CHAPTER FIVE

PREMARITAL RELATIONSHIPS, MARRIAGE, AND PARENTHOOD:
IMPLICATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH

Figure 5.1 This Hmong couple, both age 17, had their first child when they were 16 years old. Early marriage is still common among ethnic minority young people in the study area.

Evidence suggests that ethnic minority young people may face greater sexual and reproductive health risks than their Kinh counterparts for various reasons. First, while there is a cultural predisposition toward premarital sex among some ethnic minority groups such as Hmong (UNAIDS et al. 2000), this segment of the Vietnamese population is not well-equipped with knowledge about human reproduction and sexually transmitted diseases. Compared to the Kinh, they also have significantly less access to quality reproductive healthcare for several reasons, including their remote residence, language barriers, and cultural beliefs (WHO 2003). Further, reproductive health risks are known to be greater for early childbearing. Early marriage and early pregnancy remain quite common among many minority couples. For example, while the rates of birth delivery at home have been decreasing throughout the country, the practice remains common among minority mothers in remote mountainous areas, causing a great deal of concern about safe motherhood (WHO 2003).

In this chapter, we explore these health and social issues in the context of Vietnam’s emerging HIV/AIDS epidemic. We describe the ethnic and intergenerational differentials in transitions to marriage and parenthood among young people in the study area, with a focus on
the implications of these transitions for sexual and reproductive health.\textsuperscript{14} First, we examine the patterns of precoital behavior, sexual initiation, mate selection, and access to reproductive health services among unmarried young people. We also describe trends in wedding practices, prevalence of inter-ethnic marriages, timing of marriage and first birth, and extent of son preference in the study villages. In addition, we review the use of and access to family planning and other reproductive health services, including abortion, among young married couples.

**Before Marriage**

**Romantic Relationships and Precoital Behavior:** Over the past few years, improved road accessibility and increasing availability of motorbikes have remarkably increased the mobility of the villagers in the study area, particularly young people. A sizable proportion of them, Kinh in particular, have traveled outside the villages to study or to work. At the same time, these new roads have also brought people from various places into contact with the villagers. We find that such increased mobility has had significant impact on the premarital behavior of both Kinh and minority young people. A generation ago, young people’s romantic relationships were often under the close scrutiny of parents and older relatives (with an exception for the wartime period when many young men were mobilized to join the military). There was usually little contact between future spouses before marriage. Even among those who were in romantic relationships, precoital behavior such as holding hands, kissing, or petting was reportedly rare. Arranged marriage was common among both Kinh and ethnic minorities in the study area.

\textsuperscript{14} A substantial number of young people, especially women, move out of the study area after their marriage because of the practice of patrilocality. Also, some young people who migrated to study and work in other areas may get married and settle down elsewhere. Therefore, the experience of marriage and parenthood described in this chapter may be selective of the experience of those who are less likely to be away or move out of the villages. Young women from other areas who are married to local men and moved to the study area usually have rural backgrounds.
partners without their parents’ supervision. Hand-holding among unmarried young couples is common. Kissing and petting are not frequently reported as precoital behavior (this might be true but it could also be due to underreporting). In general, young people from the study area think that their dating habits are quite different from those of their peers in Vo Nhai’s district town Dinh Ca, whom they refer to as bolder, more modern, and more lavish.

A majority of young people choose their own partner. Some meet their future spouse while working or studying outside their home villages. Others make acquaintances with the opposite sex in festivals, markets, or weddings. For example, many Hmong courtships begin at the time of the annual New Year’s celebrations. Boys move from village to village for the purpose of meeting girls and participating in festivals where they have relatives. The primary means for meeting young people of the opposite sex during the New Year is a ball game that takes place at the festivities. Boys in one line face girls in another and toss small fabric balls back and forth. The New Year's game typically provides an outlet for the emergence of more intense romances. Young people of different ethnic backgrounds also reportedly have greater opportunities to form romantic relationships than in the past.

Knowledge about Reproductive Health among Unmarried Young People: Despite increasing opportunities for young people to become involved in romantic relationships or to engage in precoital and sexual relationships, access to reproductive health knowledge among young people is limited. This is particularly the case for ethnic minorities and Kinh who have little education (e.g., less than lower-secondary education). The first issue concerns their knowledge about puberty. Perhaps due to a high prevalence of child malnutrition in mountainous areas, young men and women in the study area usually experience a delay in puberty. The delay is longer among ethnic minorities than Kinh. Young people usually report the first sign of puberty after age 15. Many do not have any knowledge about puberty before their first experience. They are more likely to learn about this physiological change from teachers, friends, older siblings, or television programs rather than from their parents. Parents, particularly those with low education, often say they feel awkward discussing the issue of puberty with their teenage children. After the first sign of puberty, young women are often instructed that they could become pregnant if they have sex. For some minority villagers such as Dao, timing of puberty suggests young people’s preparedness for marriage and family formation.

In addition to their limited knowledge about puberty, most unmarried young people appear to have little practical knowledge about safe sex, family planning methods, HIV/AIDS, and sexually transmitted diseases. A majority of them hear about sex education from school or from television programs. Many young people, including those who have little schooling, have heard about HIV/AIDS and can name a few types of contraceptive methods. Young women seem to be slightly more knowledgeable on these issues than men. However, it is questionable whether the knowledge that young people possess is practical. For example, they are confused about what a condom looks like or about the female’s safe period. Further, as elsewhere in Vietnam, it is widely perceived in the study area that knowledge about sexual and reproductive
health is more relevant to those who are married and that it is not necessary for unmarried young people to have such knowledge.

**Premarital Sex and Access to Reproductive Health Services:** We do not attempt to measure prevalence of premarital sex in remote mountainous areas, but rather to understand the contexts that influence such behavior as well as its social and health consequences. Although sexual initiation before marriage is considered socially and morally unacceptable by a majority of young and old villagers regardless of their ethnicity, premarital sex is not uncommon in the study area and is believed to have been increasing across all ethnic groups over the past few years. In fact, a small proportion of young people respond that premarital sex is acceptable if the young couple intend to get married. Consistent with the trends in premarital sex, premarital pregnancy is also said to be on the rise—suggesting that there is inadequate knowledge of and access to birth control methods.

According to the villagers, they have become more integrated with the outside world—thus, receiving new ideas and values from urban areas that alter the sexual behavior of unmarried young people, including an increase in premarital sexual activities. Moreover, some villagers believe that an increasing availability of birth control methods, particularly condoms and contraceptive pills, are responsible for the rise in premarital sexual activities among young people. Contrary to some villagers’ perception, however, modern birth control methods are not readily available for unmarried young people in the study area. Villagers who lived in urban areas appear to have greater access to contraceptive methods and other reproductive health services than those who never leave their home villages. While there is currently no shortage of contraceptive supplies for married couples, unmarried people do not have easy access to these supplies, except for those who have opportunities to travel frequently outside their villages. Condoms and contraceptive pills can be purchased at local drug stores. However, there is no private pharmacy in Phuong Giao Commune. In Trang Xa, there is only one such store located in the center of the commune.

For young people who are still in school (usually at the upper-secondary level), premarital pregnancy frequently disrupts their education. They are usually asked to drop out of school to take on parental roles. There are also a few reports of unmarried young women who underwent abortion. Because public health facilities only perform abortion for married women, those who are unmarried are forced to seek private providers in Thai Nguyen City. Most premarital pregnancies in the study area result in hasty marriages.

We find no evidence to support the notion of a cultural predisposition toward premarital sex among Hmong villagers. Hmong villagers—young and old—seem to have attitudes toward premarital sex that are similar to those of Kinh and Dao. While the Hmong’s love market is popularized in some tourist destinations in Vietnam as places where young people can freely court one another, such a marketplace does not exist in our study area. Moreover, the “catch-hand” (bat vo) practice, in which a female Hmong is taken by a male and his relatives for the purpose of marriage with or without her agreement, is very rare in the Hmong village in our

Many Hmong villagers refer to this practice as backward and as a grave insult to parents.

Marriage

Marital Timing: Marriage is considered one of the most important life-course events for young people in the study area. When young people get married and start their own family, they are regarded as becoming “full” adults. Marriage generally takes place early and is nearly universal in the study area. The Village Census collected in 2005 provides cross-sectional data to examine differentials in timing of marriage across ethnic groups. Figure 5.3 presents proportions of villagers ever married by age, sex, and ethnicity.

Results suggest that females generally marry at an earlier age than males. This pattern is consistent among both Kinh and ethnic minorities. In 2005, slightly over half of Kinh women ages 20-24 were married, compared to only one third of men. Moreover, ethnic minorities married earlier than Kinh. Proportions of minority young people ages 20-24 ever married were approximately 65 and 50 percent for females and males respectively. Teenage marriages exist, but the proportions of young people ages 10-19 who have been married are rather low, particularly among Kinh women and both Kinh and minority men. Results suggest that a majority of villagers in all ethnic groups were married by age 30.
Figure 5.4. Proportions ever married: Comparing Kinh villagers in Clusters A and B

Figure 5.4 shows patterns of marital timing among Kinh villagers in Clusters A and B. As mentioned in Chapter 3, Cluster B is more socioeconomically developed than Cluster A. This perhaps explains why young people in Cluster B were more likely to delay their marriages. For example, about 30 and 50 percent of young men and women ages 20-24 in Cluster B respectively are married. Meanwhile, over 40 and 60 percent of their male and female counterparts in Cluster A are married. In addition, we find that teen marriages are uncommon among Kinh in both clusters.

Figure 5.5. Proportions ever married: Comparing Dao and Hmong villagers

While the differences in marital timing among Kinh in our study area are modest, Figure
5.5 reveals interesting sex and ethnic differentials in marriage timing between Dao and Hmong
villagers. Unlike Kinh, teen marriage is still quite common among Dao and Hmong, particularly
females. The 2005 Village Census suggests that about 15 percent of minority women ages 15-19
were married. Proportions of Dao and Hmong women ages 20-24 who were married are almost
identical (about 65 percent); however, results suggest divergent patterns among Dao and Hmong
females after age 25. Nearly all (96 percent) Hmong women ages 25-29 were married. However,
we observe a delay in marriage among some Dao women in the age groups 25-29, 30-34, and
35-39 years. We suspect that this divergent trend might be due to reporting errors or biases.

In general, Hmong men married at an earlier age than Dao men. Sixty percent of Hmong
males ages 20-24 were married, compared to only 40 percent of Dao males. For all age groups,
marriage rates appear to be lower among Dao men relative to their Hmong counterparts. Hmong
males married at a later age than Hmong females; however, the differences seem to be small. By
their early 30s, almost all Hmong males and females in the study area were married. In contrast
to the Hmong, the differences in marital timing between Dao men and women are quite
substantial. For those in their teens and early 20s, proportions of Dao males who were married
were lower than females. There is a drop in marriage rates among the cohort of Dao males ages
30-34 that merits further investigation.

The census does not allow for an assessment of changes in median age at marriage over
time (across birth cohorts). However, the in-depth interviews with young people and their
parents suggest a clear trend toward delay in marriage across all ethnic groups in the study area,
particularly among young Kinh. For the parental generation, females usually married when they
were in their late teens (for Kinh) and in their middle teens (for Hmong and Dao). Meanwhile,
both Kinh and minority men from the parental cohort generally married in their early 20s
(slightly earlier among Hmong males). A few men delayed their marriage because they were
called to serve in the military during the Vietnam War.

In general, today’s young people get married at a later age than their parents, particularly
Kinh and those who have at least lower-secondary education. Early marriages remain the
practice among some Hmong and Dao villagers from poor households who have little or no
education and little experience outside their home villages.

While the legal age at marriage in Vietnam is 18 years for females and 20 years for
males, many young people in the study area think that an ideal time for marriage should be
after age 20. Men are expected to get married at a later age than women. Along with what they
consider an ideal age at marriage, young people often discuss individual characteristics one
should possess before making a transition to marriage. These characteristics include completing
schooling, being emotionally mature, and having a stable job and income.

In recent years, a few couples in the study area married before they reached legal age. Some people delay
registering their marriage until they reach age 18 or 20; others lie about their age when they register their marriage.
However, it is more difficult to be legally married before the legal age because documents such as a household
registration book (ho khau) record birth dates for all members at the time of marriage registration.
On average, young Kinh women in the study area marry at an older age than their minority counterparts. For Kinh, the early- to mid-20s appear to be ideal times for young women to get married. A delay in marriage until the late 20s and early 30s usually causes worries for young women and their families, particularly if they continue working primarily in the family farm sector. Parents express concerns for their daughters’ future, especially old-age security. However, it seems that parents worry less if their daughters have good education and are able to secure a job in the formal wage sector.

**Inter-Ethnic Marriages:** A majority of today’s younger generation in the study area has freedom to choose their own spouse. Romantic love is often cited as one of the most important criteria for young Kinh and minority villagers when selecting their husband or wife. Moreover, young people often prefer a spouse who shares a similar household economic background. Both men and women from poor households, for example, emphasize that they would rather marry someone who is poor like them rather than marrying someone rich because they do not want to be looked down upon by in-laws. Education is another major criterion for spouse selection. Young men prefer marrying women of equal or lower levels of schooling. Meanwhile, women look for someone with similar or higher educational attainment as their partner.

Ethnicity remains an important criterion for spousal selection. In addition to language differences, some villagers refer to different cultural practices and lifestyles between Kinh, Dao, and Hmong as factors deterring inter-ethnic marriages in the study area. This is particularly the case for the relationship between Kinh and Dao. For example, rumors have spread in Kinh villages that some Dao have an ability to cast spells on people whom they dislike and that Dao shamans have a connection to the world of spirits. Because of such rumors, Kinh of older generations sometimes disapprove of their children befriending or having romantic relationships with Dao. From the Dao perspective, they would like to maintain the cultural practice of spirit worship via shamans and thus prefer to marry within their own group.

Other factors contributing to low inter-ethnic marriage rates among Kinh, Dao, and Hmong are the minorities’ lower human and social capital – particularly economic status and educational attainment, which are two important criteria for spousal selection. While young Kinh, Dao, and Hmong appear to welcome the idea of marrying into a different ethnic group, large ethnic gaps in educational attainment and household wealth call into question the issue of compatibility between Kinh and their ethnic minority partners.
Changes in Wedding Practices: Given the rapid growth of the economy of the study area in the past few years, a majority of households have witnessed unprecedented increases in levels of disposable income. A substantial proportion of this newfound wealth (i.e., increased disposable income and new assets) is often spent on family members’ wedding celebrations – one of the most important events in village life. Villagers unanimously agree that weddings have become much more lavish now, compared to how they were in the past. This is particularly true of the weddings of minority villagers such as Dao and Hmong.

In the study area, marriage implies an agreement between two families. While young people usually have freedom to choose their own spouse, parents on both the bride’s and groom’s sides are still in charge of most tasks in a wedding organization, including selecting a wedding date, negotiating a bride price, and arranging wedding parties. After young people decide to get married, they inform their parents. The parents of the groom visit the bride’s parents to officially ask for her hand. Then, negotiations regarding wedding date and bride price begin. After reaching an agreement, the plan for the wedding celebration is announced to relatives and other villagers. Weddings are usually organized at the end of each year’s harvest season, which takes place around November and December. A wedding celebration often takes place over 2-4 days. Wedding parties are usually held separately at both the bride’s and the groom’s house, even if they are from the same village.

Bride price is said to have been skyrocketing over the last decade. In the past, bride price usually consisted of 80-100 kilograms of pork, rice, and rice wine. Cash was not usually requested by the bride’s family. Today both Kinh and minority families may ask for cash only or for cash and other traditional gifts – depending on economic status of the two families. The cash may range from a few hundred thousand to several million VND. In the study area, Dao and Hmong families are known to ask for a higher bride price than Kinh. The amount can sometimes be more than the annual income of an average household. In addition to lavish gifts of material goods to their daughters, some families spend a substantial amount of money on wedding clothes for the bride.
After Marriage

Post-Marital Living Arrangement: Newlywed couples in the study area usually live with the groom’s parents for at least the first few years of their marriage. This pattern is consistent among both Kinh and minority villagers. According to this pattern of living arrangement, young people work on the husband’s family farm. Income earned from the sale of agricultural products is pooled together and managed by the husband’s parents. However, this pattern of living arrangement and collective household economy appears to have been disrupted over the past few years, as an increasing number of married young people (mostly men) migrate to work outside the study area or work as day wage laborers.

Young couples usually receive permission from the husband’s parents to move out and establish their own households after the birth of their first child. Depending on their economic condition, the husband’s or the wife’s parents might offer young couples some assets such as a piece of land and a buffalo. For some fortunate couples, the in-laws may also help build a house for them. When young couples move out from the household of the husband’s parents, they have independence to manage their own agricultural production and income. They sometimes have to take care of their own debts too.

Family Size Preference: Both Kinh and minority couples usually have their first birth a year or two after marriage. The first-birth interval is usually short because birth control is not practiced widely by newlyweds. Fertility has declined remarkably over the last decade, particularly among Kinh and to a lesser extent among Dao and Hmong. While most young people ages 15-29 interviewed in our study grew up with at least 4-5 siblings, nearly all of them want to have no more than two children of their own. Preference for a smaller family size among the young

Figure 5.7. A poster promoting Vietnam’s two-child policy. Fertility has declined remarkably over the last decade in the study area, particularly among Kinh and to a lesser extent among Dao and Hmong.
generation is very strong, perhaps because many of these young people had first-hand experience during their childhood of poverty and other population pressure on land.

Figure 5.8. Dao mother and son. She and her husband have three older daughters, and she told the interviewer she would have continued having children if her fourth child had not been a son.

Despite a strong preference to have only two children, a substantial number of young people in the study area cannot achieve their desired family size and composition. As in many rural areas of Vietnam, son preference in the Northern Uplands remains very strong. Compared to their Kinh counterparts, ethnic minority women often feel greater pressure particularly from husbands and in-laws to have a son.

Old-age security is cited as one of the main reasons for strong son preference in the study area. According to the villagers, sons are preferred because they can continue the family lineage and care for elderly parents, while daughters usually have to follow their husbands after their marriage. Nonetheless, thanks to increased mobility and women’s growing socioeconomic status and autonomy through education and work (Kinh women in particular), attitudes toward son preference have begun to change.

Access to Family Planning and Reproductive Health Services: Interviews with older villagers reveal that the desire to have a small family size among villagers of all ethnic groups may have existed for a long time. Older villagers reportedly experimented with the rhythm method, withdrawal, and, in some cases, medicinal herbs believed to prevent pregnancy. However, prior to 1990, married couples in the study area had very little knowledge of or access to modern birth control methods. Not until the mid-1990s were family planning programs implemented in the study area – first in Trang Xa and later in Phuong Giao Communes. At present, contraceptives are distributed free-of-charge to any married villagers who would like to practice fertility control.

According to the current family planning scheme, in each study village there is at least one population volunteer, who gives advice on family planning and distributes a monthly supply of contraceptives such as birth control pills and condoms to villagers. Population volunteers are recruited from a pool of farmers who are literate, have a few years of education, and are
currently married. In all study villages except Village B4 (the Hmong village), population volunteers are female. Each population volunteer receives a small monthly salary and is supervised by a commune-level population officer.

Prior to the implementation of the family planning program, the IUD was the only modern method available to women in remote mountainous areas. Yet, accessibility to the method was very low since the medical staff in charge of IUD insertion traveled to these areas very infrequently. Another alternative for women at that time was to travel to Thai Nguyen City at their own expense to have an IUD inserted. In the study area, family planning became popular first among Kinh villagers. The idea of fertility control was later accepted by their minority counterparts. When family planning was still a new concept for many villagers, some women, particularly ethnic minorities, were forbidden by their husbands or in-laws to have an IUD inserted.

Family planning is now widely accepted by villagers. There is no longer resistance to contraceptive use among minority residents in the study area. A majority of married villagers perceive that they have adequate access to family planning. While the IUD remains the most widely used method, the number of married villagers using birth control pills has increased in recent years. Married women can now have an IUD inserted at a commune health center. In addition to free distribution by population volunteers, birth control pills and condoms can be purchased at drugstores in town. During the field work, we found married young people to be quite knowledgeable about family planning.

There are a few issues that raise concerns about whether the family planning needs of young people in remote areas are being met, whether they are fully informed about family planning options, and whether they receive quality reproductive health services. For example, a substantial number of women express discomfort related to the use of the IUD or birth control pills; however, most of them have little knowledge of and access to other family planning alternatives. Side effects such as back pain, stomach cramps, fatigue, bloating, and spotting are reported. A majority of women try to endure the physical discomforts caused by the contraceptive methods they are using. Meanwhile, others stop using contraceptives altogether. Some resort to traditional methods such as a combination of withdrawal and rhythm, even though they do not have a clear understanding about their safe period.

When these traditional methods fail, married women usually seek menstrual regulation or abortion. Menstrual regulation can be performed at commune health centers, while abortion is performed only at the district hospital in Dinh Ca. During the field work, it was not unusual to meet women in their 20s or 30s who had undergone at least one or two menstrual regulations or abortions. Conversations with these women reveal that some of them do not appear to have a full understanding about the possible negative side effects of these procedures.

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16 In the past, abortion was also performed at Trang Xa commune health centers. At present, women who seek abortion in the study area are referred to the district hospital in Dinh Ca.
While condoms are one of the major family planning methods distributed by village population volunteers, they have not achieved widespread popularity in the study area. It is widely perceived among both young and old villagers that women rather than men should be responsible for fertility control. Many husbands refuse to use condoms, even though they are aware of the discomfort experienced by their wives when using an IUD or contraceptive pills. This is particularly the case for ethnic minorities. Perhaps because of minority women’s significantly lower status than that of their Kinh counterparts, they appear to lack bargaining power in this area of negotiation with their husbands.

While population volunteers are generally effective in delivering contraceptive supplies such as condoms and pills to most eligible villagers, they reportedly fail to reach married couples who live in more remote parts of the study villages. This is particularly true among minority villages where road accessibility is rather limited. Moreover, while adequate family planning supplies are delivered to the majority of villagers who need them, some volunteers do not give adequate information to the recipients about how to properly use each method. Thus, a substantial number of young married couples in the study area still fail to achieve their family size goals.

![Figure 5.9 Young mothers from a remote village in Phuong Giao Commune and their young children. The mothers walk up to three hours to the commune health center, where their babies are vaccinated. The Vietnamese government provides free health care for children younger than six years of age.]

Childbirth and Pre- and Post-Natal Care: A majority of young married women in the study area, particularly those with little experience outside their home villages, become mothers by the time they reach their early 20s. Vo Nhai’s recent economic development, particularly the establishment of commune health centers in the 1990s, has had a positive impact on the transition to motherhood among many young women, particularly Kinh. In the past, pregnant women receive poor pre-natal care. Women reportedly received inadequate nutrition and rarely had health check-ups during their pregnancy. They also usually had to work in the fields until just before their delivery.

Delivery at home, particularly for the first birth, is no longer common in the study area. When a woman in the study area becomes pregnant, she is often advised by village population
volunteers or village health workers to get a health check-up every trimester at commune health centers. Medical professionals at commune health centers usually determine due dates for the women. If they think a caesarian section might be needed, they refer the woman to the district hospital a week or two before the due date. Sometimes despite encouragement from the local safe motherhood campaigns run by the commune health centers, ethnic minority women, particularly Hmong, may still be reluctant to have their delivery attended by medical professionals (especially men) or to give birth at the commune health centers.

A majority of first-time mothers give birth at the commune health centers. Some Kinh women from well-off families may travel as far as the district town to deliver their baby. For the second or higher-parity births, a substantial number of women, particularly ethnic minorities, reportedly prefer to give birth at home. In some cases, home birth delivery takes place unintentionally because women do not have enough time to travel to the commune health station or because the families do not have any means to transport the pregnant women to the medical facilities. Since it was not until very recently, especially for the ethnic minority villages, that inter-village roads were constructed, it took a substantial amount of time to travel from home to the commune health center. When women deliver at home, their mothers or other experienced villagers usually assist them.

Figure 5.10. A Hmong mother carrying her baby back from work and the market. Heavy demands for women’s labor in agriculture, particularly due to rapid economic growth and a lack of farm machinery, account for substantial risks to maternal and child health.

According to health workers and villagers, maternal mortality has been very rare in the study area in recent years. While childbirth may not pose a health threat to young women in the study area, heavy demands for their labor in agricultural work, particularly due to rapid economic growth and a lack of farm machinery, account for substantial risks to maternal and child health. Many first-time mothers, particularly Dao and Hmong, reportedly have to rush back to work not long after their deliveries.