Grown (1987); Dixon-Mueller (1993); Correa (1994); Hartmann (1995); Sternberg (2000); Seltzer (2002); Eager (2004); MacDonald et al. (2013); Edstrom et al. (2015); Slauson-Blevins and Johnson (2016); and Hardee et al. (2017) concluded that due to this perception, FP programmes have been overwhelmingly targeting women. This study confirms this conclusion in the finding that women continue to be the primary target of FP today, despite the incorporation of men since the International Conference on Population and Development (ICPD) in Cairo, in 1994. Women continue to bear the burden, while men are excluded from their responsibility and their own RH/FP needs are neglected.

In this study, all male and female participants, including the key informants who are FP promoter/service providers, perceived that women are the contraceptive users, not men. Both men and women felt that attending FP counselling and the outreach are more the women's responsibilities than the husband's. Therefore, FP is naturally viewed as not interesting for men.

The Cultural Perception: Use of Contraceptives

The cultural perception has a substantial impact on the behaviour of men regarding the use of condoms. As mentioned in Chapter 5, the gender norms in the Mangkong society that define men as the head of the family, the decision-maker and the breadwinner who goes out to work and generates income, as well as the one who does the 'tough' work. Women are seen as responsible for the reproductive role, as a primary caregiver who should stay at home taking care of children and undertake household work. Such gender norms are typical among patriarchal societies in most developing countries (Bayray, 2012; Adango et al., 2013; Estrom et al., 2015; Slauson-Blevins and Johnson, 2016), while recognising the variety of contexts. As such, both men and women perceive that women are the contraceptive users, resulting in little use of male contraceptives.

While this finding supports most of the other studies above, it is important to acknowledge the context-specific nature of men's involvement. The study by Maharaj (2000) indicates the increasing willingness among men in Ghana to use condoms, however, it is not the case in the Mangkong context. Out of the 13 male participants, only two men would consider using condoms, but only if their wife could not tolerate the side-effects anymore and only if they could not afford any female contraceptive methods. Most male participants refer to "we, the Mangkong men" as the main reason why it is not common to use condoms among them, unlike the Lao men (Lao Loum or Lao-Tai). Natoli, Holmes, Chanlivong, Chan and Toole study (2010) on condom use among the Lao-Tai men in Vientiane Capital concluded that while it is not common to use condoms within marriage, men often use condoms when they have extramarital affairs. Thus, the

word ‘unlike the Lao men’ here entails the cultural difference. The Mangkong men believed in the sanctity of marriage. As such, men who used condoms might be perceived to have affairs outside marriage and seen as unfaithful by others in the community.

Apart from the cultural perception, this study suggests that the reasons why the Mangkong men were reluctant to use condoms are associated with the structural obstacles discussed in the following section. It is essential to note that some of the structural issues are influenced by cultural perceptions, for instance the attitudes of the health providers, and misconceptions, amongst others.

Structural Barriers: Misconceptions and Fears

While studies by Sternberg (2000); Bayray (2012); Adango et al. (2013); Kassa et al. (2014); Koffi (2018) concluded that misconceptions and fears about male contraceptives are one of the factors that results in few male contraceptive users, this study suggests another insight to such misconceptions, which concerns the way condoms are promoted. Misconceptions about condoms and vasectomy persist even among the health providers and health promoters. Rather than promoting condoms as one of the contraceptive choices for birth spacing and birth limiting, it seems to be disproportionately promoted in the context of STIs, and HIV/AIDs prevention, especially within a relationship outside marriage. As a result, men do not want to use condoms, because they fear their peers might tease them or their wife might doubt them. Thus, both men and women were reluctant to use condoms.

There is also a fear about sterilisation that this might undermine their manhood or the fear that something might go wrong due to the surgery. For example, among all the male participants, only one man (CP2) mentioned that he would consider vasectomy, but only if the surgery does not cause any side-effects - the inability to work in the field. Thus, there is fear among the Mangkong men about vasectomy that it might cause physical inability. Even among the health

promoters/service providers, such as the village chief, there was acknowledgement that they have this fear.

Structural Barriers: Access to Male Contraceptive Methods

This study found there was limited access to a wide range of male contraceptives and, therefore, supports Dixon-Mueller (1993), Eager (2004) and Fennel (2011), who argue that there has been little or no progress in the development of male contraceptives. While there is a variety of female contraceptive methods, only two male contraceptive choices are available globally (Adango et al., 2013; Mbizvo et al., 2014). Furthermore, difficult physical access also hinders men from obtaining a sterilisation service (Adango et al., 2013). In Nong District, a sterilisation service is not available; the people have to travel to Sepon District, which is approximately 50km away, in order to obtain this service.

Ironically, men's involvement in FP has been actively promoted without a practical commitment to produce more choices for male contraceptive methods. If men are to fully participate in FP programme, or if gender equality in FP is to be achieved, one of the fundamental problems that needs to be addressed is to balance male and female contraceptive methods. In this way, both men and women can have equal access to a wide range of FP methods and will be able to make choices of their own.

Structural Barriers: Poverty

Most participants are farmers living in poverty. At the time of the fieldwork, specific data on the poverty rate among the Mangkong was not available. However, as mentioned in Chapter 5, the Mangkong has the highest poverty rate in the country. Evidence from the interviews suggests that many participants found affordability was one factor, among others, that hampered their access to FP services. Therefore, poverty hinders men's use of the sterilisation service, due to its high cost (Mbizvo et al., 2014).

Structural Barriers: The Attitudes of the Health Providers

This finding supports the 1995 study by Hartmann, which suggests that health providers fail to provide comprehensive information including side-effects to women. The present finding adds another insight to this issue. The research showed that neither women, nor men, were provided with detailed information and did not feel involved. Even though some men expressed their interest in FP information and methods, they were not engaged in the counselling. This finding on health providers' perceptions and bias against men is consistent with Greene and Levack (2010), who report that too often women are exclusively targeted in FP. Consequently, men are excluded from the counselling service. Furthermore, there was a reluctance on the part of health providers to talk about men's contraceptives, due to the cultural perceptions, let alone engage men in the conversation.

7.2.3 Policy and Practice Barriers: The Disconnection

The Lao government's strong commitment, as well as ambitious and supportive policies, are in place. The Lao National Reproductive Health Policy 2005 specifically spells out the essence of men's involvement in FP. However, the findings suggest that there is a gap between policy and practice, as the policy has not yet been adequately translated into practice on the ground.

Communications Strategies

The Information Education and Communication (IEC) strategies for men's involvement remains inadequately implemented. The present research findings are consistent with the study by Tafese et al. (2013) in Ethiopia, which found the common problems were the lack of IEC materials, as well as the use of such materials during the counselling. This study indicates that some health providers do not use IEC materials during counselling (see Figure 5.4). At the time of the

fieldwork, the poster was not even shown on the information board. Moreover, the messages on the poster used the official Lao language, which has limited value among ethnic groups, especially among ethnic women who do not read or speak the Lao language.

The RMNCH Strategies and Action Plan specifically outlines the participation of each ethnic group in the development of the IEC materials. Such a participatory approach in IEC design is essential, as it not only entails participation as an end in itself, but also ensures the materials and messaging are effectively designed, according to each ethnic group's culture. However, this seems rather ambitious. It is not clear how the government will implement, or ensure, the full participation of each ethnic group on the ground, given that there are 49 ethnic groups. This is especially problematic with the limited resources. Thus, it is very likely to remain an ideology rather than effective practice, due to the lack of concrete planning and an adequate budget allocation.

Decentralisation

Implementing men's involvement in FP at the community level appears to be challenging. As discussed in Chapter 2, decentralisation entails the allocation of decision-making in planning and implementation to local levels. There are two issues that emerged from decentralisation in practice from this study. First, this finding was contrary to the study by Hardee (1998), which concluded that decentralisation was restricted due to the hierarchical system therefore the majority decision-making power remained with the central levels. Although such hierarchy remains prominent in Laos, this study suggests that local authorities seemed to hold power in implementing FP intervention at the community level. For instance, although the CBDs programme has ended, the Nong District health office continues to support the programme. However, such practice also means that there is a lack of consistency and coordination between the provincial and central levels. Also, it is important to note that Savannakhet province has the highest funding gap in implementing FP programmes (see Chapter 5). Thus, the

continuity of the CBDs might be supported by other sources, such as user fees. For example, both the midwife at health centre A and the CBD charge an injection fees (although at different prices).

Second, this finding reflects upon the common problems of financial issues and human resource capabilities at the local level (Hardee, 1998; Mayphew et al., 2000; Byrne et al., 2012). For example, the phase out of the CBDs programme and the delay in implementing the integrated outreach service depended on budget availability. Moreover, the capacity of the staff at the programme level to undertake planning and the skills of the health providers at the service delivery level are both insufficient. Therefore, decentralisation is difficult within the existing poor healthcare infrastructure (see Chapter 5), coupled with other issues, such as monitoring and evaluation (M&E) and data collection at the local level. The health official from the Maternal and Child Health Centre (MCHC) recognised such issues and acknowledged that implementing the activities outlined in the RMNCH Action Plan remains challenging, especially at the local level.

The Missing Component in the Action Plan

Despite the specific emphasis on men's involvement in RH/FP outlined in the RH Policy 2005, this essential element was not translated into concrete activities in the RMNCH Action Plan (see Table 5.1). According to the health official, men's involvement is included in the health promotion through the IEC strategies (posters, radio, and so on), outreach and counselling services at the health centre. However, these elements were not specifically stated, hence, the element of men's involvement is missing in the Action Plan. Such absence is aligned with the conclusion made by Greene et al. (2006) and Adamou et al. (2017) arguing that men's involvement has not yet been prioritised.

The Lao government's understanding of masculinity tends to be limited to hegemonic masculinity. In the RH Policy, the government stresses men's role as supportive husbands and responsible fathers, and share control and responsibilities within the household. This policy assumed that men were

previously unsupportive, irresponsible and controlling. This seems to overlook other aspects of masculinity, especially different masculinities among the ethnic groups. Importantly, the narrow understanding of masculinity might imply the lack of ethnic participation in the process of policy-making. Inappropriately, the view of masculinity remains within the worldview of the dominant Lao-Tai policy-makers.

Although there is no explicit definition of men's involvement in the policy, the government seems to view men as *supportive partners,* rather than seeing them as beneficiaries or *clients* who have equal needs to women in respect of access to FP services, or as *agents of change*. There are no statistical records of men as contraceptive users in Laos. As discussed in Chapter 2, many FP programmes do not prioritise include men's involvement and this is coupled with the lack of a clear definition or indicators of men's involvement (Greene et al., 2006; Adamou et al., 2017). Interestingly, this study found in the government statistical records that the indicators[29] on condom use and vasectomy have been placed under women. There is also a lack of sex-disaggregated data concerning the use of contraceptives. Most indicators target women exclusively, including the latest Reproductive Health Survey in Laos conducted in 2005, and the Lao Social Indicator Survey (LSIS) I in 2012 and LSIS II in 2017.

Neither the Lao National Family Planning Costed Implementation Plan (CIP), nor the Reproductive, Maternal, Neonatal, and Child Health (RMNCH) Strategies and Action Plan include any measurement of men's contraceptive use. The commitment of the Lao government made at the FP2020 only aims to increase the contraceptive prevalence rate (CPR) among women. FP programmes that disproportionately target women, due to their reproductive role, remain unchanged.

The discussion above echoes the limited indicators of male contraceptive users in the study of Hardee et al. (2017), who found that the CIP among five African

[29] For example, the Lao Social Indicator Survey II, 2017 presents the "percentage of women currently married or in union who are using or (whose partner is using condoms)" (p. 91).

countries includes men as supportive partners for increasing the number of female contraceptive users, rather than including men as contraceptive users.

Limited Resources

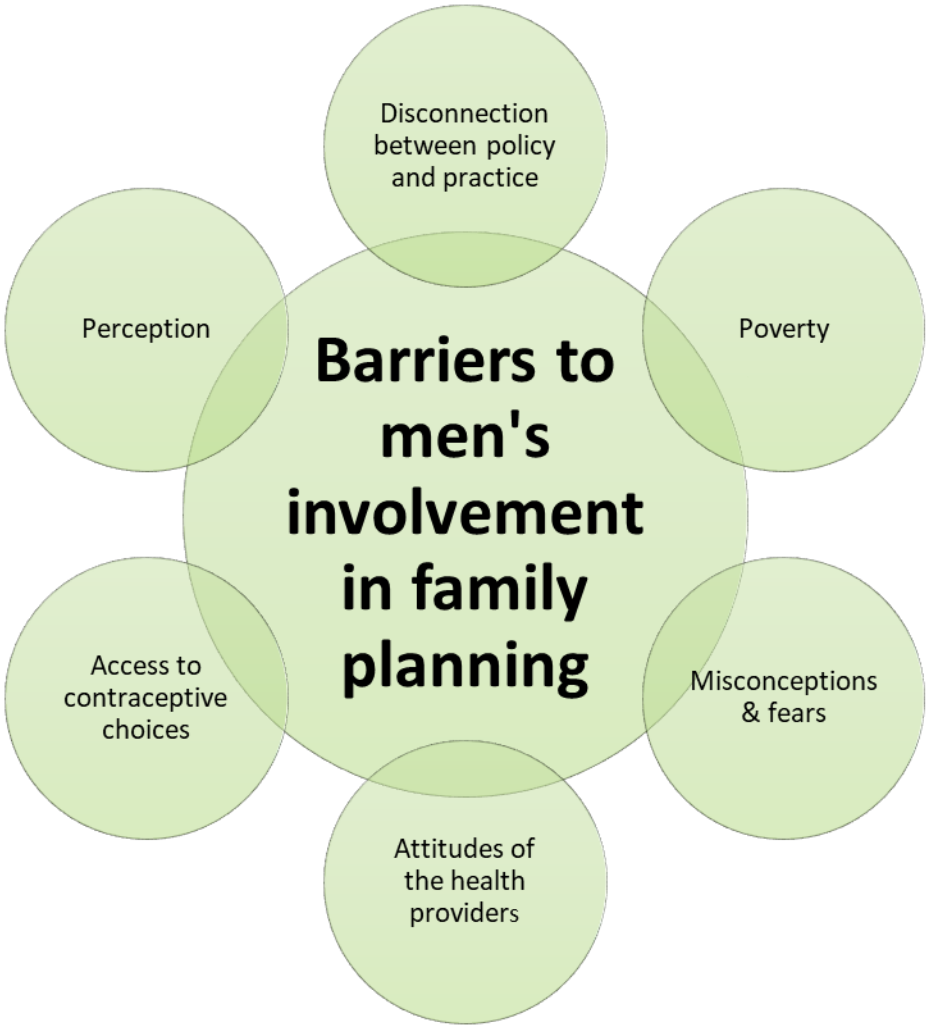
The Lao government's low expenditure in the health sector leads to over-reliance on external funding. According to the World Bank (2016), the Lao government's total health expenditure as a share of GDP was only 1.0%, as of 2013. This compares to higher rates in neighbouring countries, like Thailand (3.6%), Vietnam (2.5 percent) and Nepal (2.6 percent). Although the expenditure was slightly increased, in 2014, to 1.9 percent, Laos is still left far behind.

According to the Lao National Family Planning CIP, over half of the funding for FP programmes is from external sources. At the provincial level, Savannakhet province, where this study took place, is facing the largest funding gap in FP programmes. Such high reliance on donors raises concern for the sustainability of the programme.

According to the health official, currently the World Bank provides incentives for the government as motivation to increase the CPR, in order to assist the government achieve its set target by 2020. The government needs to double its efforts to increase the number of contraceptive users throughout the country and accelerate the progress. The dilemma is that such over-reliance on external funding could diminish individual human rights for the sake of national goals, in another words, the collective interest wins over individual interests Therefore, Laos is still facing significant challenges in implementing the national SRH/FP programmes.

The summary of various barriers to men's involvement in FP is shown in figure 7.1.

Figure 7.1: Barriers to Men's Involvement in Family Planning



Source: The Author, 2019

7.3 Women's Empowerment in Family Planning

Drawing on the work of Kabeer (1999) and Rowlands (1997), within the FP context, women's empowerment implies the awareness of women regarding RH/FP, including their rights to access comprehensive information and an affordable and quality FP service, as well as the right to make choices of their own regarding FP. The awareness of their rights in respect to FP stimulates their inner power that leads to the ability to exercise their rights, make a decision and have access to the resources of the FP information and service. Within the scope of this study, two indicators were applied to measure women's empowerment, namely personal empowerment, for instance women's power within or 'agency' (self-esteem, autonomy) and secondly, empowerment in a close relationship, where their power within leads to an increase of their ability to discuss and negotiate with their spouse to make a joint decision and take on shared responsibility in FP. It is essential to keep in mind that empowerment is context-specific and multi-dimensional. As discussed in Chapter 3, this study focuses on women's *power within* and empowerment in a close relationship.

7.3.1 Women's Power Within

The findings indicate partial alignment with the first dimension – women's power within. Women have limited awareness of FP. The knowledge of contraceptives among all the female participants was limited to only three methods – the pill, injections, and implants. Although there is access to free condoms, this was not seen as an option for the couples. In addition, women are not aware of their rights to consult with the providers regarding side-effects.

The empowerment framework adopted in this study seems to have difficulty in explaining empowerment among the Mangkong women in the FP context. First and foremost, this study contradicts the general assumption that generalises ethnic women are a homogenous group of shy and vulnerable women, particularly in the patriarchal society. To demonstrate this difference, the setting of this study was a couple interview, in which both wife and husband participated

together. Such a setting provides a glimpse into the power relationship between wife and husband. The general assumption, including mine, was that the women might not be able to talk freely in such a setting with their husbands participating. Surprisingly, the finding showed that the women were more outspoken and more articulated than the men. The observations during the interview indicated that while women talked, men quietly listened and supported them. There was no case where men interrupted or showed any attitude that hindered the women from speaking.

While these women's confidence suggests that they have the *power within*, it seems to be contradictory in the context of FP. Women's self-confidence seems to fall under *internalised oppression* (Rowlands, 1999; Kabeer 1999), which refers to the cultural perception of women in their current role and situation, which they accept and perceive as natural and normal. Women's self-confidence was demonstrated through their perception as the contraceptive users. The observations during the interviews suggested that the women confidently spoke about FP due to their knowledge about FP and their role as a contraceptive user. Women are the ones who use contraceptives and this, coupled with their reproductive role, reinforces their responsibility in FP. Thus, those women whose husbands participated in the interview spoke confidently about FP without any sense of fear, even with their husband sitting next to them.

However, it is important to not generalise that all Mangkong women are confident and outspoken, even though they may appear the same. Not all women have this characteristic equally. The level of women's self-confidence seems to be on a spectrum and depends on several factors and circumstances. It is essential to consider factors that distinguish ways in which some women are more confident than others. Rowlands (1998), Mosedale (2005) and Eerdewijik et al. (2017) suggest that empowerment is context specific, influenced by class, ethnicity, family position, age, power relations and other factors such as individual personality, socio-economic and educational background, also influenced the

level of women's internal strength, as manifested by Mrs. Chan (CP10), Mrs. Nee (CP1), Mrs. Lee (CP4), respectively (see Chapter 6).

Women's Autonomy

Autonomy here refers to the degree of power women have over their mobility, mainly with respect to access to FP information and services, and the act of making a choice, such as choosing preferred methods without prohibition or restriction. The findings suggest that it is critical to analyse women's autonomy through different perspectives. Primarily, it is necessary to analyse alongside the core principle of FP – to provide individuals and couples with accessible, affordable and quality FP information and service, with a wide range of contraceptive methods (UNFPA, 2017).

On the one hand, women might have the autonomy to choose and access their preferred methods. According to Charmes and Wieringa (2003), power is exercised by individuals who either resist or accept the unjust reality. This study found that all participating women have access to the health centre to obtain the service and they chose the contraceptive by themselves, without coercion or prohibition or incentives. The action which women take to get the contraceptives in these circumstances might be considered autonomous, since they take this action by themselves.

However, the explanation above seems inadequate to show true autonomy. Women's mobility autonomy and decision autonomy are closely linked to culture and structure. There are several rationales to explain this. First, lack of autonomy concerns the unequal access and the power structure in the community (Batliwala, 2007). Although women chose the contraceptives by themselves, their choice was made within limited options, since not all methods are available at the health centre. Although a condom is available for free, women do not include it as an option because of the underlying perception and the unwillingness of their husbands to use condoms. Second, women have little knowledge of FP methods, due to the health providers not providing comprehensive information and choices

including side-effects. The health providers often charge a service fee or ‘registration fee’ of different amounts depending on the financial situation of women. This reflects the power relationship between the providers and the clients.Third, poverty also causes a lack of autonomy among women. As discussed in Chapter 3, for women to be empowered they need to have access to resources (Kabeer, 1999). However, women do not have financial resources that enable them to choose their preferred methods. The lack of means of transport also impede women’s autonomy. Particularly, women who live far away from the health centre often rely on their husband for transport, as they do not know how to ride a motorbike.

Importantly, women’s mobility and decision autonomy are dependent upon their husband. As mentioned in Chapter 3, the ICPD, the Beijing and UNFPA (2000) strongly advocate for the role of men to be supportive of women’s choices. Although such a supportive role from men was demonstrated by all male participants, men remain the primary decision maker in the Mangkong family (see Chapter 5). Thus, women need to get permission from their husband regarding FP. Based on the conceptual framework and the principle of FP as mentioned above, this study concludes that women do not have the autonomy to choose and access their preferred contraceptive methods.

Women’s Decision-Making Power

Decision-making power is central to empowerment. As discussed above, there is a precondition of awareness and access to resources before every decision can be made. The discussion above already examined some aspects of power within which are important for decision-making. A lack of awareness of rights for decision-making, as well as rights to access full information on FP, which in turn inform the decision-making of women, have been highlighted. Such a lack of awareness is also associated with a variety of influential factors such as cultural perceptions, lack of access to information and services, education, poverty, and economic subordination. In this study, most female participants were farmers with

little to no education. Coupled with the expectations of their cultural norms, these women often depended on their husbands regarding decision-making.

This finding is consistent with other studies, such as Dudgeon and Inhorn (2004); Adango et al., (2013), Estrom et al., (2015) and Tilahun et al. (2015); who concluded that in patriarchal societies in many developing countries, men are the final decision-maker in the family and the determinant for women's RH/FP. As mentioned in Chapter 5, in the Mangkong society men are the decision-makers who play a key role in allowing or restricting women's use of contraceptive methods.

7.3.2 Empowerment in Close Relationships

Spousal Communication

This study is consistent with many studies on men's involvement in FP, which suggest that, as a result of men's involvement, there is increased spousal communication on FP (Maharaj, 2000; Rosliza & Majdah, 2010; Bayray, 2012; MacDonald et al., 2013; Kassa et al., 2014). For example, all female participants discussed FP with their husband regarding whether and when to have children and how many children they want to have, as well as which FP methods they wanted to use for either birth spacing or birth limiting.

Joint Decision Making

The ICPD called for redistributing power relations between men and women (Batliwala 2007; UNFPA, 2000), especially in respect of RH/FP that requires men and women to make the decision together. This finding indicates that out of 13 couples, there are eight couples who made a joint decision about FP. However, men remain the final decision-maker in the family. As discussed in the sections above, women need to seek approval from their husband for the contraceptives.

Shared Responsibilities

Many studies concluded that men's involvement increased shared responsibilities within the household, especially household work and childcare (Maharaj, 2000; Sternberg, 2004; Rosliza & Majdah, 2010; Bayray, 2012; Adango et al., 2013; Ezeanolue et al., 2015). This study confirms such positive results, as all the Mangkong men have helped their wife in doing housework and taking care of children, particularly during their wife's pregnancy and childbirth.

However, as discussed earlier in this chapter, there is little shared responsibility regarding the use of contraceptives. Research in Ghana (Maharaj, 2000) and in Vietnam and India (MacDonald et al., 2013) suggest that there is an increase in the willingness of men to use condoms, while other studies concluded otherwise. As mentioned, it is essential to recognise that men's involvement is context-specific. In the context of Mangkong, it is not common for men to use condoms or undergo sterilisation due to cultural and structural barriers.

7.3.3 The Impact of Men's Involvement on Women's Empowerment

The dominant role of men in the family has a particular influence on women's empowerment in FP. However, many other issues have a significant impact on their level of empowerment. As such, men's involvement alone does not necessarily lead to women's empowerment.

The findings of this study support the empowerment literature, acknowledging that empowerment is context-specific and multi-dimensional (Rowlands, 1998; Kabeer, 1999; Mosedale, 2005; Eerdewijik et al., 2017). It is crucial to consider empowerment's multidimensional nature and other influential factors. Thus, the work of Moser (1989) about *strategic gender needs* and *practical gender needs* are useful to the analysis of empowerment. As discussed in Chapter 3, the concept of *strategic gender needs* lies within the gender analysis and relationship between men and women, with the aim of overcoming women's subordination. The patriarchal and patrilocal nature of Mangkong society, as well as the cultural perceptions, determine and shape the status and position of men and women,

the gender roles and the relationship between Mangkong men and women. *Practical gender needs* refers to the immediate needs, such as access to resources of FP information and service, as well as other factors that either allow or restrict access to FP, including poverty, access, the attitudes of the health providers, distance, means of transportation, education, employment, and so forth.

7.3.4 Strategic Gender Needs

The husband may not be the only decision-maker. In the Mangkong society with a patriarchal and patrilocal structure, women move to live with their husband after marriage and become a member of their husband's family. Such a marriage pattern implies that there are influential members in the family other than the husband. For example, the elders in the family also need to be aware of FP and support women. It would be difficult for women to make their own choice without the approval of this influential elder, even when the husband supports the wife. This finding is consistent with the Family Planning Situation Analysis Report (FPSA) 2015 regarding the restriction of women in making decisions due to the patriarchal nature of society. The nature of Mangkong society also reflects the Third World Feminists literature on women's subordination (Kabeer, 1999; Batliwa, 1997). The status of the Mangkong women within the household remains low. Although they have access to land for agriculture, they do not necessarily control the resource since it belongs to their husband.

Cultural Perceptions

As already discussed earlier in this chapter, cultural perceptions and rules also shape gender roles in society. For instance, the Mangkong men are the head of household and the main source of the family income, while the Mangkong women are the primary caregivers. This context reflects the work of Moser (1989), who concluded that women's triple role is often unrecognised, as it is seen to be normal and natural. The Mangkong women assume the RH role, the productive

role, and the role of attending the community meetings or events, such as the outreach. Validating the existing literature, particularly Batliwa (2007) and Kabeer (1999), Mangkong women's empowerment is not limited to women's control over their RH, but also both non-material and material resources, which in turn have an impact on their RH.

Education

Another cultural perception is gender disparity in education. As mentioned in Chapter 5, men are more valuable than women with regards to education. Men are given the opportunity to attend school, whereas women are not. Such deprivation of women's rights to education impels women to become more dependent on their husbands. For instance, women relied on their husband to read the appointment card for them, as they do not understand. Such reliance has several implications.

On the one hand, it adds more value to men's involvement, since there is a need for men to be there for their wife. If men are actively involved, this may have a positive impact on women's RH outcomes. However, the current involvement seems to be problematic in practice, which may lead to adverse effects for both men and women's RH outcome.

On the other hand, lack of education among women only exacerbates gender inequality and women's vulnerability at the broader level in areas like contribution to the community and society. Moreover, education is crucial for women to empower themselves, which also influences their practical gender needs.

Peer to Peer Communication

Peer to peer communication and relationships with other women tends to be influential. In the Mangkong context, trust is seen to be essential and this is demonstrated in the relationships between people in the community through harmony and peer to peer communication. women referred to their peers as the

reason why they decided to get an injection. Also, many women did not consult with the health providers about side-effects because their peers did not do so. Peer to peer communication also has an impact on the women's contraceptive choices, as briefly mentioned earlier. The relationships between women in the villages is central to the collective behaviour change. The women felt confident when they talked to their peers, and they were more willing to talk to their peers than to the health providers.

This finding aligned with Rowlands' collective empowerment (1998), which shows the potential of women's collective action to be a driving force for change at the societal level. However, such power among women may not necessarily challenge the inequality in the society if other practical gender needs are not addressed.

7.3.5 Practical Gender Needs

The findings support the study by Rahma (2013), who suggests that apart from attitudinal and value changes among men and women, external factors such as social, economic considerations are essential in facilitating such changes. This study is also consistent with Batliwa (2007), who concluded that without transforming existing unequal power structures and social inequality, including access to resources, true empowerment would be hard to achieve. This access to resources includes access to comprehensive information and contraceptive choices, quality of service, education, and employment.

Contraceptive Choices

The findings suggest that women have limited contraceptive choices. As discussed elsewhere, women only have three options. However, some women do not want to take pills, and many women could not afford the implants, which leaves women with no choice but to accept the injection which is more affordable. Such limited choices aligned with the critiques of FP (Kabeer, 1992; Robinson &

Ross, 2007) who claim this violates women's human rights, especially the rights to access a complete range of contraceptive methods. Such diminished rights are associated with poverty and the access to comprehensive information, which is also closely linked to the health providers' ethical attitude.

Women's Employment

The finding indicates economic subordination among the Mangkong women, which reflects the studies by Johnson (1995), Hartmann (1995), Sen and Grown (1987) and Correa, (1994). The increased employment opportunities in Nong district provides the people with job prospects.

However, women are not provided with employment opportunities. The implication of this shifting from farming to employment in the industry is enormous. On the one hand, the opportunity exacerbates existing gender inequality, since women do not have the same opportunity to work. On the other hand, when men are employed they earn an income, which improves a family's well-being. However, it might result in men having control over the income, which makes women more vulnerable and more reliant on their husband in relation to accessing the FP service. This adds further power to men. As a consequence, the existing unequal power relationship between wife and husband may be exacerbated.

Thirdly, there is a tendency that men could be even further excluded from their responsibility, especially regarding the use of contraceptives. Since they have control over the income, they have a say in the expenditure. As such, there might be no room for negotiation for shared responsibility regarding the use of contraceptive methods. Lastly, women do not know how to ride a motorbike and this leaves them relying upon their husband. Since their husband works full time outside their home, they may wait for their husband to take them to the health centre or district hospital after work. However, this might be challenging if the health centre or hospital do not have flexible service hours for women, or when there is an emergency.

Quality of Care

Although the quality of care (see Chapter 2) has been emphasised since the 1990s, most FP programmes failed to meet the appropriate standards. This study is consistent with other studies in the context of developing countries, such as Hartmann (1995), Kumar and Gupta (1999), Kantner and Kantner (2006), and Mbizvo et al., 2014, which concluded that in practice there had been an inadequate quality of service

Importantly, the attitude of the health providers towards the clients is a crucial determinant for quality service and the RH outcome of women (Mannava, Durrant, Fisher, Cherish and Luchters, 2015). However, as this finding suggests, apart from the inadequate quality of care, the attitudes of the health providers resulted in a failure to provide full information, including side-effects and the complete range of contraceptive methods. Mbizvo et al. (2014) concluded that the issue of provider's attitudes is common in developing countries.

Several implications stem from the above section. Firstly, the lack of awareness among the women of their right to comprehensive information poses a difficulty for women who, as a result, cannot claim their rights with the health providers. All the women experienced side-effects, but most of them were not aware of their right to consult with the health providers, and some of them were reluctant to talk to the providers. A few women simply made their own decision to switch without consulting the providers. The finding found that women often made their personal choice at home before going to see the health providers. Similarly, the health providers did not provide full information, but merely provided the service with little-detailed information given to the women.

Secondly, all the women only had a little knowledge of the three FP methods. Many of them said that the health providers did not provide details on FP methods including its side-effects. Some women said that they knew about side-effects only after they used the contraceptive methods, but not through the information that the provider offered . Furthermore, the provider did not check on the health condition of the clients before providing a contraceptive service.

Thirdly, although other methods are available in the district hospital, women may not be able to access this. Problems of access arise from: distance and lack of transport; communication barriers; trust issues, as well as a lack of ethnic health staff in the hospital. Moreover, the permanent methods of vasectomy and tubal ligation are only available in Sepon District, which is approximately 50km away from Nong. To access these permanent methods, transportation is needed. It is essential to note that there are overlaps between strategic gender needs and practical gender needs.

7.3.6 Policies

At the policy level, the FP programme continues to overwhelmingly target women, mainly focusing on long-acting methods such as the injections, IUDs, and implants. The health official emphasised that to achievie the Lao government's RH goal and commitment for FP2020, the top priority is to increase the contraceptive prevalence rate (PRC) and reduce the unmet need among women. According to the health official, the CIP 2017 suggests that focusing on long-acting methods may help achieve this goal.

More importantly, the goal continues to heavily target women, with little mention of men's involvement. Men are seen as a supportive partner who will encourage an increase in the use of contraceptives among women. Laos is not the only country with such a strong emphasis on women, as there are many developing countries that have such a focus (Hardee, Croce-Galis & Gay, 2017).

In addition, it is not clear how the government would promote long-acting methods among ethnic women. The potential issue stemming from such a focus is that women may be even more vulnerable, which can be explained in several ways.

The Violation of Women's Human Rights

The urge to achieve the PRC, using incentives as a motive to accelerate progress, tends to push the health providers into promoting and providing information limited to the long-acting methods. Such a practice seems to be contradictory to the human-rights-based approach that has been strongly promoted since the ICPD, such as the right to access a full range of contraceptive methods within the theory of voluntarism. The promotion of long-acting methods might worsen the existing violation of women's right to comprehensive information. This promotion may also influence women's autonomy to make choices based on their preference and suitable for their health condition. In this way, it reflects the conventional FP approach criticised by Seltzer (2002), who argued that women are forced to accept contraceptive methods in order to increase the number of users. The concern is that, as this finding suggests, women may be pushed into taking the long-acting methods, which are likely to neglect their other RH issues and importantly the woman's own choice.

Access to Long-Acting Methods

It is not clear how the government would ensure access to these methods, especially at the community level, since these women only have access to the pill, injections, and implants. IUDs were rarely mentioned either by the women or by the health providers during the interviews. The inconsistent and high cost of implants often leaves women with no choices but to accept the injection as the only option, since most of them do not want to take the pills. This existing issue raises the question of how the government would make sure that women, especially ethnic women, have access to long-acting methods as outlined in the plan.

The Top-Down Approach

The policies and action plans were designed and implemented by the government officials who are mostly Lao-Tai with support from development

agencies. For this reason, there is a transfer of the Western concept of empowerment without any consideration of the locals' perspective . There is little involvement of ethnic groups in the design and planning of the FP programme. Thus, the strategies and plans outlined in the government's documents are top-down, based on the assumptions of the policy-makers and practitioners at the central level. If true empowerment is to be achieved at all, it is necessary for the programme design to take into account the ethnic diversity and the views of these ethnic groups especially in respect to community-based interventions.

The government priorities and the urgency to increase PRCs are very likely to repeat negative aspects of FP history, for example the Neo-Malthusians driven approach (Hartmann, 1995; Seltzer, 2002; Eager, 2004; Robinson & Ross, 2007; Frey, 2011). Despite the different purposes, the approach seems to be similar in wanting to increase the number of users, yet do not consider the circumstances of women's health conditions, status, or other cultural and structural issues. Such concerns raise a dilemma in respect to the ultimate goals of FP programme. There is limited connection between increasing the statistics in order to reach the goal and improving the quality, well-being, and empowerment of women.

Lack of Qualitative Evaluation

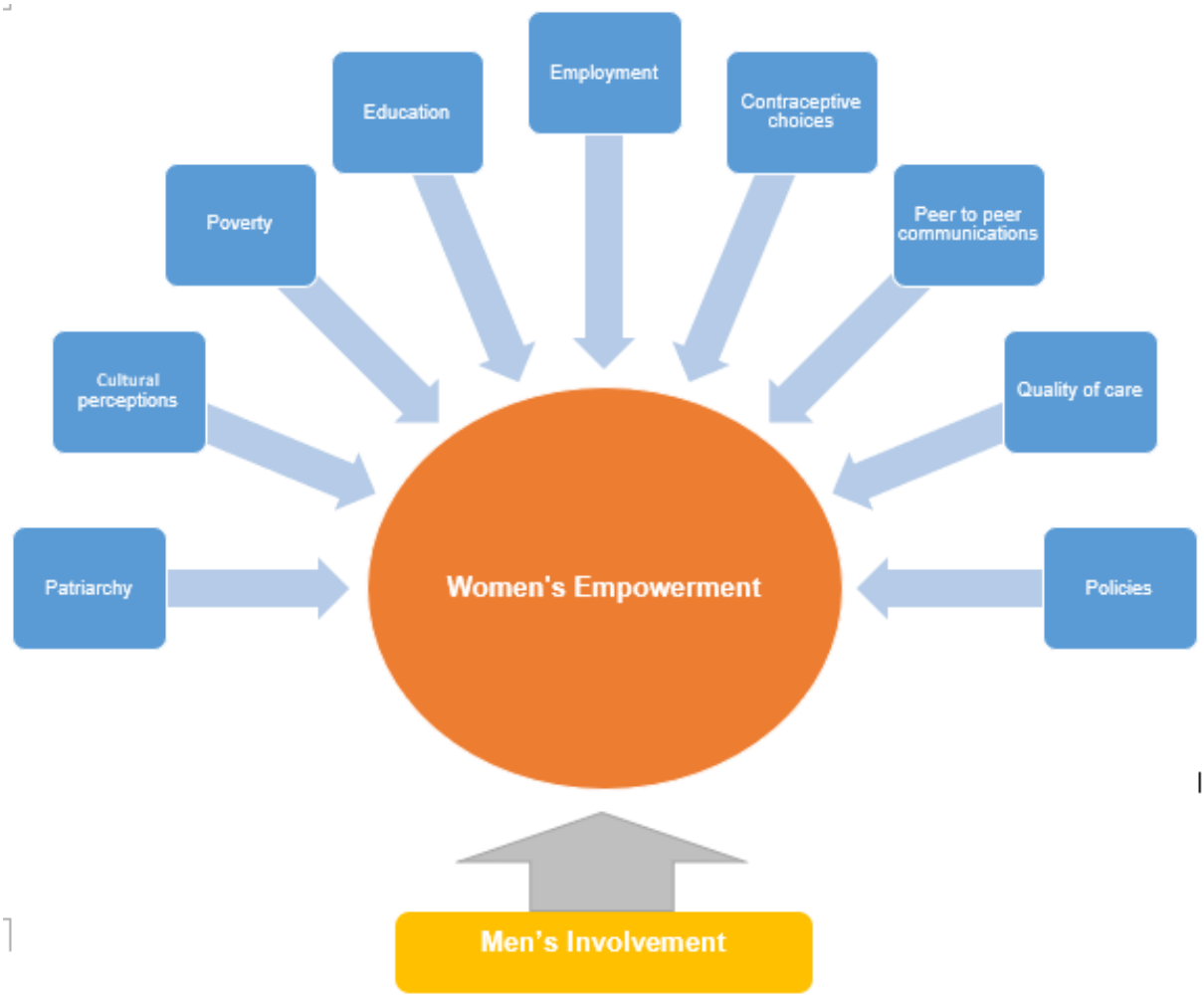
No indicators or assessments of women's empowerment in FP or women's experiences affected by the FP programme were found within the scope of this study. According to the health official, there is no such assessment by which to measure the impacts of FP on women's lives, especially concerning their RH. She added that proxy indicators are applied to measure women's empowerment such as the contraceptive prevalence and the number of women having access to FP.

The lack of such evaluation of women's experiences reflects the top-down approach discussed by Kabeer (1999), who suggested that there is a need to measure women's empowerment beyond access, but to also measure empowerment in areas such as control and the decision-making power of women.

While there is a significant amount of literature on women's empowerment in FP in developing countries as discussed in Chapter 2, specific studies in the context of ethnic groups in Laos has been limited. Cornwall (2005) urges that we need to reflect upon the use of the term empowerment that often remains as 'nice-sounding words to dress up business as usual.' (p. 1044). In doing so, an evaluation of women's empowerment in FP is needed for tracking the progress and identifying gaps, as well as providing ways forward.

The summary of influential factors that have an impact on women's empowerment is shown in Figure 7.2. There is a need to address the strategic gender needs alongside the practical gender needs to provide an enabling environment for women to empower themselves.

Figure 7.2: Influential Factors on Women's Empowerment



Source: The Author, 2019

7.4 Chapter Summary

This chapter concludes that men's involvement and intervention is not linear. This study indicates that various barriers hinder men's full involvement in FP. It is an oversimplification to simply incorporate men into the existing FP programme, without considering its complexity and interconnected issues. There is an inadequate understanding of masculinities alongside gender norms and other social and cultural factors that influence the construction of masculinities and gender norms in a society. As a result, most FP programmes that involve men in

developing countries are still based on the narrow assumption of masculinities, which create men as the ‘problem’ and ‘obstacle’ for women’s development. As such, men are integrated as an instrument or a contributor or a supportive partner for the goal of women’s empowerment. In this way, men’s other roles and experiences, such as subordination and disempowerment, are neglected.

Importantly, this study concludes that men’s involvement in FP does not necessarily bring about women’s empowerment. Other influential factors also have a significant impact on the level of women’s empowerment. These factors concern *strategic gender needs* and *practical gender needs*. This study suggests that these needs are mutually inclusive, in that they must be addressed alongside each other. If true empowerment and gender equality in FP is to be achieved, it is crucial to focus on both men and women, rather than target women in isolation.

In sum, this study calls for recognition of both men and women as individuals, couples, and clients who have the right and need to obtain accessible, affordable, acceptable, and quality voluntary FP. Ultimately, both men and women can play a key role as an agent of change to bring about real changes at both the micro and macro level.

CHAPTER 8: CONCLUSION

8.1 Introduction

This chapter draws conclusions from the findings and discussion with the aim of answering the research question:

> Does men's involvement in family planning increase women's empowerment, and in what ways?

In order to answer this question, it is important to recap the conceptual framework of empowerment used in this study. Drawing on the empowerment conceptualisation of Rowlands (1998) and Kabeer (1999) discussed in Chapter 3, alongside the FP definition in Chapter 2, women's empowerment within a FP context is defined as women being aware of FP information and services, including their rights to access this service, and women becoming more confident in exercising their rights to decide on family size and contraceptive use, including communicating with their spouse to make joint decisions and share responsibilities. This study draws on the assumption that men's involvement supports and promotes women's *power within*, which leads to increased spousal communication, joint decision making and shared responsibilities regarding the use of contraceptives, household work, and childrearing.

This study applies a qualitative approach by using three data collection methods: 1) semi-structured interview; 2) informal observations; 3) document analysis. I interviewed 13 Mangkong couples and two women who are currently using FP methods in six villages in Nong district, as well as several key informants: the district health staff; the village chief; the midwife; the health provider; the community-based contributor (CBD); and the health official from the Maternal and Child Health Centre (Ministry of Health) in Vientiane Capital. Informal observations helped build rapport with the community and learn about Mangkong gender roles. I also critically reviewed several government documents and grey literature.

Four implications emerged from this study, which contribute to existing knowledge and call for the consideration of a shift in approach to FP programmes that involve men. This chapter will discuss these implications by commencing with a recognition of positive outcomes of FP programmes that involve *men as supportive partners.* The second implication is that despite such positive outcomes, this element of men's involvement alone does not necessarily lead to women's empowerment, due to interconnected issues that need to be addressed, such as barriers including strategic gender needs and practical gender needs. Thirdly, the empowerment conceptual framework adopted in this study cannot fully explain empowerment of the Mangkong women, hence, a culturally embedded model of empowerment is needed to define its meaning within the Mangkong context. Lastly, it is necessary to move beyond women's empowerment to include men through a gender-inclusive approach, which requires a nuanced understanding of masculinity and gender norms, and ultimately includes both men and women as *agents of change*.

8.2 The Role of Men in Family Planning

This study suggests that the role of men in FP is crucial. Although there is no clear definition of men's involvement, the current strategies for men's involvement in FP in Laos are more of engaging *men as supportive partners*, rather than involving them in the three aspects altogether: *supportive partners*; *clients*; and *agents of change*. Therefore, the findings and discussion on men's involvement in this thesis is more about the men's role as supportive partners. Results from the interviews also indicate some issues concerning men's SRH needs. However, this study concluded that FP programmes in Laos are still far from engaging men as agents of change.

As discussed in Chapter 5, in the Mangkong society with dominant men and subordinate women, it is the men who make the decisions in the family that influence every sphere of both men and women's lives, including RH and FP. Men play a crucial role in determining health-seeking behaviours and RH health

outcomes for women. This means they can either oppose or support their wife in making decisions and utilising FP services. This involvement therefore tends to reinforce the norm that men hold the decision-making power as described by Greene et al. (2006).

The Positive Change: Involving Men as Supportive Partners

This study found a few positive outcomes of involving men as supportive partners in FP. First, all the men interviewed are aware of the benefit of FP for birth spacing and birth limiting. The main reason Mangkong men support their wife to access FP is the economic factor. All couples referred to poverty, and that having too many children would only exacerbate poverty. Thus, FP allows them to have fewer children and more time to work in the field.

Regarding spousal communication, all couples discussed FP with each other, in order to plan whether or not they want to have children, when they want to have children, and how many children they want to have, and discussions included which contraceptive methods to use. Regarding joint decision-making, out of 13 couples, there are eight couples said they discussed and decided together on the number, timing, spacing and contraceptive methods. However, men remained the final decision maker, as the women had to ask their husband before choosing their preferred contraceptives. Therefore, the role of men has a significant impact on women's decision-making power.

The Problems of Men's Involvement on the Ground

Despite the positive outcomes identified above, this study concludes that men's involvement in practice is quite problematic. As discussed in Chapter 7, there are numerous interconnected issues concerning men's involvement in FP. The levels of involvement are constrained by cultural and structural barriers, both of which are equally important. All participants in this study perceived that FP is women's responsibility because women are the contraceptive users, not men. While men

usually make a decision on behalf of women in almost every sphere, including RH/FP, they referred to women when it came to taking responsibility for the use of contraceptives.

Such cultural perceptions also shaped the way health providers deliver services. Men were excluded from the counselling service, as the health providers only target women and did not provide FP information to men. This may be the result of the current RH policy (see Chapter 5), which does not prioritise targeting *men as clients.* Therefore, men were not seen as beneficiaries of the FP service. Instead, they were viewed as only *supportive partners* who can help increase women's access to FP. Such exclusion is seen as an inequity between men and women regarding access to FP.

At the policy level, this perception remains significant. The Lao government has a RH policy in place, which states explicitly the role of men within the two aspects of men's role: supportive husband and responsible father (see Chapter 5). Whether the government considers the ethnic perspectives in understanding masculinity is not clear. However, it seems that the context of the Lao-Tai is more dominant than the non-Lao-Tai context. Given that policies and programmes are designed and planned at the central level, and most policymakers are dominant Lao, it is, accordingly, likely that the definition of masculinity is limited to the context of Lao-Tai.

As a result, the approach to implementing the FP programme tends to be top-down. The policy may not be compatible or may even be contradictory to the non-Lao-Tai ethnic groups in practice. For example, while it is common for the Lao-Tai men to use condoms outside marriage (Natoli et al., 2012), the Mangkong men think otherwise (see Chapter 7). Structural factors, especially the way condoms were promoted, also hindered men's use of condoms. For example, the village chief and the health provider said that men should use a condom when they stay in a hotel, rather than promoting condoms in a broader FP context. Such limited promotion seems to be based on the context of dominant Lao

masculinity, where there is an expectation that men drink alcohol and have sex outside marriage (Natoli et al., 2012).

Even though the RH policy focuses on involving men as supportive partners, this was not translated into concrete planning, despite its significance. As discussed in Chapter 7, the RMNCH Action Plan (see Chapter 5) lacked indicators of men's involvement as supportive partners. Moreover, there was lack of detailed planning and this led to inconsistency and resource dependency when implementing an on-the-ground FP programme that involved men. Problems included the limited skills and capabilities of the health providers in engaging men in counselling, as well as a lack of culturally appropriate IEC materials with a specific focus on the Mangkong. Therefore, if FP could involve men in a more nuanced way by setting a clear goal on how to involve men, understanding masculinity in the context of each ethnic group and addressing these barriers, the strategy could yield a major positive outcome for RH/FP for both men and women.

Influential Factors for Women's Empowerment

This study also concludes that FP programmes involving men do not necessarily lead to women's full empowerment unless the programmes address strategic gender needs (patriarchal system, cultural perceptions, power relations); and practical gender needs (education, employment, access to quality FP services). These gender needs are interconnected. For example, even though a FP service is available, women may not be able to access it due to the opposition of their husband. Conversely, women may be disempowered even though men support women's access to FP, due to the limited information and poor quality of service providing only a few contraceptive choices. Moreover, availability and affordability were further obstacles. Notably, while condoms were provided for free, these were not seen as an option for women, due to the cultural perceptions already highlighted.

8.3 Limitation of Empowerment Conceptual Framework

The conceptual framework of empowerment adopted in this study cannot fully explain the Mangkong women's empowerment in the context of FP. Firstly, the empowerment concept stemmed from Western feminists, such as Rowlands, and Third World feminists mostly in the context of South Asia, such as Kabeer. As discussed in Chapter 3, empowerment is a buzzword and has been translated into local languages without taking into account local perspectives. The context-specific nature of empowerment requires consideration of diverse cultural contexts encompassing influences of personality, age, social, economic and educational background, and so forth. Therefore, the framework seems to be inadequate to explain empowerment among Mangkong women.

Secondly, although women showed their *power within* through their perceptions as contraceptive users, it is not sufficient to conclude that they are empowered. Due to cultural perceptions, women internalised themselves as the ones responsible for FP. It is this internalisation (see Chapter 3) that prevents women from understanding their rights and awareness of FP and that FP should be the responsibility of both men and women as a couple. Therefore, in this context, *power within* does not reduce women's burden; rather it places even more burden on women because there is no room for them to negotiate with their husband in order to share responsibility regarding the use of contraceptives.

Thirdly, even though all women in this study made the decision to choose their preferred contraceptives and had the mobility and autonomy to access the health centre, women chose their contraceptives within limited choices. This was coupled with little involvement of men as a client. As a result, there are even fewer choices for women, since male contraceptives were not seen as an option for them, even if they are available at the health centre. As indicated in Chapter 6, Mankong men were not willing to use any male contraceptive methods.

8.4 Culturally Specific Empowerment Model

Who should define empowerment? This thesis faced difficulty in using Rowlands' and Kabeer's empowerment conceptual framework to explain women's empowerment in FP within the Mangkong context. There is a contradiction between the concept of *power within* and the experiences of Mangkong women. While Mangkong women expressed their confidence through their outspokenness in their reproductive role as contraceptive users, it seemed to be more of an *internalised oppression* rather than self-confidence or internal strength as defined by Rowlands and Kabeer. As discussed in Chapter 3, with such internalisation, women accept the cultural perceptions and norms, which means that they continue to bear the burden of FP instead of seeing it as a couple's responsibility. Thus, internalised oppression is a central feature hindering women from understanding their rights and value, resulting in an acceptance of their subordinate position in the family, community, and wider society.

As an outsider using the empowerment concept, which stemmed from a Western feminist (Rowlands) and South Asian feminist (Kabeer) perspective, to draw a conclusion on whether or not Mangkong women are empowered, I was put in quite an uncomfortable situation. In the worst case scenario, I saw myself as an outsider attempting to define empowerment from my perspective, based on Western literature and ignoring the fact that the local people are the ones responsible for defining their own lives and problems (Chambers, 1995).

If true empowerment in a FP context is to be achieved, it requires a theoretical shift of the empowerment model. There is a need for a culturally specific empowerment concept defined by the Mangkong community. In defining this, the government and development agencies need to adopt a participatory approach to involve the Mangkong community in FP programme designs and planning processes. It is necessary to recognise that there is no one-size-fits-all approach. Many lessons from the past have shown that taking a simplistic and top-down approach is not effective (Cornwall, 2005).

8.5 Gender Empowerment

This study suggests that a shift in the FP approach is needed. Despite universal recognition that RH and FP concern both men and women, the FP approach remains women-centric. Recently, there has been a growing number of studies calling for integrating men into RH/FP beyond the role of mere contributor (*men as supportive partners*) in order to promote women's empowerment and gender equality (Sternberg & Hubley, 2004; Dudgeon & Inhorn, 2004; Anderson, 2005; Greene & Levack, 2010; Dworkin et al, 2015; Estrom et al., 2015; Hartmann et al., 2016; Hardee et al., 2017). They urge the FP programme to focus on men as an individual/client who also have the rights and the needs for RH/FP, alongside their role as supportive partners and agents of change. This study joins this literature calling for a gender-inclusive approach to implementing FP programmes, by from shifting a women-focus to a gender-focus, which involves men in a more nuanced way. In doing this, the first step is to have a nuanced understanding of masculinity.

8.5.1 Understanding of Masculinity

Masculinity is socially constructed and shaped by social, cultural, political and economic issues (Dworkin et al., 2015). Recognising that masculinity is not homogenous and that there are various forms of masculinity in different societies is the first step towards a better understanding of masculinity. Understanding masculinity requires reflection on gender norms and the intersectionality that constructs masculinity in a particular society (Estrom et al., 2015). With a nuanced understanding, a FP programme can be designed in a way that works best for men's involvement.

Ultimately, it requires an insight of masculinity in the context of Mangkong and an understanding of how men define themselves as a 'man' in Mangkong society. Chapters 5 and 6 briefly discussed the difference between the Lao-Tai men and the Mangkong men regarding their views and use of condoms. While it is common for the Lao-Tai men to use condoms outside marriage, the Mangkong men held

a firm position opposite to this. This is a critical point to understand the differences between masculinity in various ethnicities, as it lays a foundation for culturally appropriate planning and implementation of FP programmes that work best for men in this ethnic context.

In sum, the practice of men's involvement in FP programmes is problematic due to various barriers that hinder men's full participation in FP. This study insists that it is necessary to recognise that men experience masculinity differently. This study also provides evidence on disempowerment among men because men are not a homogeneous group. They also need FP information and services. Importantly, if men are to be fully and meaningfully involved, a change at a broader level needs to be made. The government needs to think about the questions: What is the definition of men's involvement? How will the government involve men? What are the indicators for such an involvement?

8.5.2 Moving Beyond Women's Empowerment

Besides the understanding of masculinity, this study suggests that it is essential to recognise that focusing on women's empowerment alone is insufficient within the context of FP. Many previous studies have illustrated lessons learned from the single-sex approach in FP, which have shown its ineffectiveness. Particularly in the context of RH/FP, changes are required in both men and women (Kabeer, 1999). Ultimately, everyone in society has a role to play in order to bring about real change (Greene & Levack, 2010).

Given that FP is an issue for both men and women, the term 'women's empowerment' may seem to privilege women, which may reinforce the notion of FP as a women's issue. Thus, this study calls for considering gender empowerment rather than women's empowerment. In this way, not only does the FP programme recognise various versions of masculinity but also shifts the expected norm. Ultimately, FP programmes should target both men and women as both are beneficiaries/clients and agents of change.

8.6 Future Research and Practical Recommendations

Given that there are limited studies on men's involvement and its impact on women's empowerment in FP, this study calls for more research, primarily in the context of ethnic minorities in Laos, that can inform the design of FP programmes in ethnic cultural contexts. In addition, this study urges more research on women's empowerment from the perspective of ethnic women.

Importantly, this study hopes to initiate critical thinking, discussion and assessment about men's involvement, including its definition: What does men's involvement mean? A further question is: How do we involve men in a meaningful way that benefits both men and women? This study also hopes to provide practical recommendations for the Lao government, especially the Ministry of Health, as well as international agencies. Recommendations include:

1. Revision of National Reproductive Health Policy
    - Redefine masculinity by involving ethnic minorities.
    - Recognise and include men's other roles such as clients and beneficiaries.
    - Consider men equal to women with rights and needs for SRH information and service.
    - Provide a clear definition on men's involvement: Whether to involve men as supportive partners, clients, and/or agents of change.
    - Consider the framework developed by Greene et al. (2006) found in Chapter 2.

2. Concrete planning on men's involvement
    - Translate men's involvement strategies into concrete planning
    - Set clear indicators including monitoring and evaluation
    - Set budget allocation for implementing the programmes.

3. Capacity and skill training

- Provide knowledge and skill training for community health providers including an understanding of gender norms, masculinities, and the culture of specific ethnic groups.
- Address misconceptions among health providers by providing accurate information about FP and contraceptive methods, especially male contraceptive methods.
- Provide gender and cultural sensitivity skills training, interpersonal communication training, especially counselling skills with a focus on engaging men, or men and women as a couple effectively.

4. Effective IEC strategies and tools
    - Use a participatory approach to involve the ethnic community in designing IEC materials with culturally specific messaging.
    - Conduct a pilot project to test the effectiveness of the materials.
    - IEC needs to be seen as an essential tool for FP promoters and service providers to address misconceptions, by providing accurate information to the community.

5. Universal access to FP for all
    - There is a need for special attention to and a solution for those ethnic minorities who cannot afford the FP services.
    - Ensure the consistency of FP service costs through transparency and accountability at the community, district and provincial level.
    - Ensure that both men and women, especially ethnic groups in rural areas, are provided with accessible, affordable, quality FP service and a full range of contraceptive methods.

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Appendices

Appendix 1: Interview Questions

Semi-structured interview guiding questions[30]

1. For primary participants (Mangkong couples)

Themes/Objectives	Guiding questions
How men are involved in Family Planning (FP)/Reproductive Health (RH), and men's and women's views of this	1. Where do you get FP information and services from? 2. With whom do you go to the facilities to get FP? 3. Do you think you should accompany your wife to get FP/RH services at the health centre? Why/why not? (ask the husband) 4. Do you think your husband should accompany you to get FP/RH service at the health centre? Why/why not? (ask the wife) 5. Do you both present together when the CBD come to visit your home? Why/Why not? 6. What do you think about the outreach activities/health education provided by CBD/Health providers/ Community midwife? Is it useful? What do you get from them? 7. Is there any changes in your life since you have been involved in the FP? What has changed? What do you think about these changes?
If FP/RH involving men results in an increase in women's self-esteem, autonomy, decision-making power regarding their Reproductive Health,	1. How many children do you have, want to have? (Queries as to whether there are difference noted between men and women? Boys are very valued in Laos in some ethnic groups) 2. Who should decide whether, when and how many children to have? Why? 3. With whom do you usually talk to about having children? (Queries whether they talk to their spouse) How do you feel when you talk to the person? 4. With whom do you usually talk about contraceptives? (Queries whether they talk to

[30] Questions under the themes may not necessarily be asked in the order listed. People tend to talk in a circular roundabout manner. The themes and questions outlined however things I am interested in understanding.

and their ability to negotiate with their husbands in decision-making processes	their spouse) How do you feel when you talk to the person? 5. What do you think about contraceptives (Various types)? Should women use them? Or should men use them? Why/Why not? 6. Do you choose which methods you want to use? Why/why not? 7. Does the CBD/community midwife explain the side-effects to you? 8. What do you do when you do not want any more children/spacing? 9. Can you tell me what has happened/changed in your life since you have access to FP info and services?
Shared responsibilities such as child caring, household chores, fieldwork	1. What do you think is the main role of women/men in the family? 2. Who do you think should be responsible for taking care of children and house work? Why? 3. What is your hope for your children in the future?

2. For Key informants

- How long have you been working in the Family Planning (FP) programme?
- Can you describe men's involvement in the FP programme?
- What do you think about such initiatives?
- What are the impacts of such initiatives? Is there an increase in men's participation? Can you explain how? Do women/men have increased knowledge about FP?
- How do you approach communities to promote men's involvement in FP? How do you engage both men and women? What are the reactions of the community when you first introduce initiatives which look to include men? What about the specific reactions of men and women?
- Can you describe before and after examples of men's involvement in FP? What has changed so far? Have you seen any changes in men and women's perception and behaviour regarding reproductive health (RH)/FP? What are they?
- What do you think are the barriers to men's involvement in FP? How can we address/improve this?

- (CBD & Midwife) Can you tell me the process of engaging both men and women during the FP counselling/outreach activities? What methods do they prefer? Why? Do you inform them the side-effects?
- Do women come to health center to get FP alone or they come with their husband?
- Can you tell me the opening and closing hours of health center? When (what time) women/men usually come and get the service? Do you speak ethnic language? (This question is trying to understand access; trying to understand if the clinic is only open during times when men or women are traditionally busy)

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Beyond Women's Empowerment: Exploring the Role of Men in Family Planning among the Mangkong Ethnic Group Lao PDR

INFORMATION SHEET
for Ministry of Health Lao PDR

Researcher Introduction My name is Vanly Lorkuangming, I am a Master's student in International Development at Massey University in Palmerston North, New Zealand. I am currently doing a research thesis to fulfil requirement of Master's degree. The focus of my research is to understand women and men's involvement in family planning in Savannakhet province in Laos. Specific district and villages will be decided upon in consultation with relevant officials from the Lao PDR Ministry of Health. My field work will be conducted from 21 May to 14 June.

Project Description and Procedure For my project I will look to interview married couples aged 20-30 years old, who have been involved in family planning for a year. I am interested in understanding what people think about family planning, and how they discuss and make decisions about family size, timing and spacing, as well as which family planning methods they prefer to use. In addition, I would like to interview key informants, as to opinions on strategies which look to involve men in family planning programs.

a). Selection criteria
I am interested in interviewing 10 Mangkong married couples aged 20 – 30 years who have been accessing family planning information and services for at least one year; and key informants such as Government officials, village chiefs, male and female community-based distributors, and male and female community midwives.

b). Research assistant recruitment
My intention is to also hire a female and male assistant to help me translate Lao language to Mangkong language and vice versa. It would be more helpful if they also have knowledge about family planning.

c). Compensation for participation
I will look to compensate for people's time, primary participants and key informants approximately 50,000 LAK/day; Research

assistants/Translator100,000 LAK/day; any District accompanying staff 120,000 LAK/day

d). Data Management

All of the information (data) I gain from interviewing you will be used for research purposes only. The data will be stored as password protected digital file. After the completion of the field research, a summary of the project findings will be made available either in written form or presented orally to those at the village level.

Invitation to Participate

If you are willing to take part in this research, I will conduct an interview with you. Depending on your preference, the interview can be taken place at your home, your work place or elsewhere where you feel comfortable and at any time you are available. The interview may be recorded if you feel comfortable, otherwise there will be just note taking. Pseudonyms will be used to protect your privacy and confidentiality.

Participant's Rights

All participants are under no obligation to accept this invitation. Anyone who decides to participate, has the right to:

- decline to answer any particular question;
- withdraw from the study until one month after the data collection period ends;
- ask any questions about the study at any time during participation;
- provide information on the understanding that their name will not be used – rather a pseudonym will be assigned or generalized reference will be made to roles i.e. health worker; Government official
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview;
- be compensated for their time

Project Contacts

If there are any questions regarding the research project, please do not hesitate to contact:

Miss Vanly Lorkuangming
Institute of Development Studies, Massey University, Palmerston North, New Zealand
[redacted] (New Zealand) or [redacted] (Laos)
E-mail: [redacted]

Alternatively, please contact my supervisor at any point during the study.

Dr. Rochelle Stewart-Withers
Institute of Development Studies, Massey University, Palmerston North, New Zealand +64 6 356 9099 ext. 83657
E-mail: r.r.stewart-withers@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 18/22. If you have any concerns about the conduct of this research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicsouthb@massey.ac.nz

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ຊື່ໂຄງການ: ສຶກສາກ່ຽວກັບການມີສ່ວນຮ່ວມຂອງຜູ້ຊາຍໃນດ້ານການວາງແຜນຄອບຄົວ, ກໍລະນີສຶກສາຊົນເຜົ່າມ້ຽງກອງຢູ່ແຂວງສະຫວັນນະເຂດ ສປປ ລາວ

ໃບແຈ້ງຂໍ້ມູນບົດວິທະຍານິພົນ

ນຳສະເໜີນັກສຶກສາປະລິນໂທ

ຂ້າພະເຈົ້າຊື່ ນາງ ອັນລີ ລໍກວ່າງມີ້ງ, ເປັນນັກສຶກສາປະລິນຍາໂທ ສາຂາການພັດທະນາສາກົນ ຢູ່ທີ່ມະຫາວິທະຍາໄລແມັດຊີ ຢູ່ເມືອງພາເມີສຕັນນອດທ໌ ປະເທດນິວຊີແລນ. ຂ້າພະເຈົ້າກຳລັງດຳເນີນບົດວິທະຍານິພົນ ເພື່ອສຳເລັດການສຶກສາລະດັບປະລິນຍາໂທ. ຫົວຂໍ້ທີ່ຂ້າພະເຈົ້າຂຽນແມ່ນກ່ຽວກັບ ການມີສ່ວນຮ່ວມຂອງຜູ້ຊາຍໃນການສ້າງຄວາມເຂັ້ມແຂງໃຫ້ແກ່ແມ່ຍິງທາງດ້ານການວາງແຜນຄອບຄົວ: ກໍລະນີສຶກສາ ກຸ່ມຊົນເຜົ່າມ້ຽງກອງຢູ່ແຂວງສະຫວັນນະເຂດ, ສປປ ລາວ.

ສະຫຼຸບຫຍໍ້ກ່ຽວກັບບົດວິທະຍານິພົນ

ບົດຂອງຂ້າພະເຈົ້າແມ່ນມີຈຸດປະສົງສຶກສາກ່ຽວກັບການມີສ່ວນຮ່ວມຂອງຜູ້ຊາຍໃນດ້ານການວາງແຜນຄອບຄົວ. ຈ້າພະເຈົ້າຢາກຂໍສຳພາດທ່ານເພື່ອຢາກຮູ້ວ່າທ່ານມີຄວາມຄິດແນວໃດກ່ຽວກັບໂຄງການວາງແຜນຄອບຄົວທີ່ສົ່ງເສີມການມີສ່ວນຮ່ວມຂອງຜູ້ຊາຍ ລວມທັງສິ່ງທ້າທາຍຕ່າງໆໃນການດຳເນີນວຽກງານການມີສ່ວນຮ່ວມຂອງຜູ້ຊາຍໃນດ້ານການວາງແຜນຄອບຄົວ ເປັນຕົ້ນ.

ທ່ານຈະໄດ້ຮັບຄ່າຕອບແທນໃນການເຂົ້າຮ່ວມການສຳພາດ 50,000 ກີບ.

ທຸກໆຂໍ້ມູນທີ່ໄດ້ຈາກການສຳພາດທ່ານແມ່ນຈະຖືກນຳໃຊ້ເຂົ້າໃນບົດວິທະຍານິພົນຂອງຂ້າພະເຈົ້າເທົ່ານັ້ນ. ທຸກຂໍ້ມູນຈະຖືກເກັບໄວ້ບ່ອນທີ່ປອດໄພ. ຫຼັງຈາກສຳເລັດການສຳພາດທັງໝົດແລ້ວ, ຂ້າພະເຈົ້າຈະໃຫ້ບົດສະຫຼຸບຫຍໍ້ຜົນທີ່ໄດ້ຮັບຈາກການສຳພາດ ເປັນເອກະສານ ຫຼື ອະທິບາຍປາກເປົ່າ

ການເຊີນເຂົ້າຮ່ວມການສຳພາດ

ຖ້າຫາກວ່າທ່ານມີຄວາມຍິນດີທີ່ຈະເຂົ້າຮ່ວມຂະບວນການຄົ້ນຄ້ວານີ້, ຂ້າພະເຈົ້າຂໍເຊີນທ່ານເຂົ້າຮ່ວມການສຳພາດ ໃນເວລາ ແລະ ສະຖານທີ່ ທີ່ສະດວກຕໍ່ທ່ານ ຊຶ່ງອາດຈະສຳພາດຢູ່ທີ່ເຮືອນຂອງທ່ານ ຫຼື ບ່ອນເຮັດວຽກຂອງທ່ານ ຫຼື ບ່ອນອື່ນໆ ທີ່ທ່ານເຫັນວ່າສະດວກສະບາຍ. ໃນລະຫວ່າງການສຳພາດ, ຂ້າພະເຈົ້າຈະຂໍອັດສຽງຖ້າຫາກທ່ານເຫັນດີ,

ຖ້າທ່ານບໍ່ເຫັນດີໃຫ້ອັດສຽງ, ຂ້າພະເຈົ້າກໍ່ຈະຈົດໃສ່ປຶ້ມ. ຊື່ຂອງທ່ານຈະຖືກເກັບເປັນຄວາມລັບ ແລະ ນຳໃຊ້ນາມແຝງແທນ.

<u>ສິດທິຂອງຜູ້ເຂົ້າຮ່ວມໃຫ້ສຳພາດ</u>

ທ່ານບໍ່ມີພາລະໃດທັງນັ້ນໃນການຍິນຍອມເຂົ້າຮ່ວມໃຫ້ສຳພາດ. ຖ້າທ່ານຕັດສິນໃຈທີ່ຈະເຂົ້າຮ່ວມ, ທ່ານມີສິດທິດັ່ງລຸ່ມນີ້:

- ປະຕິເສດທີ່ຈະຕອບຄຳຖາມໃດໜຶ່ງ;
- ຖອນໂຕຈາກການສຳພາດ;
- ຖາມຄຳຖາມໄດ້ທຸກຄຳຖາມກ່ຽວກັບບົດຄົ້ນຄ້ວານີ້;
- ຮັບຮູ້ວ່າຊື່ຂອງທ່ານຈະນຳໃຊ້ໃນບົດໄດ້ຖ້າຫາກທ່ານຍິນຍອມໃຫ້ຂ້າພະເຈົ້ານຳໃຊ້, ຊື່ຂອງທ່ານແມ່ນຈະໃຊ້ນາມແຝງແທນ
- ເຂົ້າເຖິງບົດສະຫຼຸບການສຳພາດ ຫຼັງຈາກທີ່ສຳເລັດການສຳພາດ
- ຂໍໃຫ້ປິດເຄື່ອງບັນທຶກສຽງໄດ້ທຸກເວລາລະຫວ່າງການສຳພາດ
- ໄດ້ຮັບຄ່າຕອບແທນ

<u>ຜູ້ຕິດຕໍ່ບົດວິທະຍານິພົນ</u>

ຖ້າທ່ານມີຄຳຖາມກ່ຽວກັບບົດວິທະຍານິພົນ ຫຼື ຂະບວນດານຄົ້ນຄ້ວານີ້ ກະລຸນາຕິດຕໍ່

ນາງ ວັນລີ ລ່ກວ່າງມີ

Institute of Development Studies, Massey University, Palmerston North, New Zealand

ທີ [redacted] (ປະເທດ ນິວຊີແລນ) or [redacted] (ປະເທດລາວ)

ຫຼືອີເມວ: [redacted]

ຫຼືຕິດຕໍ່ອາຈານທີ່ປຶກສາຂອງຂ້ອຍໄດ້ທີ່:

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ຫຼື ຕິດຕໍ່

ທ່ານ ສົມເດດ, ຫົວໜ້າສຸກສາລາເຂດດົງນາສານ ເມືອງນອງ, ແຂວງສະຫວັນນະເຂດ
ໂທ: +85620 91784150

ໂຄງການສຶກສາສະບັບເລກທີ *18/22* ນີ້ໄດ້ຜ່ານການທົບທວນ ແລະ ຮັບຮອງໂດຍຄະນະກຳມະການເລື່ອງຈັນຍາບັນໃນການເຮັດບົດຄົ້ນຄ້ວາ *Southern A* ຂອງມະຫາວິທະຍາໄລແມັດຊີ ປະເທດນິວຊີແລນ. ຖ້າທ່ານມີຄຳຖາມເພີ່ມເຕີມກະລຸນາຕິດຕໍ່ຄະນະກຳມະການເລື່ອງຈັນຍາບັນໃນການເຮັດບົດຄົ້ນຄ້ວາ *Southern B*, ທ່ານ ດຣ ໂຣແຊ ສຕີເວີດ ໄດ້ທີ່ *06 356 9099 x 83657*, ຫຼື *humanethicsouthb@massey.ac.nz*

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Beyond Women's Empowerment: Exploring the Role of Men in Family Planning among the Mangkong Ethnic Group in Lao PDR

CONFIDENTIALITY AGREEMENT

I ..... (Full Name - printed) agree to keep confidential all information concerning the project on an investigation into Mangkong women and men's involvement in family planning in Savannakhet province, Lao PDR.

I will not retain, disclose or copy any information involving the project.

Signature: ..... **Date:** .....

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

ຊື່ໂຄງການ: ສຶກສາກ່ຽວກັບການມີສ່ວນຮ່ວມຂອງຜູ້ຊາຍໃນດ້ານການວາງແຜນຄອບຄົວ, ກໍລະນີສຶກສາຊົນເຜົ່າມັ່ງກອງຢູ່ແຂວງສະຫວັນນະເຂດ ສປປ ລາວ

ຂໍ້ຕົກລົງການຮັກສາຄວາມລັບ
CONFIDENTIALITY AGREEMENT

ຂ້າພະເຈົ້າ (ຊື່ ແລະ ນາມສະກຸນ).....

ຕົກລົງເຫັນດີຮັກສາທຸກຂໍ້ມູນກ່ຽວກັບໂຄງການສຶກສາກ່ຽວກັບການມີສ່ວນຮ່ວມຂອງຜູ້ຊາຍໃນດ້ານການວາງແຜນຄອບຄົວ ກໍລະນີສຶກສາຊົນເຜົ່າມັ່ງກອງຢູ່ແຂວງສະຫວັນນະເຂດ ໃຫ້ເປັນຄວາມລັບ.

I agree to keep confidential all information concerning the project: an investigation into Mangkong women and men's involvement in family planning in Savannakhet province, Lao PDR.

ຂ້າພະເຈົ້າຈະບໍ່ເປີດເຜີຍຂໍ້ມູນ ແລະ ຈະບໍ່ເກັບຂໍ້ມູນທີ່ກ່ຽວກັບໂຄງການດັ່ງກ່າວນີ້ໄວ້.

I will not retain, disclose or copy any information involving the project.

ລາຍເຊັນ: ..... **ວັນທີ:** .....
Signature **Date**