ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND YOUTH FRIENDLY HEALTH SERVICES AMONG YOUNG RURAL PEOPLE IN KHAMMOUANE PROVINCE, LAO PDR

NATIONAL REPORT

ACCESS TO SEXUAL AND REPRODUCTIVE SERVICES AND YOUTH FRIENDLY SERVICES AMONG YOUNG RURAL PEOPLE IN KHAMMOUANE PROVINCE, LAO PDR

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### List of Acronyms

<table>
<thead>
<tr>
<th>Items</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual Reproductive Health</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of South East Asian Nation</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Office</td>
</tr>
<tr>
<td>PHD</td>
<td>Provincial Health Department</td>
</tr>
<tr>
<td>DK</td>
<td>Don’t know</td>
</tr>
<tr>
<td>DS</td>
<td>Disagree</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FGDB</td>
<td>Focus Group Discussion Boy</td>
</tr>
<tr>
<td>FGDG</td>
<td>Focus Group Discussion Girl</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GGHE</td>
<td>General Government Health Expenditure</td>
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<tr>
<td>HC</td>
<td>Health Center</td>
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<tr>
<td>HCP</td>
<td>Health Care Provider</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICPD</td>
<td>International Conference Population Development</td>
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<tr>
<td>IDI</td>
<td>In-depth interview</td>
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<td>INGOs</td>
<td>International Non-Governmental Organizations</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>KNCHR</td>
<td>Kenya National Commission on Human Rights</td>
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<tr>
<td>Lao PDR</td>
<td>Lao People’s Democratic Republic</td>
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<tr>
<td>LSIS</td>
<td>Lao Social Indicator Survey</td>
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<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOES</td>
<td>Ministry of Education &amp; Sports</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality rate</td>
</tr>
<tr>
<td>NAYFS</td>
<td>National Adolescent and Youth Friendly Services</td>
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<tr>
<td>PNC</td>
<td>Postnatal Care</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>SRH</td>
<td>Sexual &amp; Reproductive Health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual &amp; Reproductive Health &amp; Right</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexual Transmitted Infections</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate (TFR)</td>
</tr>
<tr>
<td>THE</td>
<td>Total Health Expenditure</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>VHV</td>
<td>Village Health Volunteer</td>
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<tr>
<td>VL</td>
<td>Village Leader</td>
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<tr>
<td>YFHS</td>
<td>Youth Friendly Health Services</td>
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</table>
Executive Summary

Introduction
For many youth around the world, and especially unmarried young women and those marginalized by ethnicity or other markers of inequality, the right to reproductive health remains elusive. The objective of this study was to examine the access youth from ethnic minority populations have to basic sexual and reproductive health services. The study also sought to understand their perceptions and those of key community members of the characteristics of youth friendly health services (YFHS) for young marginalized people in the Lao PDR.

Methods
This was an exploratory, qualitative study undertaken in two districts of Khammouane province, in central Lao PDR. We undertook focus group discussions (N = 8), and in-depth interviews (N = 8) with young people from minority backgrounds aged 15-24 years. We selected this population because of their multiple markers of disadvantage (e.g. ethnicity, health literacy, low socio-economic status and remote location). In addition to interviews with young people, we conducted interviews with 8 health care providers and 32 community leaders (8 villager leaders, 8 village health volunteers, 8 parents and 8 teachers). All data was collected between 29 June to 10 July 2018. Data analysis was performed by using the inductive approach.

Results
The study revealed early sexual debut and marriage with early marriage often the result of unplanned pregnancy. While having some understanding of contraception, the young people included in this study were often unaware and uninformed about other reproductive health issues and most did not recognize the health and social risks associated with early marriage, early pregnancy and childbirth, and STIs. Incomplete understanding among community members was also evident, which, alongside taboos around discussing pre-marital sex, act as barriers to promoting sexual and reproductive health for unmarried minority youth. Individual, socio-cultural and service provider factors were factors affecting minority youth access to SRH services. These factors included cultural beliefs and restrictions imposed by parents and community; shyness and fear of parents. Differences were observed between married and unmarried young people with married young people having much better access to services than unmarried young people. Furthermore, while married young people felt comfortable using public services, unmarried young people relied mainly on private pharmacies and self-treatment.

Most of youth and the key informants were unaware of the concept of YFHS. The main characteristics of YFHS proposed by participants were convenient location and operating hours, able to maintain privacy and confidentiality, affordable and with specially trained staff supported by national guidelines, and a hotline for young people.

Conclusion
The types of SRH services available to male and female minority youth were limited to contraception, mainly condoms, pills, and injectable contraception. Access to SRH services by the male and female youth can be improved through community awareness, providing sexual and reproductive health education, use of media, building youth-friendly centres. Youth-friendly centres or clinics should aim to bring SRH services close to adolescents/youth. The government and other stakeholders should also hold community awareness and sensitization programmes on benefits of SRH services to pave the way for cultural
acceptance and use of services by male and female youth. Health care providers at health centres should be responsible of all activities regarding adolescent/youth reproductive health in each health centres catchment area including schools, community and at the health facilities. Selected health care providers at the provincial and district hospitals, health centres could be trained to offer the minimum package with special emphasis on non-verbal communication skills, active listening, and the ability to deal with sensitive topics. Failure to improve access to young people will not only affect their overall health, but also their education, employment and economic prospects.
1. Overview of the ICPD in Lao PDR

The Programme of Action put human rights at the centre of development and called for a comprehensive approach to sexual and reproductive health and reproductive rights, recognizing that sexual and reproductive health services and programmes must be guided by the needs of, and must protect the human rights of individuals, especially women and girls. All government, including Lao PDR agreed that reproductive rights, gender equality, equity and women’s empowerment are essential for improving quality of life and achieving sustained social and economic growth and sustainable development. The government of the Lao PDR puts considerable efforts to encourage, promote and protect the legitimate rights and interests of Lao women in all fields: political, economic, social, cultural and family as provided for in the policy of the government, the Constitution and laws.¹

Table 1 summarizes the key indicators for ICPD+25 key themes and indicators for the Lao PDR. Despite the government’s commitment to continuing to improve the health of the population, including SRH, general government health expenditure (GGHE) as a percentage of GDP is among the lowest in the Western Pacific Region, especially from domestic sources. Total health expenditure (THE) as a share of GDP increased however, from 4.4% in 2010-2011 to 5.9% in 2015-2016. The government has set national target of 9%, using a definition of GGHE that includes “technical revenue” (user fee revenue). If technical revenue is included, GGHE increased from 4.7% in 2010-2011 to 7.6% in 2015-2016.²

Lao PDR has made substantial progress in improving its reproductive, maternal, newborn and child health (RMNCH) outcomes and service coverage over the last decade, but clear challenges remain. Based on the Lao Social Indicator Survey II (LSIS II), the average total fertility rate (TFR) for Lao PDR was 2.7 in 2018.³ Contraceptive Prevalence Rates (CPR) is both an indicator of access to contraception and reproductive health services in general. Contraceptive prevalence rate in Lao PDR is (54.1%), with the met need for contraception high (71.7%).⁴ While the method mix is expanding, implants were only introduced in 2014, and there is a need to increase awareness and availability of modern contraceptive methods, particularly long-term and permanent methods.

The adolescent birth rate has declined from 91 to 83 per 100,000 girls aged 15-19 years old, the adolescent birth rate is still high among the ethnic and rural population (110 & 115 per 100,000 girls aged 15-19 years old respectively) and suggests a lack of access to appropriate services. The MMR had declined to 206 per 100,000 livebirths in 2016⁵, however, it remain relatively high amongst rural women and those in the lower income and educational groups. The current study focused on adolescents’ access to youth friendly health services (YFHS) in rural areas of Khammouane province, Lao PDR.

As Lao PDR has only the National Reproductive Health policy which revised in 2016 and approved the revised version of the policy. In 2016, the MOH launched the National Strategy and Action Plan for Integrated services on Reproductive, Maternal, Newborn and Child Health from 2016-2025 which built on the experience gained from the implementation of the Strategy and Planning Framework for the Integrated Package of MNCH Services 2009-2015, which has been reviewed through an evaluation process that took place end of 2014 and early 2015. The Strategy addresses the critical reproductive, maternal, newborn and child health needs and rights of the Lao people through the continuum of care perspective. However to assist the implementation both at national and subnational level, the Strategy identified 11 clearly defined specific objectives, including health system areas such as health financing, health information, human resources and drug/equipment that are directly linked to RMNCH activities.
## Table 1: Key Indicators of Focus for the introduction chapter

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>L Social Indicator Survey II (LSIS II)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Population, Men women, young people % of population (Population Housing Census, 2015)</td>
<td>6,492,000&lt;br&gt;3,255,000 (3,237,000)&lt;br&gt;31.9%</td>
</tr>
<tr>
<td>2 Government Expenditure on Health in 2015</td>
<td>5.9%</td>
</tr>
<tr>
<td>3 Legislation and policies on Gender Equality</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Extent of Gender-based Violence</td>
<td>Yes</td>
</tr>
<tr>
<td>6 Legislation and Policies on Sexual Orientation</td>
<td>No</td>
</tr>
<tr>
<td>7 Legislation and Policies on Gender Identities</td>
<td>No</td>
</tr>
<tr>
<td>8 Policies on Sexual and Reproductive Health</td>
<td>Yes</td>
</tr>
<tr>
<td>9 Policy on Adolescent Sexual and Reproductive Health Services</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>National Reproductive Health Policy</td>
</tr>
<tr>
<td>10 Total Fertility Rate (TFR)</td>
<td>2.7</td>
</tr>
<tr>
<td>11 Contraception Prevalence Rate (CPR)</td>
<td>54.1%</td>
</tr>
<tr>
<td>12 Proportion of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods</td>
<td>71.7%</td>
</tr>
<tr>
<td>13 Adolescent Birth Rate</td>
<td>83 per 1000 girls aged 15-19 yrs</td>
</tr>
<tr>
<td>14 Availability and Range of Adolescent Sexual and Reproductive Health Services</td>
<td>Partial</td>
</tr>
<tr>
<td>15 Grounds under which Abortion Is Legal</td>
<td>No</td>
</tr>
<tr>
<td>16 Maternal Mortality Ratio in 2015</td>
<td>206</td>
</tr>
<tr>
<td>17 Proportion of Births Attended by Skilled Birth Attendants</td>
<td>64.4%</td>
</tr>
<tr>
<td>18 Availability of Basic Emergency Obstetric Care and Comprehensive Emergency Obstetric Care</td>
<td>1 per 500,000 population</td>
</tr>
<tr>
<td>19 Coverage of Postpartum / Postnatal Care within 48 Hours of Delivery by a Skilled Health Provider</td>
<td>72.4%</td>
</tr>
<tr>
<td>20 Youth Friendly services</td>
<td>Not implemented throughout the country yet.&lt;br&gt;Just started training 35 Master trainers of YFS and develop the National guideline of YFS.</td>
</tr>
</tbody>
</table>
2. Introduction/ Project Background

Lao PDR is a landlocked country situated in South-East Asia with an ethnically diverse population (49 distinct ethnic groups with 36.3% are Lao-Tai ethnicity). Formally a lower-income country, in 2011, Lao PDR moved to a ‘lower-middle income economy suggesting the country “is on track to achieve its long-term vision: to graduate from the Least Developed Country status by 2020.” Despite the high economic growth rate, mainly due to the country’s rich natural resources, 23% of the population continues to live below the national poverty line 2015. Furthermore, despite increasing rural-to-urban migration, 68% of the population remains in rural areas.

Consistent with its rapid economic growth, the Lao PDR is also undergoing a rapid demographic transition, characterized by a large youthful population, with 60% of its over 6,492,000 inhabitants estimated to be under 25 years of age. To maximize this “demographic dividend” increased investments in human capital, particularly in the areas of education, health, employment, protection and participation are needed to ensure that every young person’s potential is fulfilled. Within this context, further research is warranted to understand the needs of young people and to make sure no young people are left behind due to ethnicity, location, or gender.

While the Lao PDR achieved its Millennium Development Goal (MDG) target for reducing the maternal mortality rate (MMR), disparities are apparent with data suggesting rural women, and more specifically, women of minority ethnicity, are particularly disadvantaged. Early sexual debut and pregnancy, especially among rural and ethnic minority communities remains common, due socio-cultural norms and lack of access to culturally responsive sexual, reproductive and maternal healthcare services. Within the context of a country progressing to a modern economy, this is of particular concern as early age at sexual debut and early pregnancy are associated not only with higher maternal and child morbidity and mortality but also early school dropout and reduced employment options which in turn, can exacerbate existing disparities. Furthermore, while women are mainly responsible for household tasks, their voices are often excluded from local and national decision-making processes. For young women, especially those who are unmarried, they may find it particularly hard to exercise their rights including in decisions about their sexual and reproductive health. This lack of real or perceived negotiating power over sexual health can lead early sexual debut, pregnancy and sexually transmitted infections further exacerbated by a lack of access to age-appropriate and culturally responsive services.

Adolescents, and particularly female adolescents’, lack of negotiating power over their sexual and reproductive rights are both due to, and feeds into, other inequalities. Early pregnancy for example, can have deleterious impacts on education, employment and economic prospects. While available evidence is scant, in Lao PDR, available evidence, suggests unmarried adolescents and those marginalized by ethnicity or other markers of inequality, are often unable to exercise their sexual and reproductive rights. Barriers to achieving sexual rights are multi-faceted but include lack of physical access to appropriate services, socio-cultural norms around sexuality, level of education, language and discomfort in discussing sexual health with health professionals. Improving access to youth friendly SRH services is important for all young people but of particular concern for those who are already marginalized. In this study we sought to understand:

- What is the current access to SRH services among young marginalized people?
- What are the characteristics of youth friendly SRH services as described by young marginalized youth?
- What factors affect the capacity of facility-based YFHS to promote SRH among unmarried adolescents and other marginalized youth? How should YFHS be operationalized in Lao PDR?
3. Methodology

Most of the research conducted to date with minority adolescents on access to SRH has been undertaken in the highlands in northern Lao PDR.\textsuperscript{16,17} This study was therefore conducted in the lowlands of Khammouane province with participants three main ethnic groups in the province account for 94\% of the population: Lao (69\%), Phouthai (12\%) and Makong (13\%), the remaining 6\% belong to a diversity of ethnicities.\textsuperscript{18} Khammouane Province has significant lowland plains and plateaus area (78\%) as well as forested uplands (17\%) and a floodplain (5\%). In Khammouane province, there is one provincial hospital and 10 district hospitals and 90 health centers and some private clinics and drugstores. Contraception is available at drugstores, private clinics and public health facilities. Khammouane province was chosen in terms of their rural (70\% of the people live in the rural areas), the ethnicity of the Lao PDR, the focal site for the expansion of the SRHR and YFS. The poverty head rate account for the province is 27\% of the population living below the poverty line.\textsuperscript{19} Mahaxay and Xaybouathong were selected as these districts composed of different ethnicity, middle to poor district, and having access road to the village. At the provincial and district level, available SRH services are antenatal care (ANC), delivery, postnatal care (PNC), family planning and post-abortion care with STI testing and treatment are available in the provincial hospital.\textsuperscript{20} ANC and PNC are also available at the health center level.

This was an exploratory, qualitative study that used focus group discussions (FGDs), and in-depth interviews with young people from minority backgrounds aged 15-24 years and residing in Mahaxay and Xaybouathong districts in Khammouane province. The study population included unmarried youth living in the study areas, unmarried youth visiting clinics for SRH services, community elders (community leaders, parents/grand-parents) and health care service providers. The inclusion criteria were: unmarried ethnic youth and community members living within five kilometers radius from the sampled health facilities and resident in the study areas for at least the past six months. The catchment area radius of the sampling frame was based on the health facility catchment area map obtained from the district health office.

We conducted 8 FGDs using a question guide which included socio-demographic information, SRH problems among young ethnic people, young people’s awareness of facilities offering SRH services, factors determining seeking SRH services, barriers in accessing SRH services, perception of YFHS and what would constitute YFHS and their quality and factors affecting to accessibility to YF services. In total, 4 male ethnic youth aged 15-24 years old and 4 female ethnic youth aged 15-24 years old FGDs were conducted.

Other key informants were interviewed including health care staff providing SRH services to young people in the local areas. In addition, we interviewed health care providers at the province, and district levels about the barriers in accessing SRH information and services among ethnic young people, their needs of skills and knowledge to provide YFHS, attitudes of the health service providers towards provision of SRH. Community leaders such as head villagers, teachers and parents were also interviewed to get their opinions on SRH problems, factors influencing youth using adolescent SRH services, community attitudes towards provision of adolescent sexual reproductive health (ASRH) services, potential role of the community in promoting SRH, characteristics of youth friendly sexual and reproductive health services, and how to initiate YFS. In total, 8 health staff, 8 villager leaders, 8 village health volunteers, 8 parents and 8 teachers.

Interviews and FGDs were conducted in places convenient for participants and where privacy was likely to be maintained. Interviews and FGDs were audio-recorded using a digital recorder.
Permission was sought from parents/guardians and/or teachers for all participants below the age of 18 years. Individual participants were assured of their freedom to participate and to drop out of the study at any time without any consequence. Information gathered from participants was handled confidentially and the whole research process adhered to the principle of anonymity by redacting personal identifiable information of the participants on the questionnaires, interviews and FGD transcripts. Approval was also sought from relevant municipal authorities and all logistic arrangements for the study made in close consultation with relevant authorities.

Data were manually coded using a mainly inductive approach. Key issues, concepts and themes were identified a priori based on the literature but were not restrictive so as to prevent other themes emerging as we read and re-read the transcripts focusing on meaning. Throughout the analytic process, we moved back and forth between the entire data set, coding extracts and discussing and resolving any issues that arose as well as checking field notes for clarification.

The data were manually coded using a mix of deductive and inductive approaches. Key issues, concepts and themes were identified a priori based on the literature but were not restrictive so as to prevent other themes emerging as we read and re-read the transcripts focusing on meaning. Throughout the analytic process, we moved back and forth between the entire data set, coding extracts and discussing and resolving any issues that arose as well as checking field notes for clarification.

Ethical approval, including for interviews and FGD protocols was obtained from the ethical committee of the University of Health Sciences, Lao PDR. All study participants were informed about the purpose of the study before enrolment into the study. Participants were assured of privacy and confidentiality and informed participation was voluntary and they could withdraw from interview anytime without notice or without consequences. Due to low levels of literacy, witnessed verbal consent was obtained, with the permission of the ethical committee.

**Advocacy impact**

The impact of advocacy of this research is raising awareness among stakeholders of ethnic minority youth’s access to SRH services and information needs of this often neglected population; putting SRH onto key decision-makers’ agenda prioritizing the issue as an important public health issue and necessity in improving SRH indicators and the Sustainable Development Goals (SDG) goals of leaving no one behind. Ultimately the project aims to improve young people’s access to youth friendly SRH services in Lao PDR. The information generated can help the government and other stakeholders in developing strategies and policies that will enable improvement of access to SRH services by adolescents and in particular those that are at risk of being left behind. The information generated may also be used by NGOs and other relevant organizations to initiate projects aimed at enabling the adolescent girls to access SRH services.

We will disseminate the preliminary findings to the stakeholders in Lao PDR such as the health care providers, Department of Hygiene and Health promotion, Department of Curative (Ministry of Health), INGOs working with adolescents, WHO, UNFPA, UNAIDS, Ministry of Education and Sports, including teachers and key stakeholders from Lao Women Union and Lao Youth Union by organizing the meeting and workshops. The advocacy impact with the national report will impact on:

1. Asia Pacific Population Conference Mid Term Review
2. ICPD+25 review in 2019
3. National MCH Meeting
4. National Advocacy brief
4. Findings

Socio-demographic Characteristics

In total, we undertook 40 in-depth interviews: 8 youths, 8 village health volunteers (VHV), 8 head villagers, 8 parents, 8 health care providers, and 8 teachers. Three fourths of youth were in the age group 15-19 years with a few in the age group of 20-24 years. One third had finished primary school and the majority of them were single.

All head villagers were male and in addition to being village head, worked as farmers. One third of village heads had primary school level of education and were married. Half of VHV had primary level of education, and seven were male. Half of teachers were female and five had a university degree. Most of health care providers are in the age group 25-49 years and half of them are male. Majority of them are married and one third of them are Makong ethnicity. Most health staffs were mainly working at the health center and two health staff working at district health offices (Table 2).

Table 2: Socio-demographic characteristic of the interviewed key informants

<table>
<thead>
<tr>
<th>Types of Key informants</th>
<th>Adolescent girls</th>
<th>Adolescent boys</th>
<th>Village Health Volunteer</th>
<th>Head villager</th>
<th>Parents</th>
<th>HCP</th>
<th>Teacher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
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<td>15-19</td>
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<td>25-49</td>
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In total, four male FGDs and four female FGDs were conducted with two male and two female FGDs conducted in each district.

### Table 3: Characteristic of FGDs

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Perceived SRH problems

**Menstruation, early pregnancy and abortion**

According to both FGD and IDI participants, first sexual intercourse usually occurs at around 15 years with early marriage being common. Early marriage was often due to unplanned pregnancy as a result of non-use of condoms or other forms of contraception leading to pregnancy. While most participants were not aware of risks other than unplanned pregnancy, some participants noted teen pregnancy could lead to complications both in the pregnancy as well as in the relationship between the couple.

“I think in our village, girls get married quite young, at around 14-16 years. Some of them have complications during pregnancy because of young maternal age. The newborn of my friend died after delivery as the abdominal wall of the newborn was open. The doctor explained to my friend because she had teen pregnancy.” (FGDG1)

“In our village, adolescents get married around at 15-18 years old. Some of them just have basic ceremony and live together for a year before a divorce. Some of them have unwanted pregnancy and abortion. I know two cases in last years and one of them had to stay in the hospital for a week because of bleeding.” (FGDG4)

Several participants mentioned were young people became pregnant and when marriage was not perceived to be an option, women may purchase and self-administer medical abortion pills from a local pharmacy:

“Three years ago, I had an unintended pregnancy with my boyfriend. We were in relationship for a couple of months when we started having sex. After about 4 months I got pregnant. I was concerned about my menstruation did not come for 2
to 3 months, I told to my boyfriend and he said that maybe I was pregnant. After that I asked my friend and she suggested me go to drugstore to purchase pregnancy test. I tested and it was positive. I told my boyfriend first, and he said that he was not sure that it was his baby; he would like me to terminate pregnancy by taking abortion drug (Chinese medicine) from drugstore but I didn’t want to.” (Girl, 20 years, single)

“In my case I got an unintended pregnancy when I was 16 years old. I married when I was 15 years old; after living together for a year my husband had another girl and he want to leave me and I agreed with him. I cannot stand his aggressive behavior. After my divorce 2 weeks after, I knew that I was pregnant and I don’t want to continue my pregnancy and I came to get advised from my sister. She suggested me to take Chinese pill from drugstore in district. I take for 3 days and I got a little bit bleeding just for 3 to 4 days and then my pregnancy terminated. I don’t know many adolescents facing in the same situation with me or not. However, as I know many couples after living together for 1 to 2 years, we have divorce and women have an abortion because they don’t want to continue with the pregnancy after divorce because women have no money to feeding baby.” (FGDG2)

Male youth and some teachers also mentioned being aware of medical abortion pills being readily available from local pharmacies in the case of unwanted pregnancies. While sometimes concerned about a partner falling pregnant, in the male FGDs participants were less concerned of STIs as they felt their girlfriends were faithful to them and recognised if their girlfriend was pregnant they would be expected to marry the girl:

“There is no need to use contraception if having sex with my girlfriend because my girlfriend only has sex with me. No need to be afraid of anything. (What if your girlfriends got pregnant?) If our girlfriends got pregnant, we, as men, have to be responsible for that. If the parents know it, we will be fined or just marry her. In the case they don’t know and not pregnant, just let it flows.” (FGDB2)

Some teachers mentioned being concerned about STIs and some young people mentioned they had experienced STIs. Some female youth also reported menstruation problems and cramps during menstruation.

“I usually have vaginal discharge near my period but I never go to hospital for testing because I think that is a normal problem for every women near their period. Sometimes I feel pain in lower abdominal, I just boiled and drink herbal medicine from my mother.” (FGDG4)

Factors affecting young people taking preventive measures and using SRH services

Individual factors
There were several reasons that stopped youth from taking preventive measures to avoid STIs, HIV/AIDS and unintended pregnancy as discussed below.

Awareness of contraception
Most youth participants said they lacked knowledge of prevention of unwanted pregnancy and STIs or were very trusting of their male partners.

“Many unmarried adolescents are not aware of or are negligent about pregnancy prevention. Many adolescent girls trust their partner has no transmitted diseases or in case of getting pregnant their partner will be responsible. They are not aware of the consequences of unwanted pregnancy or transmitted diseases, just would like to have fun sex without prevention methods.” (Girl, 20 years, unmarried)
While a few participants said youth did not know about contraceptive methods, most asserted that most young people had some knowledge, mostly garnered from their friend or siblings. The most commonly cited contraception methods were condoms, oral pills and injection.

“I used injection because I heard information from my sister that it can prevent pregnancy and just have it every 3 months. I used from drugstore in district, 25.000 kip per time; the price was not expensive and I can pay.” (FGDG4)

Males were said to prefer not use condoms because it is not ‘natural’. As one explained:

“No men in our village use condoms. Men here don’t use condoms. It is not natural. The health staff provided family planning or birth spacing and condom was also introduced but family planning is the responsibility of the women.” (VHV1)

There was virtually no awareness or understanding of the different reproductive health problems of youth among village leaders. Many village leaders said, “Youth don’t have any health problems as they are quite healthy.” One villager also mentioned “Youth health problems are not discussed during the village meeting and during the outreach mobile team from the health centre. They just discuss vaccination of children under 2 years and maternal health.”

**Access to SRH information & services**

Most youth participants said they had limited access to SRH information and services.

“When I was an adolescent, I never know about where I could access contraception or get advice; I didn’t receive any information about contraception, treatments of post abortion or even consultation.” (Girl, 20 years, married)

Some participants however, said they received SRH information from health staff, friends and siblings. Most youth who reported using a contraceptive method, said they purchased it from private drug stores and clinics, as they felt ashamed and embarrassed about going to the public health care facility or found the public health services unwelcoming.

“I use the contraceptive pill from the drugstore, my boyfriend gave money to me to buy the pill. We don’t want to go to the health centre or district hospital because we do not feel comfortable, we feel that services provider do not welcome unmarried adolescents there.” (FGDG3)

**Marital status**

Being unmarried was a key barrier for youth using public health facilities:

“In case of married youth, this is not difficult to access to SRH services because they welcome all married women, but if you are not married yet, provider will ask about your personal status, ask many questions that are not related to health problem and some providers are angry if unmarried girl come to get the contraception method. As well as if you got unwanted pregnancy and you have induce abortion, provider don’t want to provide services and they blame adolescents and youth.” (FGDG4)

“I just accidentally used to talk with a female nurse about the birth control pills, she was from the health centre, like a joke “can I take a contraception, as I am a man?” And she said “Impossible, if you get a wife you can take her to see me for getting the birth control pills”. (FGDB1)
While married young people were provided advice on family planning and SRH when getting their children vaccinated during community outreach campaigns. Community outreach and education on SRH was not readily available to unmarried young people.

**Shyness**
Shyness and fear of disclosure to the community and parents was also an important barrier in youth and adolescents using public SRH services, even where they lived close to services.

“Shyness is a big problem that make adolescent cannot access to SRH service in public facilities. If they are ashamed to access to the service, when facing the SRH problem they cannot find the good way to solve their SRH problem. Moreover, they try to use the pharmacies to get drugs for self-treatment of STIs or unwanted pregnancy without supervision of a health provider.” (HCP, 35 years)

**Cultural factors**
Community attitudes towards using SRH services

Community attitudes towards premarital sex norms about discussing sexual issues are also a hindrance factor for youth to use SRH services. As one person, reflecting a view of several of the participants noted:

“In Lao culture, it is not accepted to have sex before marriage. Therefore, use of family planning services for unmarried women, including youth, is leading with stigma.” (HCP, 45 years)

“Based on our culture aspect that adolescents did not allowed having sex before marriage. If we promote FP or SRH services to unmarried adolescents community might be a little bit angry to us. When we promote contraception to unmarried adolescents/youth, the community perceived that this seemed to promote them to have sex.” (HCP, 28 years)

**Support from partners**
Some participants suggested support from their male partners was an important factor in using condoms or other contraception methods.

“For me, the factor could help me adopt contraception is support from my boyfriend. I think all of unmarried women if man supports them to use preventive measures from SRH problems women also welcome to use.” (Girl, 18 years)

**Service Provider Factors**
Availability of SRH information and services for young people

The SRH services available at the province and district include ANC, delivery, PNC, family planning, post-abortion care; however, family planning, delivery, ANC and PNC are also available in HC. Post abortion and STI treatment care are available in district hospital. STI testing and treatment are available in the provincial hospital.

Most of the services for SRH are viewed by both community members, including youth and the health services themselves, as being for married youth. For example, at the village level, the village health volunteer (VHV) was cited as the source of SRH information, but they provide SRH education to married couples only. While some providers agreed unmarried youth could access SRH services, they also admitted it was difficult and they had limited experience or training in how to treat unmarried youth:
"Regarding to my working for 5 years in this HC, I have not seen unmarried adolescent come to use the services yet. No case of unmarried adolescents. We have no experience of SRH services to adolescents, we have adolescent from 15 to 19 years old come to use contraception method but all of them were married." (HCP, 40 yrs)

**Attitudes of providers towards providing SRH services**

Attitudes of providers towards providing SRH services are an important characteristic of SRH services for youth to use or not use SRH services. The youth participants were afraid that the providers would not provide them contraception and blame them, or be angry with them, so unmarried youth often lied to the providers, telling them that they were married.

"Every time I went to district hospital with my boyfriend, we told to district providers that we are married and we would like to use injection prevent pregnancy. If I said I am unmarried, provider might not sell injection for me. The district hospital and health center asked clients about personal information and married status. They don’t want to sell contraception for unmarried adolescents; moreover, they might blame us and will gossip us to community." (Girl, 18 years)

Friendly attitudes of providers, keeping their confidentiality and anonymous were issues raised by participants that would support them in using public health facilities. Some youth mentioned that providers asked them a lot of questions, making them feel embarrassed or ashamed.

"There should have services provider phone number or hotline service to give personal advise or SRH information specifically for adolescent and do not ask about personal information that not related to their problem." (FGDG3)

"Youth feel not included in the service and not privacy for them. Provider also asked many questions that make adolescent feel a shame to go there." (FGDG4)

"Another thing to support me is easy access to drugstore, the provider in the drugstore not ask unnecessary question such as name, married status, why do you want to buy the method; they just sell to us and give an advises if we would like to know more information. I feel comfortable, easy access in drugstore. If you are in the young age and not married yet, provider did not allow you to use preventive measure; they will tell to your community and make adolescent a shame. Providers just promote contraception to married women." (Girl, 18 years, unmarried)

Many health staff said they felt they could not provide SRH services to unmarried young people due to concern within the broader and negative community attitudes towards SRH of unmarried youth.

"We cannot provide contraception to them because they are not married yet, we are concerned that if their parents know they receive contraception from our HC they will blame us. For STIs or post abortion care, also have no unmarried adolescent come to use the services before. But in this case, we can refer to district hospital because we have no material and drug to treat them." (HCP, 30 years)

Some health care providers however held more positive attitudes towards unmarried youth suggesting that healthcare providers should be more welcoming towards unmarried youth and maintain confidentiality. One person also said there should be some youth specific campaigns including peer-to-peer education as currently there are no youth specific services and most facilities do not have spaces dedicated to youth.

In increasing access to SRH services for youth, the importance of educating community
members and families was however also mentioned critical first step in making them more open to FP promotion for youth.

“If we want to have collaboration from community to promoting SRH services to unmarried adolescent, we need to have advocate the SRH to them first and then advocating the role of community about promoting youth access to SRH information and services. The promoters should be the empower person to make easy understanding and collaboration from community.” (HCP, 28 years)

Most of the youth and other key informants had not heard about YFS. Some providers were only aware of adolescent SRH in the MCH strategy.

“I think providers should have positive attitude and welcome youth to using the services. YFS should locate within the health care facility because HC available in many communities in rural area.” (Girl, 20 years)

“I have no idea about YFS because I never heard about YFS guideline before. Just heard from MCH district department that MOH have SRH strategy to improve access of SRH to adolescents, they distribute this strategy to MCH staff in every HC. But I didn't exactly remember the detail of strategy.” (HCP, 40 years)

Characteristics of YFHS services

Location of YF Centre

Convenient location of services is an important characteristic of YFHS. Most youth, community leaders, and VHV also suggested that the location should be at the community level where youth could easily access them. For young people a downside of this, could be that their parents and other community members could easily see them using the services.

“Location of services is also barrier because if provide the service for youth at the same place that provide for general, of cause youth not go there because of crowded, waiting for long and many people know them and family.” (FGDG2)

“Well, it should be located near the village where the youth easily access, but separate for male and female, or share the same area but separate rooms, and also have the phone number to contact specifically for consulting the doctor. And the provider should be by government or the health staff who are not too old.” (VHV1)

Youth and teachers also reported that YFHS should be independent and separate from district and HC and near the community. Some teachers suggested that the YFHS should be located outside or near schools for easy access by youth.

“I think YFHS should locate separate from district or provincial hospital or can be located near the health centre because health centre locate nearby community easy to access. However, the YFHS should provide information about SRH and contraception to adolescent not only married women; provide them an advised and make choices for unmarried adolescent to think about they need and fill full them in their need.” (Girl, 18 year)

However, some males in the FGDs mentioned that the SRH centre for youth should be in the town or away from their village as they were afraid of being seen by the known persons in their village.

“The counseling centre should be in town because we don’t want the people in our village to see us, or can be near by the village on the roadside and it must open in the daytime, or both day and night, and must be free of pay.” (FGDB1)
Some key informants suggested there should be a hotline services for young people.

“There should be hotline SRH services available for 24 hours, these can make adolescents more comfortable access to SRH services, even they are not coming to use the services. In case they have SRH problems and they cannot find the good way to solve the problem, at least they can have some one and know who could be a consultant for them.” (HCP, 45 years)

Some youth participants said providers should provide information on SRH, not only to young people but also to the broader community and parents.

“First we should provide information about SRH to parents. Information can be given to the community that it is natural for youth to have sex and they should to be made to feel stigmatized if they would like to obtain the SRH information or SRH services. Promote prevention method it is not promoted adolescents to have sex, just provide the rights information to adolescents to prevent themselves better than solving a problem after problems happen.” (FGDG2)

Privacy and Confidentiality
Privacy and confidentiality were mentioned by many participants as being important components of YFS. Some key informants also mentioned services should be friendly and easy to use, including making appointments with a welcoming waiting room, providing a safe space for youth to freely discuss SRH.

“The service should be convenient with facilities for youth during the waiting time such as internet, information sheets. Have private and separate consultation room and treatment room. Provider should keep confidentiality and privacy to adolescents.” (FGDG4)

Training providers on YFHS
Training of the health staff was a key issue raised by both male and female youth participants and providers. Providers need training on how to provide services for youth seeming to be angry with young people because they were sexually active before marriage and should know how to talk to young people sensitively about preventing pregnancy and STIs. Ideally, participants felt providers should also be close in age to the young people they serve.

“Providers also must have training how to provide friendly services for youth, do not include adolescents and youth in the general group because youth don’t want anyone know they are sexual active and they are having sex before married.” (Girl, 18 year, Unmarried)

It was felt that health care providers should be trained in YFHS, at different levels namely provincial, district and health centres. In addition, several respondents said village health volunteers should also be trained in YFHS as they know the community and the needs of adolescents and youth in their community well.

As one provider echoing a view of several providers mentioned:

“We have no training and have no experiences on how to provide friendly services for youth. I think if we would like to provide friendly services for youth, firstly we have to know the role of YFHS provider, characteristics of YFHS should be and how can YFS more attract for youth come to use the services.” (HCP1)
As another healthcare worker said:

“I think we should start with training providers on how to provide friendly services for youth because I think not many health staffs know about YFS. MOH should take a leadership role in building provider capacity on providing friendly services for youth; try to make collaborate with community to participate on promoting SRH service for unmarried adolescents. At the same time should have YFS available in HC.” (HCP2)

Guideline of YFHS
Most health care providers noted that there are no national guidelines on YFHS, only for MCH.

“No guideline to provide friendly services for youth yet. We just have national treatment guideline, child nutrition guideline, and family planning guideline.” (HCP, 40 years)

Dissemination youth friendly SRH services
Most participants said advocacy to promote the availability of YFHS and providing phone numbers of providers to adolescents/youth in order to enable them to make appointments directly with providers would be useful. In addition, meeting with youth at the community to promote YFHS was suggested.

Some health care providers mentioned that there is a need to have youth volunteers and a youth committee to provide SRH information to youth.

“In my perspective, we should have a youth volunteer in each community to contribute information about YFHS and try to push adolescent in community participate in the youth activity. We should have YFHS committee in the village and head of village should be leader. As well as have YFHS available in community that cover by 10 to 15 villages per 1 YFS or 2 to 3 HC together have 1 YFHS. We should collaborate with a youth leader selected from the community who are active and have the capacity to empower youth in the community to participate in activities) in every village to promote YFHS, and use peer-to-peer education to stimulate youth from community to participate in YFHS activity.” (HCP, 40 years)

Most HCP suggested promoting SRH to village elders, parents and the broader community:

“So, first should provide information about SRH to parents, make the right understanding about SH to parents. Try to make right way to understanding on promote prevention method it not promote adolescent to have sex, just provide the rights information to adolescent to prevent themselves better than solving a problem after problem happen.” (HCP, 35 years)

Some teachers also discussed about the role of schools in prevention of SRH problems among unmarried youth and promoting SRH information. The school also could disseminate the YFS through social media.

“The schools role toward helping unmarried adolescent to prevent STIs/HIV, early pregnancy, unwanted pregnancies is only try to instruct adolescent to prevent on unsafe sex, unprotect sex and pushing forward adolescent access to SRH services in the public center to guarantee adolescents can access to services good quality.” (Teacher, 35 years)
Some teachers also said including sexual health education and sexuality was needed. Even though UNFPA has been supporting Ministry of Education and Sports for more than a decade to develop ASRH training guide for teachers, including for Department of Teacher Education, Department of Higher Education, Department of Non-Formal Education, Department of Technical and Vocational Training. However, as ASRH is not an examinable subject in school, teachers could opt out whether to teach or not. That is why in some school they choose to teach and others not depending on the confidence of the teachers to teach. Hence UNFPA is now working with primary level schools to have CSE integrated into the curriculum so that it is part of the teaching programme and they plan to do the same with secondary level when the curriculum comes up for review.

5. Summary and Discussion

The study revealed youth experienced to early sexual debut and were vulnerable to early marriage, unsafe sex, and unwanted pregnancy. Adolescents in this study themselves however, appeared largely unaware and uninformed about reproductive health and most did not recognize the health and social risks associated with early marriage, early pregnancy and childbirth, unprotected sex and STIs. Incomplete understanding among community members also acts as a barrier to promoting SRH to unmarried youth.

Challenges for young people in accessing quality SRH services related to individual level factors, health system factors and socio-cultural norms. At the individual level, young people in this study demonstrated knowledge gaps and had limited capacity to negotiate their SRH rights. At the health services level as noted by WHO, healthcare staff are often not aware of the needs of young people, especially of those who are not married and lack the capabilities and infrastructure to provide quality YFS related to SRH. The study in Lesotho found that where healthcare professionals are judgmental and unfriendly towards unmarried young people, rather than services being places of opportunity that enable adolescents to minimise risks, they can become places of disillusionment and places to avoid. At the community level, prevailing social norms including acceptance of early marriage and negative stereotyping of young people accessing SRH, also act as barriers to positive health seeking practices.

These findings corresponded with a review conducted in Kenya which found in Kenya as in other parts of Africa, adolescents and youth experience several reproductive health challenges including early and often unplanned or unwanted pregnancy and complications due to unsafe abortion due to limited access to quality and friendly SRH care. Similarly, a strategic assessment of reproductive health in the Lao PDR found that the main SRH problems among Lao youth were early pregnancy, and unwanted pregnancy.

The preventive measures that most youth used in this study were condoms, oral pills, and injections. Most unmarried youth said rather than using public facilities, they used SRH services from private clinics and drugstores. Of some concern however, is while medical abortion using a combination of mifepristone and misoprostol is safe if administered effectively, it is unclear if pharmacists in Lao PDR are able to provide effective abortion advice, or if pharmacy workers dispense effective and safe medications in the correct doses.

Health services play an important role in reducing preventable poor health and supporting young people make a healthy transition into adulthood. This includes provision of information, counselling, services and referral. Barriers to accessing SRH include health providers’ judgmental attitudes and poor communication and counselling skills; lack of privacy and confidentiality; stigma and discrimination; facility environment that is not welcoming or provide adequate privacy; poor quality of care; providers spending insufficient
time with clients; barriers that prevent access to certain SRH services (or services denied by providers); lack of educational and other materials appropriate for young people; cost of services; inconvenient opening hours. Also important were both HCP and youth felt SRH facilities were for married couples or that facilities were unable to provide appropriate care to unmarried youth.

This study found that attitudes of health providers towards providing SRH services are the important factor for youth to use SRH services which is similar findings from previous research. Even where HCP felt they had a role in providing SRH services to youth, they felt unprepared and ill-equipped to do so. A study on provider perspectives on factors influencing contraceptive use and service provision to youth in rural Uganda also found that typically, providers did not feel competent enough to provide contraceptives to youth. A Lao study showed the negative attitudes of providers towards providing contraception to youth due to traditional customs and culture. A study examining barriers to family planning at government service delivery sites in Tanzania found that local providers often impose non-evidence-based age restrictions on provision of contraceptives to youth.

This study found out there were no youth centres or facilities that offered SRH services for unmarried youth. The United Nations Population Fund (UNFPA) advocates for and supports the efficient and delivery of a holistic, youth-friendly health-care core package that includes: universal access to accurate sexual and reproductive health information, a range of safe and affordable contraceptive methods, sensitive counselling, quality obstetric and antenatal care for all pregnant women and girls and the prevention and management of sexually transmitted infections, including HIV. Training service providers specifically to handle adolescents’ sexual and reproductive health issues is paramount to achieving this goal. While, UNFPA has just launched the National guideline for YFS, it has not been disseminated into province and district level yet. As currently UNFPA is focusing on three provinces (Bokeo, Savannakhet and Bolikhamxay) where they have correspondence girls group programme so that supply can meet demand side. MOH will expand services for the rest of the country in the coming years.

A review of approaches included in the Reproductive Health Initiative for Youth in Asia in 2007 concluded that youth centres were an important entry point for SRH information and counseling, were a convenient focal point for peer educators, and were acceptable to young people (Taylor, 2007). Locating centres in places easily accessible to young people, but where they feel they will not be stigmatized, and engaging young people in the design and delivery of centres, and providing ongoing support and resources can increase the use and acceptability of youth centres but to date only 35 master trainers from both central level as well as the nine schools around the country have been trained on the guidelines.

Youth-friendly health services are those that provide quality care that is accessible, appropriate and acceptable to young people. According to IPPF toolkits on YFS guide, these are main seven characteristics of YFHS, which are including: 1 (Trained health worker to provide competently, sensitivity and respectfully service to youth; 2 (Confidential, non-judgmental and private; 3 (Convenient opening hours; 4 (Accessible to all adolescents and young people irrespective of their age; marital status, sexual orientation or ability to pay; 5 (An effective referral system; 6 (Involvement of young people in process of design, implementation and evaluation and 7 (Involvement and gain support of family, school and community. Youth friendly health service should be based on the full understanding of the real need of youth rather than what providers perception. By incorporating the criteria of YFHS, into health services, use of services by young people has increased. Such services however are not currently available for the participants in this study. Also important is creating awareness within young people of the need to realize their rights related to SRH education and quality services. A study in Cambodia has shown when empowered young people are more likely to seek services and increase their confidence discussing sexual
matters and asking questions of health workers. Meanwhile SRH education and service have to go along to each other, for example: in sex education not only focusing on SRH issue but also providing SRH YFHS referral information to youth as well. The National Adolescent and Youth Friendly Services (NAYFS) Guideline is adapted from the World Health Organization (WHO) guide on Adolescent Health for Health Care Providers. Now the guideline is developed for the Lao context by the Ministry of Health (MoH) with support from United Nations Population Fund (UNFPA) and other development partners. The National Adolescent and Youth Friendly Services (NAYFS) guideline is a training guide for health care providers, including midwives, nurses, clinical officers and doctors in all health facilities. The aim of the training is to strengthen the capacity of service providers to respond to specific needs of adolescents more effectively and with greater sensitivity. It will ensure the integration of adolescent and youth friendly services in health centers and hospitals as well as helping providers to overcome barriers when providing services and information to young people.

6. Conclusions & Recommendations

The types of SRH services available to male and female youth were supply of condoms, provision of pills, application of injectable, and information on SRH services. Factors influencing access to SRH services included socio-cultural factors; individual hindrances; shyness and fear of parents; information barriers and service provider barriers. Lack of YFS is another important factor prohibiting youth accessing SRH services. Characteristic of Youth Friendly Services should effectively attract young people, respond to their needs and retain young clients. Access to SRH services by youth can be improved through implementing YFS, community awareness of YFS, providing sexual and reproductive health education for the youth, building of facilities for the youth, and broadcasting in the media.

Government

- Enacting policies that advocate for youth’s contraceptive needs, including systematically supporting their eligibility for SRH information and services. Increase access to sexual and reproductive health information and services for adolescents and youth. Legal, regulatory and social barriers exist which prevent young people from accessing sexual and reproductive health information and services. Comprehensive sexuality education and youth friendly health services, which encourage the engagement of adolescents and youth, and are respectful and confidential, enable young people to make decisions about their sexual and reproductive health in a positive and responsible way.
- The existing FP and SRH services are not promoted at all to adolescents and youth. The link between information and services should be increased. The youth friendly health services should be integrated into the existing reproductive health services at the provincial, district and health centre levels. Take consideration the international standards and best practices of YFHS regarding sexual and reproductive health and relevant youth issues, adapt in to Lao context seeking to improve the services and meet to the real need of youth.
- Disseminate the National guideline for Youth Friendly services widely throughout the country.
- Ensure quality of care of providers by providing specific counselling and recommended to make appointment specific date with the clients to follow up for the next visits and the clients could return any times when they have problems. Counselling should be included as a core component of the SRH service. Counselling provides young people an opportunity to procedure their thoughts and feelings regarding SRH problems and concerns etc.
- Subsidizing prices to increase to SRH services accessibility for younger users as cost is often a deterrent.

Government, UN agencies & CSO
• To consider a SRH mobile clinic approach and in cooperation with school health services so that these services are taken to the schools on specific days as an interim measure to developing youth friendly services.

• There is a need to train more service providers on attitude transformation and communication, knowledge and skills in dealing with the youth so that they may be friendly and appealing to them, this will attract them to the clinics or facilities and in turn improve utilization of the services. Recently, the MOH and UNFPA developed and launched the YFHS guideline at the national level, so, there is a need to ensure the implementation of NYFS guideline are well implementing and taking place for all health facilities, not only in city/urban areas but also in rural/mountainous areas.

• To put in place adolescent-friendly centres or clinics, which will bring these SRH services close to adolescents. The government and other stakeholders should hold community awareness and sensitization programmes on the benefits of SRH services to pave way for cultural acceptance and hence use and access to SRH services by male and female youth. Health care providers at health centres will be responsible of all activities regarding adolescent reproductive health in each health centre catchment area including schools, community and at the health facilities. Selected health care providers at the health centres will be trained to offer the minimum package with special emphasis on non-verbal communication skills, active listening, and the ability to deal with sensitive topics.

• Ensure that the service facility is located at a place, which can be easily accessed, by diverse groups of young people including both boys and girls (married and unmarried) of the community/locality/city as well as marginalized groups of that community. The environment should be comfortable and clean with sufficient place for people to wait till they meet with the service provider. The rooms where counseling and clinical services are provided should ensure privacy in order for young people to talk openly. Youth friendly reading material, posters etc. should be placed in the facility so that young people have opportunities to gain information about a wide range of issues.

• Publicizing the services including the type of services offered, timings and location etc. is essential to ensure that young people are aware of the existence of the services. This should be done through print and electronic media or community orientations, and youth volunteers and the dissemination should be in the places are those frequented by young men and women of the community such as schools, colleges, hostels, market places, workplaces etc.

CSOs

• Schools and the community to deliver reproductive health services, clients should be transferred to the nearest health centre and be given services. All sites delivering ASRH services should be not discriminating in any circumstances; the environment should be appropriate and friendly to all like handicapped and HIV positive young people.

• Opportunities to discuss SRH related issues with peer through supervised group discussions may also help young people gain information as well as gain an insight about how other young people may have similar or different experiences. However, not all young people could access to peer groups, availability of telephone help lines, online counselling services, services in schools, mobile services etc. can also be explored.
Appendices

Guideline for interview unmarried adolescents

I. Socio demographic
   Name, Age, Sex, Education, Living arrangement, Family background….

II. SRH problems
   What problems do you feel you face because of your sexual and reproductive behaviour?
   Have you accessed any SRH services in your area?
   What are the SRH services currently provided in your area?

III. Preventive Measures used
   1. What prevention measures have you been using to prevent SRH problems: STIs, HIV/AIDS and early pregnancy? Why?
   2. What factors could enhance or hinder you from adopting preventive measures from SRH problems?
   3. Have you heard about availability of YF services? What are YF services? What are the elements of YF services? Who uses these services and why?
   4. What factors could facilitate or hinder unmarried adolescents from using YF services at the health facilities?
   5. What do you think could be done in order to attract more unmarried adolescents to SRH services at YF facilities?
   6. How would you like the quality of services at YFRH facility to be like so that you would be interested to visit the facility?
Guideline for interview community leaders (Head villagers, parents and teachers)

Name of Interviewer: __________ Location: _________ Date: _______

1. How would you describe the sexual and reproductive health problems facing unmarried adolescents in your community? Comment on occurrence of STI, HIV/AIDS and early and unwanted pregnancies.
2. What measures do people in your community use to avoid contracting STIs, HIV/AIDS and unwanted pregnancy?
3. Do young people in your society use health facilities for their health care? What services are commonly used and why? Who can use the services?
4. What are the community attitudes towards provision of SRH services like condoms and contraceptives to unmarried adolescents?
5. What roles do the community take in order to assist unmarried adolescents prevent STIs, HIV/AIDS and early and unwanted pregnancies?
6. Have you ever heard about youth friendly reproductive health services? What have you heard? What are the factors that might be influencing the unmarried adolescents to use or not to use YFRH services in your community?
7. If you have heard about YFRH services, what role did your community take in the initiation and designing of the programme? Did the youth in your society participate in the initiation? What role did they take?
8. What do you think could be done in order to attract more unmarried adolescents to use YFRH services?
9. What role has your government/political system’s roles in promoting sexual and reproductive health for the adolescents?
Guideline for interview Health care providers

Name of Interviewer: __________ Location: __________ Date: ______
Facility Type: Public

1. What SRH services are provided at your facility? Who can access these services?
2. What guidelines/policies does your facility use for the provision of SRH services to the youth? Do these guidelines consider unmarried adolescents as an important group to receive SRH services?
3. What factors do you think affect unmarried adolescents’ utilisation of SRH services at your facility?
4. What measures are taken to ensure that quality services to the youth including unmarried adolescents? From whose point of view is the definition of quality care based - clients or the providers?
5. What are the attitudes of the health service providers towards provision of SRH services to unmarried adolescents?
6. How would you describe the availability of supplies and other resources for the operations of the facility?
7. What problems does your facility face in the provision of SRH services to the youth? Why?
8. What procedures do you follow when a youth client visit your facility for SRH services? – ask also about confidentiality, privacy, physical examination, follow up care.
9. What comment would you give on the effect of the location and setting of your clinic to attracting unmarried adolescents to use the services?
10. What would you say is the government/political commitment towards promotion of YFRH services?
11. What strategies are used to mobilise the community and the youth about the availability of YFRH services?
12. What measures do you have in place to promote gender equity and equality to eliminate gender-based discrimination during service provision?
13. What cadre of staff do you have at your facility? Are both male and female providers available? What about youth counsellors?
14. What do you think has been the role/effects of the community in supporting/encouraging unmarried adolescents to use SRH services at your facility?
15. How did your facility initiate the YFRH programme? Who were involved in the designing of the programme? What roles did each stakeholder play?
16. What do you think can be done in order to promote utilisation of SRH by unmarried adolescents?
Endnotes

1. ICPD. International Conference on the Population Development.
16. Sychareun V. Meeting the contraceptive needs of unmarried young people: attitudes of formal and informal sector providers in Vientiane Municipality, Lao PDR.


25. Sychareun V. Meeting the contraceptive needs of unmarried young people: attitudes of formal and informal sector providers in Vientiane Municipality, Lao PDR.


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42. Asia Resource and Research Center for Women (ARROW). The essence of an innovative programme for young people in south East Asia: a position paper on comprehensive sexuality education including youth friendly services, meaningful youth participation and rights-based approaches in programming 2012.
43. MOH & UNFPA. The National Adolescent and Youth Friendly Services (NAYFS) Guideline (2017).
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This research is part of State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25) monitoring initiative by ARROW. This initiative includes 13 partners and generates monitoring evidence around twenty-five years of implementation of the ICPD Programme of Action (ICPD POA) in the respective countries for advocacy. The evidence from the report is expected to inform the Mid-term Review of the 6th Asia Pacific Population Conference (APPC) in 2018 at the regional level, the national policy dialogues in 2019 at the national level, and the ICPD+25 review in 2019 at the international level.

ARROW is a regional and non-profit women’s NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women’s health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organizational development.

About Faculty of Public Health

The Faculty of Public Health is one of the six Faculties located at the University of Health Sciences, Laos and was established in 2018. The Faculty is responsible for higher education of different fields such as Master Program of Public Health, and has a unique leadership position in undergraduate and postgraduate studies in the Field of Public Health. The objectives of the Faculty of Public Health are to achieve the following human resource development goals:

1. Provide higher level of undergraduate & Postgraduate Studies in Public Health Education.
2. Conduct Researches in Public Health to promote health and participate in community Health services.
3. Train specialists in different fields of Public Health personnel in response to current & emerging needs of the local people.
4. Provide technical services to the local people.
5. Integrate technologies and practice, and interrelate research and educational activities.
6. Collaborate with different partners at the national and international levels.

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