

Family Planning Situation Analysis

Lao People's Democratic Republic



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FOREWORD

The United Nations Population Fund - UNFPA, together with other development partners, has been supporting the Ministry of Health to implement its Family Planning programme over the past two decades. This programme has been mainly implemented as part of a larger maternal health programme and has not been specifically assessed, thus highlighting the need for updated analysis on the situation of Family Planning in the country. In response to this need, UNFPA commissioned analysis with the specific purpose of assessing the current situation of family planning in Lao PDR, so that it would provide an evidence base to inform UNFPA's support, as well as the Government's future programming in the area. The analysis is also expected to assist UNFPA in developing a more integrated approach to family planning in the country in line with the global UNFPA Family Planning Strategy "Choices not Chance", and the International Conference on Population and Development (ICPD) Action Plan, which emphasise the broadening of contraceptive choices, improving quality of care, and ensuring reproductive rights.

The report outlines the current landscape of Family Planning in the areas of policy, service delivery and resources. It notes the gains that have been made in increasing the contraceptive prevalence rate and in the reduction of maternal mortality and unmet need for family planning, and highlights remaining challenges and disparities by region, age and ethnicity. A key conclusion of the analysis is that efforts to increase awareness and knowledge about contraceptive methods have paid off. It notes that targeted programmes such as the Vientiane Health Centre for Youth and Development have achieved success in terms of responding to SRH needs of young people for accessible and affordable information and counselling on sexual and reproductive health matters, including clinic services. Similarly, it acknowledges that Community-based Distributors (CBDs) of contraceptives who bring information, contraceptives and supplies to rural communities with limited access to clinic-based services have allowed women to access services which they otherwise would not have. However, the report also highlights an over-reliance on short-acting methods which puts women in a vulnerable position, especially when stock-outs occur which will increase the risk of unplanned pregnancy and unsafe abortion. On the other hand, it notes that joint work between the Maternal and Child Health Centre (MCHC), UNFPA and the Population Services International (PSI) in addressing misconceptions about the use of Long Acting Reversible Contraception (LARC) in selected provinces has led to a four-fold increase in IUD users and implant uptake. In addition, the report finds a high variance in service delivery, predominantly in communication and clinical skills of service providers and contraceptive security which affects the quality of services. Consequently, a key recommendation of the report is to strengthen the rights-based approach to Family Planning programming in Lao PDR.

We hope the findings and analysis of this report will be utilized in policy and programme planning enabling Lao PDR to achieve the next MMR target of 120/100000 live births, CPR goal of 70% and reduced unmet need for family planning to 10% by 2020.

On behalf of UNFPA, I would like to extend our sincere thanks and appreciation to all of our partners who provided invaluable inputs to the Situation Analysis on Family Planning in Lao PDR, in particular the team of the Ministry of Health, especially staff of the Mother and Child Health Centre and the two consultants, Dr. Katharine Ba-Thike and Ms Vimala Dejvongsa.

A handwritten signature in black ink, appearing to read 'H Mohtashami', with a long, sweeping flourish extending to the right.

Dr Hassan Mohtashami
UNFPA Representative

List of Acronyms

AAAQ	Availability, Accessibility, Acceptability, Quality of care
AEC	ASEAN Economic Community
ASEAN	Association of South East Asian Nations
ASFR	Age-specific Fertility Rates
BCC	Behaviour Change Communication
BS	Birth spacing
CBD	Community-Based Distribution
CBO	Community-based organization
CIEH	Centre of Information and Education for Health
CHAS	Centre for HIV/AIDS STI
CPR	Contraceptive Prevalence Rate
DHIS 2	District Health Information Software 2
DLI	Disbursement Linked Indicator
DMT	Decision-making Tool for FP Clients and Providers
DRF	Drug Revolving Fund
EC	Emergency contraception
EPI	Expanded Programme of Immunizations
FP	Family Planning
FPSA	Family Planning Situation Analysis
GDP	Gross Domestic Product
GoL	Government of Lao People's Democratic Republic
GGHE	General government expenditure on health
GPRHCS	Global Programme for Enhancement of Reproductive Health Commodity Security
HEF	Health Equity Fund
HIS	Health Information System
HMIS	Health Management Information System
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPC	Interpersonal communication
IT	Information Technology
IUD	Intra-Uterine Device
JICA	Japanese International Cooperation Agency
LAM	Lactational Amenorrhoea Method
LARC	Long-acting reversible contraception
Lao NCAW	Lao National Commission for the Advancement of Women
Lao PDR	Lao People's Democratic Republic
LDC	Least Developed Country
LSIS	Lao Social Indicator Survey
LWU	Lao Women's Union
MDGs	Millennium Development Goals
MCHC	Maternal and Child Health Centre
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
MRA	Mutual Recognition Arrangements
MSM	Men having sex with men
NERI	National Economic Research Institute
NSEDP	National Socio-Economic Development Plans
INGOs	International Non-Government Organizations

NGOs	Non-Government Organizations
NPA	Non-Profit Association
NPDP	National Population and Development Policy
NRHP	National Reproductive Health Policy
OCP	Oral contraceptive pills
ODA	Overseas Development Assistance
PNC	Postnatal care
PoA	Programme of Action
QIQ	Quick Investigation of Quality
RCN	Referral and Counselling Network
RH	Reproductive Health
RHC	Reproductive Health Commodity
RMNCH	Reproductive, Maternal, Newborn and Child Health
RTI/STI	Reproductive Tract Infection/Sexually-Transmitted Infection
SAS	Stock Availability Survey
SDG	Sustainable Development Goals
SOMHD	Senior Officials Meeting on Health and Development
SRH	Sexual and Reproductive Health
SWC	Sector Wide Coordination
THE	Total Health Expenditure
TMA	Total Market Approach
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHCYD	Vientiane Health Centre for Youth and Development
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization

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Executive Summary

A Family Planning Situation Analysis (FPSA) was conducted to assess the current situation of family planning, its determining and influencing factors, and to develop an evidence base to inform UNFPA's support, as well as the Government's future programming in the area. The FPSA report can be seen as a rapid investigation of the breadth of policies and implementation experiences for reproductive health and family planning. With respect to review of programmes, the focus was on those that were implemented more recently within provinces and districts supported under the UN joint programme.

Findings

An engaged policy dialogue, efforts to embed policy in service delivery and an established and continued confidence amongst clients in FP methods familiar to them, now largely characterizes the family planning landscape although service provision and resourcing continues to be challenging. The Ministry of Health and few development partners have made investments in family planning, initially through the birth spacing programme (1995) followed by the National RH Policy (2005) and the Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services (2009). Several laws and policies articulate the commitment of the Government and provide the framework for maternal and reproductive health programmes. This has led to a reduction in maternal mortality, reduced unmet need for family planning from 27 per cent (LRHS 2005) to 19.9 per cent (LSIS 2012) and increased Contraceptive Prevalence Rate for all modern methods that rose from 28.9 per cent (LRHS 2000) to 49.8 per cent (LSIS 2012). However, there are inequalities by region, geographic areas, age and ethnicity. The FPSA examines stakeholders and the level of investments in

sexual and reproductive health care that while leading to large health gains, have not received government budget allocation commensurate with political commitment for FP and sexual reproductive health matters.

The resultant efforts to increase awareness and knowledge about contraceptive methods are acknowledged in the report. However, in terms of programming through a rights-based approach, there remains an opportunity for more improvement. Reproductive rights are mentioned in the National RH policy and although a rights-based approach is not explicitly mentioned in the Policy or Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services (2009), both include mechanisms to strengthen health systems (duty-bearers) to improve the coverage and quality of sexual and reproductive health information and services, particularly to vulnerable groups (rights-holders).

The report discusses key challenges and examples of good practice found at the local levels, which promote FP objectives. For instance, health literacy is related to women's education level (which is lowest in the south) and influenced by traditional gender norms and power dynamics in rural areas. Support by men for women's RH and RH care is still weak which negatively impacts on women's decision-making. On the other hand, the FPSA saw targeted programmes such as the Vientiane Health Centre for Youth and Development, which was set up to respond to SRH needs of young people for accessible and affordable information and counselling on sexual and reproductive health matters including clinic services, was successful. The Maternal and Child Health Centre, UNFPA and Population Services International have conducted targeted interpersonal com-

munication to address misconceptions and determine women's needs and barriers to using LARC in selected provinces, resulted in increased demands for services. These activities were conducted simultaneously with improving skills of providers at the respective health facilities, which lead to a four-fold increase in IUD users. Community-based distribution of contraceptives brings information, contraceptives and supplies to rural communities with limited access to clinic-based services with referral linkages to secondary health service levels. However, CBD needs to be more widespread to have an impact on increasing access in hard-to-reach areas.

An area that presents a significant risk to the progress, which has been achieved thus far, includes the prominence of short-acting methods. It must be emphasized that this puts the national programme in a vulnerable position. With a notable gap between knowledge of modern contraceptives, which is 94 per cent, and use, which is 42 per cent. The gap is wider for long acting reversible contraception (LARC) where IUD use is 1.6 per cent and 0.1 per cent for the implant, which has not been extensively introduced (launched in late 2014). In addition, stock-outs could have a quick and detrimental effect on women's access to their method of choice, which could in turn increase their risk of unplanned pregnancy and unsafe abortion. The quality of services is highly variable at the service points visited. The quality of service delivery is affected predominantly by communication and clinical skills of service providers and contraceptive security.

In conjunction with the risks of stock out, the information and reporting systems related to FP is characterised as having a lack of accurate data in relation to the utilization of family planning services and products. The FPSA found that new systems for procurement and distribution are being trialled (such as mSupply). However, the lack of accuracy in data has ramifications in forecasting, procurement,

distribution, referrals and paving the way for continuation of stock-outs to occur. The report examines these issues from the perspective of health personnel at local levels who encounter the efficiencies as well as ineffectiveness of the system.

Short-term recommendations include the development a costed implementation plan based on the National Family Planning Action Plan and FPSA recommendations; the revision of the National Reproductive Health Policy to incorporate rights-based approaches; the incorporation of family planning in national development plans and frameworks and in the basic package of MCH services as defined in the Health Sector Reform Framework and advocating for inclusion of FP under Universal Health Coverage together with a budget-line for RH/FP commodities, equipment and supplies. Evidence-based advocacy needs to be sustained to increase commitment of key policy-makers from the Ministries of Health, Planning and Investment and Finance; and representatives of the National Assembly and National Committee for the Advancement of Women about specific RH/FP issues and to influence the budget allocation process.

Other recommendations are to employ a targeted and segmented approach for social and behaviour change for vulnerable populations, e.g. couples in remote areas, youth and adolescents both in urban and rural areas and men in ethnic communities, through traditional and electronic media in a culturally sensitive manner. To facilitate the provision of quality rights-based FP services, the principles of rights-based approaches and quality of care should be employed during training and service provision. Integration of FP services during antenatal, postnatal, following post-abortion complications and during routine childhood immunization contacts will increase access and convenience for clients. In addition to advocacy on the information and service needs of adolescents and youth, the concerned

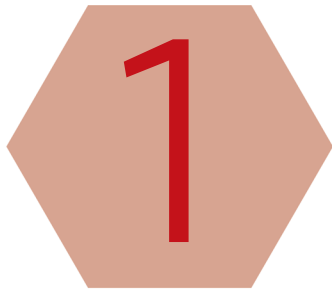
government departments in partnership with INGOs, NPAs and youth representatives will need to expand the good practices on youth information and services. Flexible, culturally-sensitive approaches to respond to the needs of the youth who live in diverse social and cultural contexts will need to be developed.

Public-private partnership for demand generation activities and for training on long-acting reversible contraception, social marketing to expand the range of contraceptives and promotion of healthy contraceptive behaviours and training of pharmacy staff to provide a variety of family planning methods will diversify channels for services and marketing. This includes investigating the feasibility of a total market approach for FP commodities for Lao PDR. Information sharing and exchange opportunities with NPAs and INGOs should be fostered and capacity building of FP focused NPAs in provinces outside Vientiane Capital.

Long-term recommendations include the development of comprehensive communication strategies for behaviour change, which are culturally appropriate; and improve the quality of FP services through institutionalizing pre and in-service training on rights-based provision of services; and support for infrastructure and organizational set-up. The equitable deployment of health staff and task shifting will serve to strengthen work force in hard-to-reach areas.

A rigorous consideration of multiple sources of information and various dimensions of issue will help to better define and understand RHSC issues. Continuous improvement for information systems will need to cover training of personnel and establishment of practical tools for information management; harmonization of reporting forms across departments and ensuring that health staff at all levels and in particular at the District Hospitals and Health Centres can access collated information and reports.

The FPSA report posits that the overwhelming acceptance and continued demand for FP services and methods is the cumulative outcome of previous partnerships under the country programmes. Under projections of population growth, it can be expected that demand for FP services will also increase. The future country programmes are well-positioned to transition support into improved management systems for RH commodities, contribute to strengthening technical and institution competencies and expanding partnerships in order to increase efficacy and efficiencies of programme resources.



Introduction

Broadening contraceptive choice, improving quality of care, and ensuring reproductive rights are central in the delivery of family planning services. These fundamental elements of the vision of reproductive health are outlined at the International Conference on Population and Development (ICPD) in Cairo in 1994. Over the past years, the Ministry of Health and its partners, including UNFPA Laos have been implementing a diverse range of family planning activities. An analysis of the broader situation of family planning in Lao PDR was conducted with objective to adopt a more integrated approach, adapts to the country context and in line with the National Reproductive Health Policy and the global Family Planning strategy, Choices not Chance.

1.1 Purpose and objectives

Purpose of the Family Planning Situation Analysis

The purpose of the Family Planning Situation Analysis (FPSA) is to assess the current situation of family planning, its determining and influencing factors, and to develop an evidence base to inform UNFPA's support, as well as the Government's future programming in the area. The FPSA aims to leverage best practices in family planning, to accelerate programme implementation and, ultimately, to increase

modern contraceptive use and decrease abortion rates. The intended audience and users of the FP situation analysis are the Ministry of Health and government counterparts in Laos, UNFPA management in the Country Office as well as UNFPA staff, other development partners and INGOs.

Objectives of the FPSA

The objectives of the FPSA are:

1. To assess the relevance and adequacy of national family planning related policies, legislation, programmes and plans, the extent to which they are implemented and the extent to which they facilitate or hinder access FP services;
2. To assess the relevance of FP related policies to gender equality, equity and the empowerment of women, and the ways in which these are interrelated with the overall economic development of the country, particularly well-being of the poor;
3. To identify the main causes of issues such as unmet need for family planning and continuation and discontinuation of use of family planning methods, identification of system-wide supply and demand bottlenecks to adequate and effective coverage of family planning; with a focus on contraceptive information and services for ado-

- lescents and youth;
4. To conduct a mapping of stakeholders relevant to FP in Lao PDR, including state, civil-society, donors and beneficiary stakeholders and the relations between them;
 5. To assess capacities (financial, programme, human resources and other elements of health systems) inside and outside the Lao PDR Government, to address family planning issues effectively;
 6. To create a country family planning snapshot. The FP snapshot is a picture of the current situation of FP highlighting key indicators and trends demonstrating how family planning is integrated and mainstreamed.

1.2 Scope

The FPSA was conducted in consultation and collaboration with government and national partners including development partners, civil society organizations and beneficiaries. The strategic vision of the Government at various levels was recorded at the different administrative levels from the central to provincial, district and village levels. Relevant stakeholders in Lao PDR were involved in all phases of the situation analysis, from the design, through the field phase and data collection and the final drafting of the report.

The FP situation analysis assessed factors that affect family planning service delivery in Laos, identified and documented supportive policies and best practices in FP programme implementation, and proposed recommendations for scaling up best FP practices and new interventions to improve programme effectiveness and increase utilization of modern contraception. The approach was centred around the needs of the citizens of Lao PDR, identifying facilitating factors and challenges, and further assessing supply and demand bottle-necks to adequate and effective coverage of family planning and proposing solutions on ways to avoid these.

The findings and observations from the FPSA were analysed within the broader context of reproductive health and the contribution of RH/FP to women's health and the relation to broader development goals.

The key findings are aligned with the five Outputs of UNFPA FP strategy 2012-2020 "*Choices not Chance*", which are:

1. Enabling environments for human rights-based family planning as an integral part of sexual and reproductive health and reproductive rights
2. Increased demand for family planning according to clients' reproductive health intentions
3. Improved availability and reliable supply of quality contraceptives
4. Improved availability of good-quality human rights-based family planning services
5. Strengthened information systems pertaining to family planning.

Recommendations on key issues in the five sub-sections were prioritized with respect to the timeframes in which the recommendations can be completed with a period defined as Short, Medium and Long-term recommendations.

2

Methodology and Process

The methodology design is a framework for gathering data to address the key objectives outlined in the TOR (Annex i). The consultant team conducted data collection for the Family Planning Situation Analysis with support from UNFPA and Maternal and Child Health Centre (MCHC) representatives from Central, Provincial and District administrative levels. A strong emphasis on participation in the TOR required a focus on qualitative methods of data collection. In order to plan and schedule for fieldwork, the consultants worked closely with the UNFPA team on the selection of provinces and districts. The following tools also guided the methodology and design:

- Situation Analysis methodology, Population Council (1997)¹;
- WHO Strategic Approach to strengthen reproductive health policies and programmes (2007)²; and
- The Quick Investigation of Quality (QIQ) developed by the Measure Evaluation Project (2001)³

Components of the FPSA Methodology

A multiple method approach was used which included desk reviews of reference materials, interviews with relevant stakeholders, and site

visits to health facilities providing family planning services. The FPSA comprised of 4 components.

Component 1: Desk review, site selection and preparation of interview protocol

A desk review of relevant documents, which included policy, and strategy documents, survey reports, programme documents, work plans, annual reviews and articles relevant to family planning, the Lao PDR health system, international and regional initiatives in reproductive health and family planning. The consultant team also developed a set of 9 interview guides and 1 facility assessment guide.

The criteria used to select sites for the fieldwork phase were as follows:

- Provinces and districts either current or previous target locations for UNFPA;
- Health Centres with distances that are near (within 5km) and far (over 15km) from District/Provincial centres;
- Districts with a range of ethnic minority communities; and
- Districts that were not a target location for UNFPA

¹ http://www.popcouncil.org/pdfs/1997_SituationAnalysisHandbook.pdf

² World Health Organisation (2007), Strategic Approach to strengthening sexual and reproductive health policies and programmes

³ Quick investigation of quality (QIQ): A user's guide for monitoring quality of care in family planning. (2001) MEASURE Evaluation Manual Series, No 2. Chapel Hill, NC, University of North Carolina at Chapel Hill.

Component 2: A mapping of stakeholders

A mapping of stakeholders relevant to FP in Lao PDR, including state, civil-society, donors and beneficiary stakeholders and the relations was conducted. The mapping process comprised of face-to-face discussion, phone calls and secondary data sources.

Component 3: Field phase

The Situation Analysis used a cross-sectional design to obtain information about facilities, providers, and clients through interviews and observations. Data collection was achieved through structured interview guides and facility inventory guide. The provinces selected for data collection were: Oudomxay Province, Savannakhet Province, Vientiane Capital, Vientiane Province and Saravan Province.

The fieldwork took 15 days to complete from 20th April – 6th May 2015. In addition to the five provincial centres reached, the fieldwork phase covered 8 Districts, 8 Health Centres, 3 Villages, 2 Clinics, 3 Pharmacies and approximately 110 interview participants.

Data collection during fieldwork

Key Informant Interviews were conducted at the central level using semi-structured interview questions with policy makers, government national partners, bilateral and multilateral donors, international NGOs working in family planning and other development partners. During fieldwork, Health officials from Provincial and District Governor's offices and hospitals were interviewed. The consultants reviewed the service records and data, observing facilities and services, and interviewing a range of individuals. At the sub-district level, local authorities, providers, and clients were interviewed. The team also met with community based distributors. With regards to the private sector providers, private clinic operators and pharmacists were also interviewed.

Component 4: Data analysis

At the end of each day, the team came together

to discuss and analyse the day's findings, with the exception of Week 2 when the consultants were concurrently gathering data in difference provinces. Analysis is based on a synthesis and triangulation of information obtained from the above-mentioned activities, desk reviews and information from interviews with key informants and field visits. The data analysis process for qualitative data sought to:

- Focus on what has been reported and participant responses
- Check for coherence and consistencies
- Check relationship between responses and issues
- Identify gaps and recurring issues
- Compare the range of responses across participants

Limitations

The 15-day timeframe for sampling four provinces and one capital city has meant that information gathered is a 'time slice' of stakeholder perspectives rather than capturing perspectives over time. A mixed method design addresses the potential weakness of capturing perspectives in a single point in time by collecting information from different sources and assessing their validity through data triangulation. In addition, the purposive sampling means that any conclusions garnered cannot claim to be representative.

3

Country Context

Lao People's Democratic Republic had an estimated population of 6.89⁴ million with a household population age 15-64 making up 59 per cent of the total household population⁵. Lao PDR is a culturally and linguistically diverse country with 49 officially recognized ethnicities and 160 subgroups⁶. It is also a country that is characterised with mountainous terrain, which creates challenges in the development of social infrastructure, transport and communication links and trade. This is further compounded by a population that is dispersed and thinly spread with an estimated 66.8 per cent of the population living in rural areas. Many places are difficult to access due to the highly mountainous landscape and up to 21 per cent of the population live in areas with no roads⁷. Although the economy is a predominantly natural resource-based, Lao PDR has experienced extremely rapid economic growth in the past five years⁸. While economic growth has increased, there is still a low level of social development, including a weak health system and limited access to health services. These

affect particularly poor people from ethnic groups, living in remote rural areas⁹.

Lao PDR is currently undergoing a period of strong economic growth and the Government has a long-standing goal to graduate from Least Developed Country status by 2020. The country has made significant progress in poverty alleviation over the past two decades with poverty rates declining from 46 per cent in 1992 to 27.6 percent in 2008. Lao PDR aims to achieve universal access to health care by 2025 and has a clear vision for health system reform as described in the Health Sector Reform Framework for Lao PDR to 2025. In terms of health governance according to the *Five-Year Health Sector Development Plan 2011-2015*¹⁰, the period from 1995 to the present, has seen an increase in the development of health legislation (laws, decrees, regulations and policies) and strategic plans and frameworks. Under the 2000 Primary Health Care Policy, there are two key components addressing maternal and child health care and nutrition. The leading docu-

⁴ World Bank Databank (2014), <http://databank.worldbank.org/data/reports.aspx?source=2&country=LAO&series=&period=>

⁵ Ministry of Health and Lao Statistic Bureau (2012), Lao Social Indicator Survey 2011-2012: Multiple cluster survey/Demographic and Health Survey, Vientiane Lao PDR

⁶ Asia Development Bank (2006), Indigenous Peoples Development Planning Document: Lao People's Democratic Republic: Northern Region Sustainable Livelihoods Development Project, DOI: <http://www.asianlii.org/asia/other/ADBLPres/2006/4.pdf>

⁷ Ibid Ministry of Health and Lao Statistic Bureau (2012),

⁸ European Commission (2009), Evaluation of EC Co-operation with the Lao PDR, Vientiane Lao PDR

⁹ Ministry of Health (2011), The 7th Five-Year Health Sector Development Plan 2011-2015; Vientiane, Lao PDR

¹⁰ Ibid Ministry of Health (2011)

ments are the Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services (2009-2015) and the National Nutrition Strategy and Plan of Action (2010-2015). Integration of MCH and Expanded Programme of Immunizations (EPI) services has also been recognized as a key strategy to further expand coverage of the services, especially in rural areas.

Family Planning Context

The annual growth rate of the population was estimated at 2 percent in 2014¹¹. While the United Nations, Department of Economic and Social Affairs, Population Division projects the population to grow to 8.25 million in 2025, and 10.88 million in 2050¹². With nearly 60 per cent of the population below the age of 25 years¹³, young people constitute a large proportion of the Lao PDR's population. Early marriage is still common, and early childbearing is not perceived as unusual. Risk-taking sexual behaviours, including low condom use, are prevalent amongst young people. For a variety of reasons, including limited access to youth-friendly sexual reproductive health (SRH) information and services, young people do not adopt safe sex practices. Lao PDR has one of the highest adolescent pregnancy rates in the region. Such behaviours also result in unwanted pregnancies and unsafe abortions, as well as a high prevalence of sexually transmitted infections.

The key indicators for reproductive health and family planning were collected under two national surveys, the Multiple Indicator Cluster Surveys and the Lao Reproductive Health surveys. In 2011, these surveys were combined to create the Lao Social Indicator Survey (LSIS) and the results were published in 2012. For

the FPSA, the indicators in the 2011-2012 LSIS, which have informed the discussion of findings are the:

- The total fertility rate nationally (occurring in the 3 years preceding the survey) is estimated at 3.2 live births for women (LSIS 2012, pg. 66). However, there are rural-urban and age differences in the number of live birth for women in these cohorts.
- Maternal Mortality Ratio (MMR) was estimated at 357 deaths per 100,000 live births (LSIS 2012, pg. IV). However it is acknowledged that in separate estimates, this figure is presented as lower.
- Contraceptive prevalence rate (CPR) for all modern methods by currently married or women in union vary in the northern, central and southern provinces being 50.8 percent; 38.9 percent and 34.5 percent respectively (LSIS 2012, pg. 87).
- Unmet need rate for modern contraceptives is approximately 19.9 per cent.
- Overall, 1 in 5 married women has an unmet need for contraception.
- Unmet need is highest in the Southern region (24 per cent) and lower in the Central (21 per cent) and Northern (17 per cent) regions.
- 50 percent of currently married women are using a method of contraception. The most popular method is the pill, used by 2 in 10 married women in Lao PDR. Injectables are the next most popular method, used by 14 per cent of currently married women.

¹¹World Bank Databank (2014), <http://databank.worldbank.org/data//reports.aspx?source=2&country=LAO&series=&period=>

¹²United Nations, Department of Economic and Social Affairs, Population Division (2012) World Population Prospects: The 2012 Revision. <http://populationpyramid.net/lao-people-s-democratic-republic/2050/>

¹³Lao People's Revolutionary Youth Union and United Nations Population Fund Lao PDR (2014). Adolescent and Youth Situation Analysis Lao People's Democratic Republic, DOI: http://countryoffice.unfpa.org/lao/drive/AYSA_Report_Eng.compressed.pdf

4

Findings and Analysis

Overview

The health of women and children features prominently in Government policies and is articulated in national and sector development plans. During the FPSA, key stakeholders at various administrative levels confirmed their commitment to improving the health of women and children of which investments in family planning is an important element. However, the budgetary allocation is not commensurate with the level of commitments made. The public sector provides 71 per cent of family service provision and a range of methods offered depends on the health facility and the presence of skilled providers. This sector is complemented by the private sector and to a lesser extent, INGOs. Outreach mobile clinics and community-based distribution agents increase the coverage of services in the remote, mountainous areas.

4.1 Development challenges, national strategies and family planning

Family Planning and the National Development Agenda

Lao PDR has achieved economic and social progress over the past two decades and the challenge is to sustain the high level of economic

growth while enhancing equitable distribution to remote and rural areas, where poverty is almost twice the rate of urban areas. The response to this challenge is articulated in the overall objective of the Eighth National Socio-Economic Development Plan (NSED 2016-2020): "Reduced poverty, graduation from Least Developed Country Status with sustained and inclusive growth through promotion of national potential and comparative advantages, effective management and utilization of natural resources and strong international integration"¹⁴.

In order to reach the overall goals of Health Sector Reform, which are: the achievement of the health related MDGs by 2015 and Universal Health Coverage by 2025, the reform is structured in three phases. Phase I (2013-2015) focuses on laying out a solid foundation for universal access to essential health services; Phase II (2016-2020) aims to ensure that essential health services with reasonable good quality are available and accessible to, and used by, the majority of the people; and Phase III (2021-2025) expects to achieve universal health coverage with an adequate service benefit package and appropriate financial protection to a vast majority of the population.

¹⁴ Ministry of Planning and Investment: Five Year National Socio-Economic Development Plan (2016-2020) Draft February 2015

Health system strengthening plays a central role in the reform strategy as evidenced by the priority areas chosen under the reform: health financing, health governance, human resources for health, health service delivery, and health information systems. Included in the targets for Outcome 2, Output 4 of 8th NSEDP- Access to Health Care and Preventative Medicine is – “Maternal mortality rate reduced to 200/100,000livebirths”. To achieve this target, all the three prongs to reduce maternal mortality: skilled attendance at birth, access to emergency obstetric and neonatal care and family planning will need equal attention and investment.

The focus is on maternal health improvement, with FP included in the basic package of services under the public health strategy. However, in costing for reproductive health, there is no indicated intention to increase the resource allocation from that of 2011. Additionally, Postpartum FP is just one among the costed interventions for maternal health so it is not clear that sufficient funds will be available to achieve the optimum expected FP outcomes. Maternal health will be the entry point for family planning and as the RMNCH Strategy and Action Plan is being developed this year, there is an opportunity to ensure that FP features more prominently including from a resource allocation perspective.

Family Planning in the context of the International Development Agenda

The commitments and progress made by Lao PDR to achieve in MDGs will be carried forward post 2015 into the new development framework in Laos¹⁵. Among the Sustainable Development Goals (SDGs)¹⁶, Goal 3: *Ensure healthy lives and promote well-being for all at all ages*, and Goal 5: *Achieve gender equality and*

empower all women and girls reflect the unfinished agenda from the MDGs. Included in the targets for these two Goals are:

- by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- by 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences

These goals and targets provide a strong rationale to accelerate universal access to rights based FP.

The preparation for integrating into ASEAN Economic Community has been on-going to ensure overall readiness by 2015. Mutual Recognition Arrangements (MRAs) are in place on testing standards in many areas. There is recognition of the need for Harmonization of Standards for human resources for health and the AEC areas of cooperation include human resources development, capacity building and recognition of professional qualifications. It is noted that recognition of qualifications is not enough to ensure market access in ASEAN. There are policies and regulatory frameworks affecting mobility and several countries have Medical Licensing Examinations. The focus is more on medical education than qualifications, which has implications to improve pre-and in-service training in Lao PDR to meet regional standards¹⁷.

¹⁵ Powerpoint presentation at Sub-regional Advocacy Workshop on MDGs for South-East Asia: MDGs Localization in Lao PDR - Ms. Phonevanh Outhavong, Deputy Director General of Planning Department, MPI, Vientiane, 24th June 2014

¹⁶ Open Working Group of the General Assembly on Sustainable Development Goals <http://undocs.org/A/68/970>

¹⁷ Jathurong Kittrakulrat et al The ASEAN economic community and medical qualification Glob Health Action 2014, 7: 24535 - <http://dx.doi.org/10.3402/gha.v7.24535>

From the Senior Officials Meeting on Health and Development (SOMHD), the vision is “A Healthy, Caring, and Sustainable ASEAN Community”. The issues are common to what member states including Lao PDR have stated in their respective health policies and strategies: (i) strengthen health system and access to care; (ii) achieve universal health coverage and increase access to primary health care; (iii) build up sufficient capacity of well-trained, motivated health workers; (iv) strengthen sustainable national health financing systems; (v) implement basic health packages, such as reproductive health, maternal, newborn and child health services; and (vi) promote equitable access to healthcare for all groups by reducing gender, geographical, social and financial barriers at all levels. In the past few years, the ASEAN Task Force on Maternal and Child Health has focused on developing regional guidelines for Skilled Birth Attendants and data harmonization of RMNCH indicators. As FP is one of the components of these activities, the entry point for universal access to rights-based family planning will be dependent on intensifying the integration of FP within MNCH services.

Policies and strategies related to reproductive health and family planning

The importance of reproductive health and gender equality for poverty reduction and the linkages between population growth, food security, rural livelihoods and the environment are recognized in national policies and strategies. These include the National Population and Development Policies; the National Strategy for the Advancement of Women; the National Reproductive Health Policy; and the National Strategy and Action Plan on HIV/AIDS/STI 2006-2010. Key programme strategies include: policy dialogue; advocacy; systems and human capacity development; integrated ser-

vice delivery; results-based management; the use of sectoral approaches; joint programmes with United Nations agencies; and a focus on decentralized levels.

The policy context for health and nutrition is strong. There is a National Health Sector Development Plan for 2011-2015, a National Nutrition Strategy and Plan of Action (2010-2015 – new Strategy and Plan being developed), and in 2009, MoH adopted the Strategy and Planning Framework for delivering an integrated package of maternal, neonatal and child health services (2009-2015). This is complemented by sub-sectoral plans such as the Skilled Birth Attendance Development Plan (2008- 2012), and the National Emergency Obstetric and Newborn Care Five Year Action Plan (2013-2017).

The gaps in the translation from policies to programmes were highlighted in reports and during interviews: insufficient human resource capacities to transform national policies into implementation plans; inadequate resources; geographical, social, cultural and financial barriers that impede access to and use of services; limited ability to address inequities and disparities within the different regions; lack of operational first line community health centres in rural areas; while in urban areas, most people rely on unregulated private care. In 2004, the “Health Equity Fund” was launched to provide free MCH services for the poor and vulnerable groups and operated in 64 districts and has expanded to other provinces¹⁸. An assessment of HEF implemented in northern Lao provinces reported that coverage increased significantly with increased utilization and coverage¹⁹. The HEF is subject to a certain extent to external donor project funding²⁰ while GoL continues to commit increasing amounts of funding for HEF²¹.

¹⁸ Annear, P. & Ahmed, S. (2012). Institutional strengthening for universal coverage in the Lao PDR: barriers and policy options, Nossal Institute for Global Health, University of Melbourne. DOI: http://ni.unimelb.edu.au/__data/assets/pdf_file/0006/623355/WP_19.pdf

¹⁹ Schwartz, J. Brad - HEF momentum: the key to Lao Universal Health Coverage - Ministry of Health, Department of Planning and International Cooperation, Health Sector Development Program Assessment Report (2015)

²⁰ Ibid. Annear, P. & Ahmed, S. (2012)

²¹ Ibid. Schwartz, J. Brad 2015

The implementation of health programmes was influenced by the decentralization process described as: Implementation of “Building province as strategy devising unit, district as a strong comprehensive unit and village as a development unit” which commenced in the second half of 2012. Nevertheless, the actual implementation has been slow and was not sufficiently effective due to the identification of the pilot districts and villages not being in accordance with the conditions of the Resolution and the Instruction from the central level; the delayed dissemination of the Resolution and Instruction at the local level, delegation of authority and responsibility of some sectors being in very general terms, lack of ownership at their local level, and limited capacity of district staff in developing plans and financial management.²² In addition to better coordination within the government, there is a need for developing district level capacity to plan and manage health programmes.

Investing in Reproductive, Maternal, Newborn and Child Health

Family planning is a strong component of maternal mortality reduction strategies and reduces 30-40 per cent of maternal deaths by preventing unwanted and potentially dangerous pregnancies. Reducing the number of unplanned births and having smaller families helps to reduce the level of need for public-sector spending in health, water, sanitation, education, and other social services. Preventing unplanned pregnancy among HIV infected women is the most cost-effective way of preventing maternal to child transmission of HIV. Family planning is an important and cost-effective investment for governments and contributes to multiple economic and health priorities, including reducing poverty. Investments in sexual and reproductive health are

critical for saving lives and reducing ill-health among women and their children and for fulfilling their internationally recognized right to good health²³.

Expenditures on health

The Government of Lao has expressed commitment to enhance the efforts to reform for better social health protection coverage, including increase in domestic funding for health. Table 4.1.1 shows the increasing trend in Total Health Expenditure (THE) per capita to 35.5 in 2011-2012.

²² Ministry of Planning and Investment: Five Year National Socio-Economic Development Plan (2016-2020) Draft February 2015

²³ Singh, Susheela, Darroch, Jacqueline E. and Ashford, Lori S. Adding it up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014 - Guttmacher Institute and UNFPA

Table 4.1.1: Total Health Expenditure (THE) per capita

Key HA Indicator	USD per capita FY 2009-2010	USD per capita FY 2010-2011	USD per capita FY 2011-2012
Total Health Expenditure (THE)	27.14	28.7	35.5

Table 4.1.2 presents the government expenditure on health and out-of-pocket expenditure on health. The total health expenditure (THE) as per cent of the GDP has remained at 3 per cent in 2010 and 2012. However, the total Government Health Expenditure as % of GDP in Lao PDR is among the lowest in the region and the government spending on health lags behind the ideal government spending on

health according to WHO of at least 5 percent of the GDP (WHO, 2013). The Lao government has committed to increase government spending to 9 percent of government expenditure to health, which is increased 3 times in the fiscal year 2010-2012. There are large disparities in government spending of health budget between central, and provincial levels²⁴.

Table 4.1.2: Lao Health Expenditure

Indicator	2010	2012
Total Health Expenditure as % of GDP	3%	3%
General Government Health Expenditure as % of General Government Expenditure	5%	5.9%
General Government Health Expenditure as % of Total Health Expenditure	47%	51%
Private Expenditure on Health as % of Total Health Expenditure	53%	49%
Out-of-pocket expenditure as % of Total Health Expenditure	42%	38%
External funding as % of Total Health Expenditure	29%	22%
Coverage of Social Health Protection (all schemes)	18.5%	

The General government expenditure on health (GGHE) as % of THE has been increasing over the last years from 35 per cent in 2000 to 47 per cent in 2010 and 51 per cent in 2012. The GGHE as % of General government expenditure has increased from 4 per cent in 2005 to 5 per cent in 2010 and 6 per cent in 2012 (the role of external assistance in the area of family planning is discussed in Section 4.3).

Development challenges and RH/FP - the inter-relationships

The main development challenge is ensuring

that the benefits from high economic growth, averaging more than 7 percent for the past five years, are evenly distributed and translated into inclusive and sustainable development. Widening gaps between rich and poor, women and men, ethnic groups, and residents of different regions of the country need to be addressed if Lao PDR is to graduate from Least Developed Country status by 2020 and achieve equitable and sustainable development in the post-2015 era.

Lao PDR has adopted a multi-sector approach

²⁴ World Bank (2012). Government spending on Health in Lao PDR: Evidence and Issues. WashingtonDC, USA.

to health and development. Evidence shows that gains in the health of women, children and adolescents since 1990, resulted from investments in the health sector as well as in other sectors.²⁵ To sustain and further enhance the improvements, the commitments need to be translated into greater government investment in the health sector.

As Laos has a large proportion of young people under the age of 24, there is the opportunity to reap a “demographic bonus” for the country’s economic development, sustainability and productivity. Systematic investment in education, health and employment opportunities for young people will lead to their improved outcomes and the longer-term benefit of increased economic growth. Young people form a large proportion of urban migrants and are highly vulnerable to risk and exclusion. Due to globalization, values, social mores and behaviour are changing rapidly in urban areas. It will be a challenge for the health sector to rapidly respond to those changes, and to explore ways to provide an attractive and adapted in-country package of preventive and curative health services, especially related to reproductive health.

4.2 National Reproductive Health Policy and goals, strategies, and achievements on family planning

National Reproductive Health Policy

The National Reproductive Health Policy (2005) envisions contributing to achieving the goal of improving the quality of life of the people and the sustainability of the national development strategy toward year 2020. Effective implementation of the RH Policy is expected to result in:

- a. Creation of an enabling policy environment and designing services to support reproductive rights and improve sexual and reproductive health of men, women and adolescents

- b. Guaranteed full coverage, equity and equal access to integrated and quality reproductive health care, services and information
- c. Motivation and support for couples and individuals to invest in, and protect their own and other people’s reproductive and sexual health

The NRHP encompasses nine elements; namely family planning, maternal and child health and nutrition interventions, prevention and control of HIV/AIDS/ STIs, prevention and management of abortion, promotion of youth friendly reproductive health, male involvement and participation in reproductive health, elimination of all forms of discrimination against women and children, reduction of breast and reproductive tract cancers, and reduction of the prevalence and psychosocial burden of infertility (Ministry of Health, 2005). The Policy addresses issues such as sexuality education and implicitly has a rights focus. It encourages men to take greater responsibility for their own sexual behaviour, as well as to respect and support women’s reproductive rights and health.

Implementation of family planning within the framework of Reproductive Health Policy

The objective of NRHP is to improve the availability and sustainability of, and access to quality family planning services to all couples and individuals of reproductive age. The strategies to ensure availability of FP services are through:

- implementing nationwide coverage of quality FP services and organizing information and education interventions
- promotion of modern, effective and safe contraceptives, including barrier methods that provide dual protection against pregnancy and STIs/RTI’s and emergency contraception
- promoting active involvement of young and adult men in family planning

²⁵ PMNCH,WHO,World Bank, AHPSR, et al. Success

The formulation of the RH Policy was not followed by the development of a strategic framework and implementation plan, which affected its operationalization. Furthermore, the focus of implementation was more on maternal and newborn health and family planning with less emphasis on management of post-abortion complications and RTI/STI and other elements of RH - which are inter-related with contraceptive services. The fragmented implementation led to unequal progress among the different elements of RH.

Reproductive rights were mentioned in the National RH policy and although a rights-based approach is not explicitly mentioned, mechanisms to strengthen health systems (duty bearers) to improve the coverage and quality of sexual and reproductive health information and services, particularly to vulnerable groups (rights holders) are among the strategies. However, the NRHP does not address the rights of adolescents, especially single unmarried adolescents. The Policy does not make reference to the empowerment of rights holders to claim their entitlements and the obligations of duty-bearers. The Policy identifies marginalized and vulnerable populations but does not describe strategies to reach them.

The implementation of the RH Policy was influenced by support from donors, e.g. FP programmes increased in coverage due to the combined efforts of Ministry of Health (MoH) and UNFPA. Discrete interventions for youth were conducted: life skills education for secondary schools was carried out by Ministry of Education, UNICEF, UNFPA and other partners; while youth-friendly services were supported by UNFPA and Lao Women's Union (LWU). Vertical approaches to individual components of the whole, such as HIV/AIDS, fragmented the sexual and reproductive health care agenda.

For the family planning component, initial efforts were concentrated on increasing the coverage of FP services and contraceptive commodity security. Demand creation was carried out through traditional awareness creation type of communication activities. Among the development partners, UNFPA provided the main support for these early efforts. In recent years, there has been an increasing focus on the quality of services through improving counselling and clinical skills of providers. However, health system issues compounded implementation: poor coverage, low health worker density and low-quality services, which affected populations in remote areas and rural residents.²⁶ The National Family Planning Action Plan for 2014-2015 and beyond was developed in 2013, and implementation is still in its early stages.

In 2009, MoH launched the Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services²⁷ which describes health system strengthening and mobilizing individuals, families and communities to achieve rapid and equitable scale-up for delivery of essential, cost-effective, evidence based interventions (Ministry of Health, 2009). Even though family planning is recognized to be one of the pillars of safe motherhood and management of post-abortion complications is a component of Emergency Obstetric Care, family planning does not feature prominently in the MNCH Strategy and Planning Framework. The emphasis was more on ensuring skilled birth attendance and providing emergency care for postpartum haemorrhage, eclampsia and obstructed labour.

Achievements

The Ministry of Health and development partners have made investments in the implementation of policies and programmes on FP, which

²⁶ Akkhavong K, Paphassarang C, Phoxay C, Vonglokham M, Phommavong C, Pholsena S. (2014). Lao People's Democratic Republic Health System Review. Health Systems in Transition

²⁷ Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services Ministry of Health (2009)

is reflected by positive trends in reproductive health indicators.

Decline in maternal mortality

Lao PDR has made significant progress in reducing maternal mortality ratio (MMR), which declined to 357 per 100,000 live births in 2009 compared to the 2005 MMR estimate from the Census (405 deaths per 100,000 live births). According to the estimates of the Maternal Mortality Estimation Inter-Agency Group, MMR stood at 220 per 100,000 live births in 2013²⁸. Declines in maternal mortality are associated with a halving of the total fertility rate between 1990 and 2012 from six to three – and associated increases in birth interval. Fertility declines are associated with improvements in the contraceptive prevalence rate together with socioeconomic and educational improvements. Although there are significant increases in the proportion of women delivering with a skilled health professional and delivering at health facilities, antenatal care coverage has shown little improvement; and coverage for interventions around delivery remains below 50 per cent. Much of the decline in maternal mortality is therefore likely to be associated with the decline in fertility and other socioeconomic improvements²⁹. It is recognized that maternal mortality remains among the highest in the East Asian Region, and therefore require sustained action to reduce the maternal mortality further to reach the target of 200 per 100,000 live births in 2020³⁰. Disparities in MMR within the country reflect the high and persistent inequities in access to and quality of basic services.

Increase in Contraceptive Prevalence Rate

The Contraceptive Prevalence Rate (CPR) for

modern methods increased from 28.9 per cent (LRHS 2000) to 35 per cent (LRHS 2005) to 42 per cent (LSIS 2012)³¹. Over 90 per cent of service delivery points were able to offer at least three modern methods of contraception including oral contraceptives (combined pill and progesterone-only pill), injectable and condoms. Sterilization services are limited, being offered mainly at provincial hospitals and at some district hospitals by a team from the respective provincial hospital. Furthermore, the availability of village-level FP services was facilitated in some areas through a community-based distribution programme, Village Health Workers and village drug kits, mobile clinics and EPI Outreach Network. Factors such as greater level of awareness, improved education levels and changing attitudes towards family size positively influenced contraceptive acceptability. However, due to contraceptive stock-outs, a mix of contraceptive methods was not always available to meet the diverse needs of individuals, so that they can choose the type of method that is best for their circumstances.

Reduced unmet need for family planning

The unmet need for family planning has declined from 27 per cent³² (LRHS 2005) to 19.9 per cent (LSIS 2012) with 12 per cent of women having an unmet need for limiting and 8 per cent having an unmet need for spacing. Unmet need is highest in the Southern region (24 per cent) and lower in the Central (21 per cent) and Northern (17 per cent) regions. In addition, there was a difference of unmet need between urban and rural areas (19 per cent versus 28 per cent). Unmet need is highest among women in Hmong-Mien headed households (31 per cent) and lowest in Lao-Tai

²⁸ Trends in Maternal Mortality: 1990-2010 WHO, UNICEF, UNFPA, The World Bank Maternal Mortality Estimation Inter-Agency Group, 2014.

²⁹ Ministry of Health Lao PDR, PMNCH, WHO, World Bank, AHPSP and participants in the Lao PDR multi-stakeholder policy review (2014). Success Factors for Women's and Children's Health: Lao PDR.

³⁰ 8th National Socio-Economic Development Plan

³¹ Ministry of Health and Lao Statistics Bureau, 2012

³² Committee for Planning and Investment National Statistics Centre and UNFPA (2005) Lao Reproductive Health Survey

³³ Ministry of Health and Lao Statistics Bureau, 2012 Lao Social Indicator Survey

headed households (18 per cent)³³. The overall decline in unmet need for contraception indicates not only increased access to contraceptives, but also changing behaviour patterns.

Reduction in Total Fertility Rate

The Total Fertility Rate (TFR) for the three-year period preceding the Lao Social Indicator survey is 3.2 children per woman. The TFR in rural areas exceeds the TFR in urban areas by 3.6 and 2.2 children per woman, respectively. The TFR has declined from 5.0 births per woman around 1997-99 to 4.7 births in 2000-02, to 4.1 and 3.6 in 2003-05 and 2006-08, and continued to decline to 3.2 in the recent three-year period prior to the survey (2009-2011).

However, the adolescent birth rate is 94 births for every 1,000 girls aged 15-19. Girls living in the Northern region have a higher fertility rate (120 per 1,000 girls) compared with girls who live in the Central and Southern regions. The fertility rate among girls living in rural areas is nearly three times higher than among girls living in urban areas (114 and 44 births per 1,000 adolescents, respectively).

The indicators highlight the inequalities by region, geographic areas, age and ethnicity and indicate where interventions will need to be directed for equitable access to RH/FP services.

Challenges

Significant improvements in sexual and reproductive health clearly cannot be achieved by the health sector alone. Sexual and reproductive health affects, and is affected by, people's personal experiences and relationships and by the broader context of their lives, including their place of residence, economic circumstances, education, employment opportunities, living conditions, and political, social and cultural environments. Multiple and complex factors

affect SRH, some of which are not within the mandate or influence of the health sector. Recognizing these interconnections, a multi-level and multi-sectoral approach needs to be adopted. This is especially relevant for vulnerable populations such as youth in general and young unmarried people in particular. Effective and evidence-based technologies and maternal and reproductive health interventions do exist, but many of these are not being implemented optimally.

The implementation of RH/FP interventions was constrained by health system issues as well as those more specific for FP. While the overall situation has improved, constraints to deliver quality RH/FP services³⁴ remain:

- Investments in programmes for RH care not commensurate with political commitment
- External assistance funding for FP has declined even though there is an increase in the number of people entering the reproductive ages and increasing demand for contraceptive choices
- Low health literacy among segments of the population with misperceptions on certain contraceptives such as IUD
- Conservative attitude of husbands and village elders regarding RH/FP and low status of women in certain ethnic groups
- Limited number and capacity of health staff to provide adequate services, especially at health centre level
- Inadequate coverage and sustainability of community-based interventions
- Limited availability of reliable ARH information and youth-friendly services for young people
- Fee for operational costs even though contraceptives are provided free a significant barrier for the poor
- Limited clinical and managerial capacity of

³⁴ Review of implementation of National Reproductive Health Policy and Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services (2011)

- health staff at subnational level
- Challenges in accessing services in mountainous areas due to distance, absence of roads and transport
- Weak systems for monitoring and managing the flow of supplies, i.e. logistics management for RH commodities, affecting contraceptive availability and choice

4.3 The role of external assistance in the area of family planning

Characterising external assistance to the Lao health system

Gathering reliable information on what investments are provided to support family planning policy and service provision is difficult at best. Therefore, the information discussion and conclusions presented here are confined to four key assumptions about the health system in Lao PDR. Firstly, that the effects of the period of decentralization (1987-1991) had negatively impacted the health policies and delivery system. Moreover, the period of re-centralization (1992-1996) did not sufficiently provide the environment to improve health equity and quality of care for the current system³⁵. Secondly, current policies focusing on economic development in relation to poverty alleviation and graduation from least-developed country status have influenced the low level of public spending and investment on social services such as health and education³⁶. Thirdly, the public health system in which the overwhelming majority of the population accesses health services is insufficiently funded, resourced and managed³⁷. Lastly, while it appears that Lao PDR receives significant amounts of official

development assistance, with respect to health financing. In addition as stated in Section 4.1, out-of-pocket spending at both public and private facilities also contributes to a significant amount of health. It is under this context that the review on the role of external assistance in family planning takes place.

There are four key themes which characterise external assistance as follows 1) funding, 2) technical support and capacity building, 3) coordination, and 4) monitoring, evaluation and research. Funding is discussed first as it underscores all dimensions of external assistance. The financial resources support material and technical inputs. However, as reproductive health commodities are dealt with under a separate section, this issue is not discussed in-depth in this section.

Funding

While domestic government spending on health has had a positive trend³⁸ public funding for the health system remains low as stated earlier even in relation to countries with a comparable level of GDP per capita³⁹. According to the Ministry of Health's 7th Five-Year Health Sector Plan (2011 – 2015)⁴⁰, there was a funding shortfall of 86 per cent for projects in reproductive health (safe motherhood and family planning). As indicated above the majority of health funding is raised from out of pocket expenses (over 60 per cent), while 15.1 per cent of health funding comes from external assistance and 18.5 per cent from social protection schemes and 5.9 per cent from Government sources⁴¹.

³⁵ Phommasack. B., Oula. L., Khounthalivong. O., Keobounphanh. I., Misavadh. T., Oudomphone. P., Vongsamphanh. C. & Blas. E., (2005): Decentralization And Recentralization: Effects On The Health Systems In Lao PDR, Department of Prevention and Hygiene, Ministry of Health, Vientiane; and WHO Geneva, Switzerland.

³⁶ World Bank, International Monetary Fund, Asia Development Bank and European Union (2007), Public Expenditure Review Integrated Fiduciary Assessment 2007 DOI: http://www.moe.gov.la/laoesdf/background_docs/Eng/Lao_Fiduciary_Assessment_2007_Eng.pdf

³⁷ Scopaz. A., Eckermann. L., & Clarke. M. (2011) Maternal health in Lao PDR: repositioning the goal posts, *Journal of the Asia Pacific Economy*, 16:4, 597-611, DOI: 10.1080/13547860.2011.610919.

³⁸ Ibid World Bank et al (2007)

³⁹ Ibid WHO and MoH (2012)

⁴⁰ Ministry of Health (2011), The 7th Five-Year Health Sector Development Plan 2011-2015; Vientiane, Lao PDR.

⁴¹ Ibid WHO and MoH (2012)

Thus the conclusion is readily drawn that dependency on the international donor community for external assistance in the health sectors is high⁴²⁴³. The above figures and field-work indicates that without external funding, the out-of-pocket costs could be even higher and therefore inequities in access to health services would be further exacerbated.

Another way to assess the situation is to look at actual funding amounts. In their examination of maternal health in Lao PDR, Scopaz et al. (2011), noted that of the total US\$708.76M⁴⁴ development assistance to support projects in Lao PDR for the year of 2009, excluding immunization projects, an estimated total of US\$7.5M was allocated specifically for maternal and child health programme implementation (inclusive of family planning projects). For that year, the two major donor agencies were UNFPA and WHO. In other words, approximately 1 per cent of overseas development assistance (ODA) to Lao PDR for 2009 was targeted for maternal and child health. Nonetheless, during the data collection phase, the contribution of international donors to family planning was fully recognized by the government representatives participating in the FPSA.

The literature reviewed for the situation analysis largely reported the limited public spending on the health system. However, there was minimal discussion on how to shift the apparent dependence on external donor contributions, reduce out-of-pocket costs and increase government investment into the health system. Discussions with key stakeholders have raised a suggestion that a multi-pronged approach to stakeholder engagement between government and non-government and International development partners is an effective strategy for funding advocacy. Participants reported that

international donors had supported engagement and advocacy projects with key agencies at the central government level, but these projects were of a short duration, such as 12 months. Participants concluded that this is not enough time to measure progress or address sensitive issues such as reproductive health and family planning.

While much of the official development assistance for reproductive health and family planning is allocated to address needs in technical training and the delivery of essential services, a proportion of funding is designated for the provision of reproductive health commodities. The analysis shows that the current level of ODA into the area of family planning while recognized as significant is not enough to meet the needs of health care clients and address the challenges in the Lao PDR health systems. Despite this, UNFPA currently provides over 90 per cent of the funds to procure contraceptives to Lao PDR. The challenges and issues relating to ensuring that the RH commodities are procured and distributed effectively will be discussed further in the coming sections.

The issue of having a single external funding source for the procurement of contraceptives was raised during discussions with stakeholders in the data collection phase, that it exposes large risks to clients as well as being an unsustainable strategy to improve the situation of family planning in Lao PDR. Having this issue raised by government partners signifies that there is an established, although informal understanding, that Lao PDR needs to shift from the position of being reliant on external funding in this area. This may provide a catalyst for negotiating a strategy that sees the transition of funding for programs from development partners to other sources (whether from social

⁴² European Commission (2009), Evaluation of EC Co-operation with the Lao PDR, Vientiane Capital Lao PDR.

⁴³ World Bank (2008). Lao PDR Public Expenditure Tracking Survey in Primary Education and Primary Health. Poverty Reduction and Economic Management Sector Unit East Asia and Pacific Region

⁴⁴ Ibid Scopaz. A. et al (2011)

health insurance, health protection schemes, philanthropic or enterprise based). The FPSA recognizes that diversifying funding sources is a significant challenge and any change to the current arrangements will be difficult.

Technical support and capacity building

External assistance is also characterized as technical support and capacity building. This comprises broadly of support in policy development, strategic planning, being informed and up to date about current international best practices in reproductive health and family planning, data analysis and reporting. The issues and challenges of reliance on international development assistance for Lao PDR are inextricable from the complex geopolitical events and history of the nation. During the FPSA desk review and data collection process, it became apparent that there is a changing role of external assistance in this area, specifically, the emergence and function of non-profit associations in Lao PDR.

While the Government enacted the 2009 Decree (Prime Ministerial Decree No. 115)⁴⁵ enabling community-based organizations (CBO) to be registered as non-profit associations, this is still in early stages. The parameters set out for how an NPA would operate remains vaguely written in the Decree. This suggests that interpretation of the limitations to what an NPA is able to provide in terms of services could be highly subjective. Therefore, the NPAs are operating in a highly risk-adverse context. Although a number of challenges remain, in terms of the extent to which CBOs may operate autonomously (such as being able to provide FP services as opposed to giving to information only), the landscape for fostering and supporting Lao civil society has moved forward.

The significance of having official status and

endorsement for NPAs to be operational cannot be overstated. It has created the potential for national experts whether in health care and other areas such as in management, research and contributing to FP service provision. The emergence of the Promotion of Family Health Association is one such example. The presence of external assistance working with Government has effectively created a viable environment for the NPA to function and thereby drawing on local technical and management personnel. The gaps and challenges are still present (low competencies, inertia of systems to change, limited autonomy), however the position of this FPSA purports that a deliberate and extended view beyond the five-year cycles of strategic plans is needed now.

Coordination

Another significant area in which external assistance can be seen is the support of various fora for programme coordination. These fora exist as working groups with other donor agencies, committees with Government as well as networks with INGO and NPA. While it is already established in other evaluations of the role of development partners in programme management and coordination, the FPSA emphasizes the important linkages that these fora and networks create. Stakeholders in the FPSA reflected that regular discussions and attendance to committee meetings were effective means ensuring current information and maintaining good relationships between implementing partners across the range of government administrative levels. This reflection is important as it underlies how stakeholders access and use information in a time constrained work context. Written reports in Lao while available may not be easily navigated and English language reports are not accessible to the majority of Government staff. Therefore, opportunities to share information and discuss at coordinating fora is an aspect of

⁴⁵ Prime Minister's Office (2009). Decree on Associations (No. 119/PM). Vientiane Lao PDR.

external assistance, which fosters stakeholder engagement and strengthens the relationship between them.

Monitoring, Evaluation and Research

Although monitoring, evaluation and research is discussed as the last area in which the role of external assistance in family planning is significant, it is perhaps an area, which will position current programme efforts to increase transparency, demonstrate outcomes and support long term planning for improving the health care system. External assistance is supporting the examination, revision and analysis of indicators relating to reproductive health and planning⁴⁶ as well as scholarly investigations into challenging but relevant topics such as health financing and the use of indicators to measure apparent success or failure against specified targets⁴⁷. Specifically, both the literature reviewed and stakeholder perspectives concur that progress towards the achievement of MDG 5 is slow, and likely to be partially achieved in 2015. Yet, when the depth and breadth of analysis is considered, the data also shows the importance of drawing on monitoring, evaluation and research to advocate with government for continued transparency and accountability. For instance, evidence showing that the age of first childbirth and access to antenatal care⁴⁸, level of government funding of maternal health, quality and acceptability of health care and donor support for maternal health programmers⁴⁹ are also key determinants in affecting maternal health outcomes. These insights were produced from external assistance into the area of monitoring, evaluation and research. Investing in having strong systems to support a rigorous evidence base is an effective strategy to inform critical conversations between development partners.

In conclusion, the role of external assistance to the area of family planning can be understood as significant. The implication of this is that public resources for the health care system are not only low but the capability to mobilise resources continues to be a challenge for the Government. As discussed above, this is particularly evident in the technical, capacity building, coordinating, monitoring, evaluation and research areas. While funding contributions provided by external assistance to the Lao health system is also considerable, as the data show, a higher proportion of health financing comes from out-of-pocket costs of health care clients. Due to external assistance it is also clear that systems for defining, collecting and measuring progress are improving as well as capabilities for critical analysis of this information. The importance of this aspect cannot be overstated.

4.4 Stakeholders in Family Planning

The stakeholder mapping process comprised of three steps: stakeholder identification, understanding roles and responsibilities pertinent to family planning and participation in networks. After identification of stakeholders, several areas are examined: their roles, expertise in reproductive health and family planning and scope of influence, gaps in capacity, service coverage and resources. The recommendations emphasize collaborative actions to bridge the issues in coordination and partnership thereby maximizing resources and opportunities. Annex iii provides an extensive description of stakeholders who are engaged directly with FP. The opportunity to increase this list of stakeholders is elaborated under the recommendations sections.

⁴⁶ Seetharam. K.S., Sedlak. P., & Pirie. A., (2011). Assessment of development results supported by UNFPA CP4 for Lao PDR: Report and recommendations, UNFPA Vientiane Lao PDR.

⁴⁷ Ibid Scopaz, et al. (2011)

⁴⁸ Ministry of Health, Lao Statistics Bureau, UNFPA and UNCIEF (2012).The Lao Social Indicator Survey, Vientiane Lao PDR.

⁴⁹ Ibid WHO and MoH (2012)

Stakeholder Identification, Roles and Linkages
The identification of stakeholders in the area of family planning canvassed any organisation that has either indirect or direct involvement in reproductive health, adolescent reproductive health, maternal health or family planning. This first filter produced an extensive list of organisations, which has either direct or indirect connections to FP work.

categories of stakeholders:

- Public Sector (further subdivided into Policy Drivers and Service Providers)
- Commercial Sector
- Development Partners
- International Non-Government Organisations
- National Non-profit Associations

This list is presented in Table 4.4.1 under five

Table 4.4.1: Stakeholders identified through the stakeholder mapping process.

Group	Organisation
Public Sector Stakeholders: Policy Drivers	<ul style="list-style-type: none"> ▪ Ministry of Health Departments ▪ Lao Women’s Union ▪ Lao Youth Union ▪ Ministry of Education and Sports ▪ Division for Social and Cultural Affairs, National Assembly ▪ Lao National Commission for Advancement of Women, Prime Minister’s Office ▪ Division for Social Development Planning, Department of Planning
Public Service Providers	<ul style="list-style-type: none"> ▪ Central and Provincial Hospitals ▪ Provincial Teacher Training Institutes ▪ Mother and Child Health District Office ▪ District Health Office ▪ District Hospital ▪ Health Centre ▪ Vientiane Youth Centre ▪ Village Health Volunteer ▪ Community Based Distribution provider
Commercial Service Providers	<ul style="list-style-type: none"> ▪ General and Specialised Clinics ▪ Pharmacies ▪ Hospitals (Vientiane Capital only) ▪ Private Wards in major hospitals (Obstetrics/Gynaecology)
Development Partners	<ul style="list-style-type: none"> ▪ UNFPA ▪ UNICEF ▪ Asia Development Bank ▪ Global Alliance for Vaccines and Immunisation - Health System Strengthening ▪ Japanese Government (JICA) ▪ Luxembourg Government (Lux-Dev)

	<ul style="list-style-type: none"> ▪ World Health Organisation ▪ Korea Foundation for International Health Care ▪ World Bank
INGO	<ul style="list-style-type: none"> ▪ Population Services International ▪ Save the Children International ▪ World Vision Lao PDR ▪ Plan International Lao PDR ▪ Medecins du Monde
National NPA	<ul style="list-style-type: none"> ▪ Promotion of Family Health Association ▪ Association for Development of Women and Legal Education ▪ Lao Positive Health Association ▪ Youth to Youth Peer Workers in Health Education and Development Association ▪ Learning House for Development

Under the Ministry of Health, there are several departments and divisions that each has a role supporting FP in Lao PDR. Two observations can be made during the visits with MoH departments. First is that while there is one main Implementing partner for UNFPA, there are a number of Sub-implementing partners. At the strategic and policy level, this means that support for coordination and information sharing is then a key imperative to maintain FP on the government's agenda. The second observation is that FP initiatives are totally under the oversight of MoH with partnerships with a few INGOs.

A number of INGOs and NPAs are working in the area of primary health care. However, the extent to which these organisations are informed or equipped to promote FP may not be as strong as other elements of health care, such as water, sanitation and community hygiene. There is an opportunity for INGOs and NPAs working in the health area to also include FP in health promotion activities and interventions.

The above table also suggests that with such a long list of organisations, family planning is well resourced in terms of personnel, technical

expertise, materials and funding sources. But this is not the case. GoL partners largely rely on programme assistance of UNFPA and this was reported to be so at each level of government. Moreover in terms of other partners or contributors, it is of note that in the search for stakeholders, no national academic institutions were found to be engaged in project research or implementation related to family planning.

The next level of criteria applied for stakeholder analysis was to examine the specific goals, functions and coverage of the organisations identified as FP stakeholders. Table 4.4.2 shows stakeholders, which have stated specific objectives and projects in family planning. When stakeholders that are directly working in the area of FP are looked at, it is apparent that the number of stakeholders is reduced. In addition, the coverage for services becomes limited.

Table 4.4.2: Stakeholders, Objectives and Mandates for FP

Group	Stakeholder with specific FP objectives and targets	Summary description of benefit to FP
Public Sector Stakeholders: Policy Drivers	<ul style="list-style-type: none"> ▪ Ministry of Health o Department Hygiene and Health Promotion o Mother and Child Health Centre (National and Provincial) o Medical Products and Supply Centre o Food and Drug Department o Health Care Department o Department of Training and Research 	Strategy, Policy, regulations, resourcing and quality assurance to area of FP
Public Service Providers	<ul style="list-style-type: none"> ▪ MCH units at hospitals (Capital, Provincial, District, Health Centre) ▪ Vientiane Youth Centre ▪ Village Health Volunteer ▪ CBD provider 	Increasing rates of contraceptive use, and choice, generation of data to show births being spaced and/or limited, referrals, access for vulnerable populations
Commercial Service Providers	<ul style="list-style-type: none"> ▪ Pharmacies 	Procurement of short term modern FP methods
Development Partners	<ul style="list-style-type: none"> ▪ UNFPA ▪ WHO 	International best practices shared with partners; informed programming, transparency.
INGO	<ul style="list-style-type: none"> ▪ Population Services International ▪ Save the Children International 	Healthier pregnancies and mothers; birth spacing and limiting, improved outcomes for newborns; referrals
National NPA	<ul style="list-style-type: none"> ▪ Promotion of Family Health Association ▪ Youth to Youth Peer Workers in Health Education and Development Association (YPHA)* 	Initial benefits: increased understanding to target populations on FP and technical training.

*Remark: The consultant was unable to speak on the phone or receive an email reply to enquires. From the desk review, it could only be determined that YPHA is a registered NPA with the Ministry of Home Affairs.

The contributions provided by the above stakeholders to FP reflect a combination of outputs and outcomes to FP related policies, funding and service provision. However, the stakeholder mapping process has identified that there are currently no significant funding sources and technical assistance outside of the current development partners for FP. Without the national capability to drive the initiatives in FP, the important gains made to date are precariously positioned and could be regressed if

development partners reduced the programme scope and scale.

When looking at the opportunities for participation in networks that include family planning, the list of stakeholders becomes even smaller (Table 4.4.3). The networks are also orientated toward coordination of programme and project management and situated mainly at the national level.

Table 4.4.3: Participation in Networks

Group	Lead on Committee/Network or Working Group	Other members
Public Sector Stakeholders: Policy Drivers	<ul style="list-style-type: none"> MCH/EPI technical working group Sector Working Group National Commission on Mother and Children The Global Partnership for Maternal, Newborn and Child Health 	<ul style="list-style-type: none"> Sub-national agencies (Provincial level) Development Partners
Public Service Providers	Not known at time of FPSEA	Not known at time of FPSEA
Commercial Service Providers	Not known at time of FPSEA	Not known at time of FPSEA
Development Partners	<ul style="list-style-type: none"> Sector based committees 	<ul style="list-style-type: none"> Relevant Ministries Programme Implementing Partners Join UN Programme Partners
INGO	<ul style="list-style-type: none"> One listed working group for Health and Nutrition (includes FP) 	Not known at time of FPSEA
National NPA	Not known at time of FPSEA	Not known at time of FPSEA

The results of the stakeholder mapping show that there are a limited number of fora that focuses on family planning. As shown here, other line ministries, the National Assembly and national level committees, posits FP within poverty eradication framework or attended to in discussions about the MDGs. As a result, FP features mainly in the donor agencies and national implementing partners committees and networks, which focus on supporting programme management and coordination funded by external assistance. The landscape for civil society organisation shows that many challenges are ahead, the least of which is the nature of government oversight, capacity and funding. While the stakeholder mapping has highlighted these issue, it is also possible to propose that the opportunity is present to increase the number of networking/communication platforms for sharing technical and material resources. The benefits to UNFPA are both

strategic and practical. The strategic benefits will be to expand capacity among the health sector partners and to inform them about the FP action plan. This will lead to the practical benefits of potential more organisations engaging with FP as a priority within respective target areas and populations.

4.5 Environment - human rights-based family planning as an integral part of sexual and reproductive health and reproductive rights

The success of family planning programmes are in a large part due to the favourable environment and political support for the programme. Despite high-level support, it is necessary to continually reinforce an enabling environment to ensure that family planning programmes can function smoothly, adequate resources are actually disbursed, and laws, regulations, and cultural barriers do not impede progress.

Findings and Analysis

Commitments of government of Lao PDR

The Government of Lao PDR has committed to achievement of the ICPD PoA and MDG targets, and to the United Nations Secretary General's Global Strategy for Women's and Children's Health in 2010 and Family Planning 2020 has identified Lao PDR as one of the 69 focus countries.

The Government, as provided for in the Constitution, laws and policies has made efforts to encourage, promote and protect the legitimate rights and interests of Lao women in all fields: political, economic, social, cultural and family. In May 2002, the Government established the Lao National Commission for the Advancement of Women (Lao NCAW) in order to promote gender equality and to eliminate discrimination against women in Lao PDR.⁵⁰

From commitments to policies and strategies

The commitments made at the international level have been translated into laws and policies that provide the framework for maternal and reproductive health. In addition to the National Reproductive Health Policy, others include the 2004 Women's Development and Protection Law, the 1999 National Population and Development Policy revised in 2006, and the Strategy and Planning Framework for the Integrated MNCH Package (2009-2012). Moreover, the 1999 Prime Ministerial Decree on the Establishment of the National Commission for Mother and Child articulates the Government's commitment to the well-being of women and children. The various laws provide a framework for better regulation and implementation of health programmes. However, the institutional capacity for translation of policy into effective implementation is still limited⁵¹.

The senior policy-makers and decision-makers from the National Assembly and Ministry of Health are aware of the Reproductive Health (RH) Policy and have either used or referred to it in implementation of activities. The same holds true for the development partners. Decision-makers from the Ministry of Health and officials and service providers from different administrative levels stated categorically the benefits of FP to the woman, her children and family and the community; and could describe the current status of RH and FP and the activities in their respective domains. Their perception of FP is beyond birth control and recognizes its contribution to economic development. They could discuss the achievements over the years and recognized the geographical, financial, social and cultural barriers to accessing care experienced by sub-groups of populations and the challenges faced by administrators with respect to low public expenditure on health, shortage of qualified staff, a secure supply of commodities and budget for outreach activities.

Expenditures on health

The Government of Lao has expressed commitment to enhance the efforts to reform for better social health protection coverage, including increase in domestic funding for health and has committed to increase government spending to 9 per cent of GDP which is increased 3 times in the fiscal year 2010-2012. There are large disparities in government spending of health budget between central and provincial levels⁵².

The *Law on Health Care (2005)* provides that all citizens regardless of sex, age, ethnic origin, race, religion or socioeconomic condition have the right to receive health-care services, and requires delivery of health care in an equitable manner. However, out-of-pocket payments are

⁵⁰Lao PDR Gender Profile. Vientiane, Lao Women's Union, Gender Resource Information and Development Centre (2005)

⁵¹ Akkhavong K, Paphassarang C, Phoxay C, Vonglokhamb M, Phommavong C, Pholsena S. (2014). Lao People's Democratic Republic Health System Review. Health Systems in Transition

⁵² World Bank (2012). Government spending on Health in Lao PDR: Evidence and Issues. Washington DC, USA.

charged in public and private facilities. The out-of-pocket expenditure as percentage of total health expenditure has decreased from 62 per cent in 2005 to 42 per cent in 2010 and 38 per cent in 2012. The out-of-pocket payment has an implication on access and equity and the burden of population in health care. The government's response is by increasing the government health budget, expansion of pre-payment schemes, and developing the health equity fund to ensure that the poor vulnerable people could access to health services in order to achieve the UHC⁵³.

Discussions during the FPSA indicated that currently the Government budget was mainly for capital investment while activities were in a large part dependent on ODA and loans and used primarily for training, supervision and procurement of contraceptives. With a view to national ownership and sustainability, government will be increasing and sustaining domestic investment in health. At present, there is a small budget line for procurement of contraceptives and for training. However, this was envisioned to change with dedicated funding for RH commodities in the national budget and co-funding with development partners for health interventions with the government funding gradually increasing relative to donor funding. Furthermore, the government would continue to procure vaccines and contraceptives through UN agencies.

The share of expenditure by "diseases" indicated that 0.7 per cent of the budget is used for contraceptive management, which was 1,126,953 in 2010-2011 fiscal year and 764,471.43 in 2011-2012 fiscal year.⁵⁴

World Bank Management is proposing a new Program-for-Results lending instrument to respond to changing development needs and

demand from borrowing countries including Lao PDR. Disbursements would be determined by reference to progress on monitorable performance indicators, rather than simply by whether expenditure had been incurred. The World Bank plans to support MoH on FP and nutrition in the upcoming strategy for country partnership. A Nutrition and Family Planning Commodity Committee in the MoH, which provides oversight to Nutrition and FP interventions, will monitor nutrition and FP status and conduct commodity mapping. A performance indicator - Disbursement Linked Indicator (DLI) at central level is: % of target provinces having 2-quarter stocks of essential family planning and nutrition commodities (this will be the result from the establishment of the committee). At provincial level, a DLI that states: % of villages in Zone 2 and 3 areas that received 4 integrated outreach sessions per year would indicate provision of equitable services to the most remote areas.

4.6 Demand for family planning according to clients' reproductive health intentions

Universal access to reproductive health is largely influenced by health and health-care seeking behaviours which can be improved by a variety of health promotion interventions.

Findings and Analysis

Contraception

Knowledge of contraceptive methods

There has been an increase in knowledge of modern contraceptive methods. Knowledge of at least one method of contraception is nearly universal among both women and men, regardless of marital status and sexual experience. Over 90 per cent of women and men have heard of a modern method. Both women and men are more familiar with modern methods

⁵³ Akkhavong K, Paphassarang C, Phoxay C, Vonglokham M, Phommavong C, Pholsena S. (2014). Lao People's Democratic Republic Health System Review. Health Systems in Transition.

⁵⁴ HealthAccounts in Lao PDR - Evidence for policy-making PowerPoint presentation, Ministry of Health - 30 April 2015

of contraception (94 and 95 per cent, respectively) than with traditional methods (68 and 69 per cent, respectively). Unmarried sexually active women and men know of modern methods in similar proportions as their married counterparts.⁵⁵

The Lao Social Indicator Survey (LSIS) also reported that nine in ten women have heard about the pill and about injectables. More men report knowledge of the pill (85 per cent) and the male condom (91 per cent) than any other contraceptive methods. Among the long acting methods, knowledge of IUD is relatively high (72) per cent and low for the implant (44 per cent) among married women. However, there is a gap between knowledge of modern contraceptives, which is 94 per cent, and use, which is 42 per cent. The gap is wider for long-term reversible contraception (LARC) where IUD use is 1.6 per cent and 0.1 per cent for the implant, which has not been extensively introduced in the public sector⁵⁶. The Lao Reproductive Health Survey (2005) reported that reasons for not using contraception include desire for more children, health concerns, lack of knowledge, husband's disapproval, and problems with accessibility and affordability of contraceptives⁵⁷, which still remain relevant at the time of the analysis. There remains a need for comprehensive and BCC targeted to couples to close the gap between knowledge and practice.

Current contraceptive use

Fifty per cent of currently married women reported currently using a contraceptive method while 42 per cent were using a modern method. The most popular method is the pill, used by 2 in 10 married women and injectables are the second most popular method, used by 14 per cent of currently married women. Five per cent of married women are sterilized, and all other

modern methods are used by fewer than 2 per cent of married women. Five per cent of married women report using periodic abstinence.

During the field visits we observed that most of the women visiting health facilities were current users who came to obtain pills or the injectable. Although approximately half of them were over 35 years with 4-5 children and did not desire to have more children, long-term methods were not discussed during the client provider interaction. Clients voiced concern about side-effects of IUD such as lower abdominal pain, migration to other parts of the body, the perceived inability to perform farming and hard work. Lying on the examination bed was culturally not acceptable for some. They were willing to "try" the implant to see if it would suit their needs. While providers could provide information on pills and injectables, they were not knowledgeable on LARC. Providers reported that for many ethnic women, the husband's approval was necessary for contraceptive use.

Source of information on contraception

With respect to access to media for women aged 15-49 years, LSIS reported that 13 per cent read the newspaper once a week, one-third listen to radio once a week and 75 per cent watch TV at least once a week. Staff from the Centre of Information and Education for Health (CIEH) and provincial and district officials reported that health messages and also those on contraception are broadcast as radio spots in Lao, Khmu and Hmong languages on national or local radio programmes. Television spots on FP are also broadcast but on a limited scale due to cost implications. Provincial and district officials used public address systems during visits to villages, both to mobilize and educate villagers.

⁵⁵ Ministry of Health, Lao Statistics Bureau, UNFPA and UNICEF (2012).The Lao Social Indicator Survey, Vientiane Lao PDR.

⁵⁶ Ministry of Health, Lao Statistics Bureau, UNFPA and UNICEF (2012).The Lao Social Indicator Survey, Vientiane Lao PDR.

⁵⁷ National Statistics Centre and UNFPA (2005) Lao Reproductive Health Survey, Vientiane Lao PDR

The public sector is the major source for information (and supplies) on modern contraceptive methods. Providers and clients mentioned that women learnt of methods mainly from friends and health staff and that in urban areas, health literacy is high. Health literacy is related to women's education level (which is lowest in the south) and traditional gender norms and power dynamics in rural areas. Literacy among young people (15-24 year-olds) is 69 per cent for young women and 77 per cent of young men. Young women and men in the Central region have the highest literacy rate while it is lowest in the South.⁵⁸ The low educational level is one of the factors associated with populations in remote, rural areas and ethnic groups having misperceptions about methods and side effects. Other vulnerable populations, young people and migrants in urban areas, face social barriers such as fear of disapproval, stigmatization or judgment by clinic staff in accessing information and services and feelings of shame that others might get to know of their visit.

There was a dearth of communication materials at district hospitals and health centres visited. A few facilities had the Lao version of the Decision-making Tool for FP Clients and Providers (DMT), but it was not used during every client-provider interaction. There were no pamphlets or brochures on FP or other RH issues and only one poster was seen at one of the health centres. Providers stated that there was one set of materials on RH/FP at the health facility, which was used during outreach visits to the villages. In some facilities, health staff had improvised their own IEC material but pasting different contraceptive methods on a cardboard. Providers are trained on counselling using the DMT but often face challenges communicating with women who present with needs specific to the Lao situation. Twenty-six per cent of current users reported that their

contraceptives were obtained from the private medical sector. The pharmacists and storekeepers interviewed during the period of the Situation Analysis indicated that they sold the pills or injectables and provided little information to their clients on the use, side effects, continued use, etc. but believed that women had already learnt from their friends.

Policies and programmes

The government of Lao PDR formulated the decree for the National Policy on Health Communication in 2012. Among the 15 points, the key points are:

- Strengthening of the health communication networks of each administrative level
- Enhancement of internal and international co-ordination and co-operation
- Development of human resources
- Promotion of Health IEC materials development and distribution and use of health media

The Centre for Information and Education for Health (CIEH) is taking the lead to conduct health communication programmes in coordination with relevant ministries, development partners, mass organizations and NGOs for implementation of a coordinated and technically sound communication strategy. CIEH has been tasked to mobilize resources, and coordinate communication interventions of different organizations working in reproductive health (and family planning) to create coherence, avoid duplication and build synergy across their work.

A Health Communications strategy with a focus on social and behaviour change was developed in accordance with the policy and CIEH and implementing IEC/BCC activities for health is in the early phases. With respect to RH, a comic book/cartoon on HIV prevention, brochures, leaflets and posters on FP and im-

⁵⁸ Ministry of Health, Lao Statistics Bureau, UNFPA and UNICEF (2012). The Lao Social Indicator Survey, Vientiane Lao PDR.

plants were developed in the past few years. However, the production and distribution were limited mainly to districts and provinces supported by development partners. Provincial authorities reported that they developed their own IEC materials, i.e. a flip chart on MNH, nutrition and family planning. However, the information on FP on a flip chart from one of the provinces is limited to one page and the illustrations were not well-designed.

Staff at provincial and district hospitals informed us that interpersonal communication needs dedicated time from trained providers and due to the client load, there was insufficient time to have a meaningful discussion with clients, and they were inclined to give the method requested. District and health centre staff conduct outreach activities, which are scheduled every three months. However, not all activities were conducted as planned due to limited numbers of staff and budget. Health administrators noted that to have effective outreach activities in villages which ethnic groups reside, it is imperative that the health staff should be a member of the same ethnic group. An example was provided of how immunization coverage had improved after a Hmong doctor joined a health centre and how native village health volunteers enhanced contraceptive uptake.

Interventions for the marginalized populations

Overwhelmingly, demand generation strategies and actions target married couples, and usually only the wife. Survey reports and discussions highlighted that the ethnic minorities living in remote, mountainous areas and young people are those who have the most needs for information and sexual and reproductive health services. Some interventions that have been developed specifically for marginalized populations are discussed below.

Interventions for the rural population

Focused IEC activities are conducted in project provinces, i.e. expanding access to FP through culturally appropriate and community-based services. Community-based distribution (CBD) is a strategy that relies on trained nonprofessional members/or retired health workers of the community to provide health services directly to other members of the community⁵⁹. CBD agents visit each household in their village(s) to discuss and provide FP information and services. Despite the promising results, i.e. increased contraceptive use, access to injectables and antenatal visits; the activities stopped in most of the villages after UNFPA support was withdrawn from Saravan, Sekong and Attapeu (see Section 4.7). Currently CBD agents are supported in four provinces: Savannakhet (South/Central), and Phongsali, Luang-Namtha and Oudomxay in Northern Laos by UNFPA.

An ongoing project carried out in four districts in Savannakhet, which seeks to address socio-cultural factors among ethnic groups, is directed towards village authorities who have considerable influence on health decision making. Village, village cluster and district authorities received training so they could discuss with young couples who are about to get married, to have a clearer understanding about the risks of adolescent pregnancy and to encourage them to practice family planning.

Targeted interventions for young people

The Vientiane Health Centre for Youth and Development (VHCYD), a programme implemented by the Lao Womens' Union (LWU) was set up with support from RHIYA to respond to the need among the young for easily accessible and affordable information and counselling on SRH matters including clinic services. The Centre provides gender-specific clinic services, telephone hotline, and outreach activities for

⁵⁹ Report for an Evaluation of two UNFPA Lao PDR Programmes: Community Based Distribution (CBD) and Individuals, Families, and Communities (IFC) Final Draft 0.3 15 January 2014

youth. A youth-friendly Referral and Counselling Network (RCN) of health service providers in Vientiane Capital for high-risk groups was established and CHAS/RCN members provide technical support to enable the delivery of quality, youth friendly services. In addition, the Youth Centre staff conducts targeted outreach for migrant factory workers in Vientiane capital. There are two toll-free numbers - one for girls and another for boys that respond to about 3,000 calls per month, in 2014, there were 43,000 calls. Condoms, oral pills, emergency contraception and implants are provided at the clinic and during outreach visits to factories.

While the Centre has mobilized resources to implement outreach and other interventions, the frequency of outreach activities is dependent on the level of funding. In the second half of 2014, 165 outreach activities took place and reached more than 8,000 youth. However, the coverage is limited to Vientiane capital with a focus on workers living in dormitories in medium to large factories. It is mainly the young people in urban areas who access the toll-free hotline and there were 43,000 calls last year. The three main “tools” of the VYCHD operations, the Hotline, Clinics and Outreach, have been evaluated⁶⁰ and are believed to be successful in reaching youth in Vientiane with information and services on SRH.

The Kaisone District Youth Counselling Service, Savannakhet was modelled after the Vientiane Youth Centre and the district health officers conduct visits to factories, villages, colleges and entertainment venues to promote services. The Savannakhet Teacher Training Institute provides counselling services and is able to provide information, training and condoms to students. Training of peer educators

is conducted so they can engage with friends about SRH and to encourage them to seek help if they need it from the service at the college.

Given that nearly 60 per cent of the population is below the age of 25 years and more than 30 per cent of the population is between 10 and 24 years, young people constitute a large proportion of the Lao PDR’s population. Despite teenage pregnancies and risky sexual behaviour being common, adolescents’ knowledge regarding reproductive health and contraceptive use is very limited⁶¹. The interventions for SRH information and services for youth in Vientiane and Savannakhet are promising, and have been reviewed for scaling up and sustainability.

Other demand creation approaches

Women’s knowledge of long-acting reversible methods of family planning, such as intrauterine devices (IUDs) and implants is lower compared to other FP methods and there are rumours, myths and misconceptions regarding the use of IUDs. To address these issues, Population Services International (PSI) introduced targeted interpersonal communication (IPC) to address misconceptions and uncover women’s needs and barriers to using LARC in Vientiane Champasak and Sekong provinces, and Vientiane capital. It has also been introduced at Luangprabang, Borikhamxay, Khammouane, Saravan and Attapeu provinces, in which the focus is at provincial level.

IPC agents are equipped with job aids and reach women through house-to-house visits and neighbourhood meetings to educate them about contraceptives and LARC. Follow up visits help IPC agents to understand clients’ stages of change and how to address the clients’ needs. These agents refer clients to the health facilities for further counselling and services. In

⁶⁰Lao Womens’ Union Vientiane Capital, Vientiane Youth Centre for Health and Development - Evaluation March 17 – April 22, 2011 - Evaluation Report

Assessment of development results supported by UNFPA CP4 for Lao PDR: Report and recommendations. Seetharam, K. S Sedlak Philip and Pirie, Antoinette - 2011

⁶¹Department of Health of Vientiane Capital (PCCA), Burnet Institute and UNFPA - Young Women’s Sexual Behaviour Study Vientiane Capital, Lao PDR (2008)

another project, women who have used long-acting methods are invited to share their experiences with other prospective users through “peer-to-peer” communication. These activities were conducted simultaneously with improving skills of providers at the respective health facilities which lead to a four-fold increase in IUD users.

Challenges in conducting IEC/BCC programmes

The challenges in conducting IEC/BCC programmes are summarized as follows:

Co-ordination across sectors

Implementation of Advocacy, IEC and BCC interventions involves coordination across various sectors, including several ministries and various mass organizations in addition to multilateral, bilateral and non-government (NGO) development partners.

Social and cultural diversity

Women in rural areas have very limited or no power in deciding when to have children and how many children to have or to decide whether to practice family planning. Disapproval by husbands ranked third among the reasons for non-use of contraception for about one out of ten non-users (9.7 per cent)⁶², which negatively impacts on women’s decision-making. As such, the awareness creation type of communication activities which have been the norm in the past are not likely to have any impact on increasing the contraceptive prevalence rate. While it may be useful for women to have information on FP methods, women may not be able to translate this information into a new behaviour because of a number of influencers within the family and the community. A behaviour change communication approach should focus not only on changing the behaviour of women but also to change the behaviour of immediate family members as

well as other community influencers to create a supportive environment for women to practice family planning.

Limited coverage of vulnerable populations

There is also limited reach of target populations due to lack of resources (human, material, financial) for advocacy, IEC and BCC activities at all levels-provincial, district and community levels. Strategies for participatory and empowering advocacy, IEC and BCC interventions are still under development and implementation often limited to ‘pilots’. Another major challenge is to reach the most vulnerable populations who live in remote areas, particularly ethnic minorities.

While traditional media has been used, there is a need to employ social media and mobile-phone and web-based approaches for young people in urban areas. There is a limited evaluation and monitoring of supported activities to inform plans for scaling up, an issue that should be addressed in future programmes.

Promising pilot projects not scaled up

Despite the existence of documented best practices or promising approaches in reproductive health communication in the country, a number of communication programmes were not continued nor scaled up.

4.7 Availability of good-quality human rights-based family planning services

The overarching strategy of family planning programmes is to offer clients easy access to a wide range of affordable contraceptive methods through multiple service delivery channels in a reliable fashion. The relationship between the quality of services provided, utilization of services, and health outcomes is well-established.

⁶² National Statistics Centre and UNFPA (2005) Lao Reproductive Health Survey, Vientiane Lao PDR

Findings and Analysis

Services in the public sector were analysed in according to the AAAQ framework of the standards with regard to health facilities, goods and services of the human rights-based approach to programmes. While Lao PDR had committed to sexual and reproductive health and rights at Cairo during the ICPD, these rights have not been explicitly mentioned in programme documents.

Availability

The public sector delivers RH services in Lao PDR through government owned and operated health centres and district, provincial and central hospitals. At the community level, health centre staff and outreach workers provide primary health care⁶³. The formal health sector provides reproductive health services through MCH and obstetric units in the hospitals and health centre clinics. In addition to family planning, services for antenatal care, delivery and postnatal care, emergency obstetric and neonatal care and management of post-abortion complications are available.

FP methods provided at the health facilities

The family planning methods provided at health facilities are described in 4.2 Contraceptive Prevalence Rate and demand generation activities for IUD in the community by Interpersonal Communication (IPC) agents and training for providers in four provinces are described in Section 4.6 Demand creation approaches.

Tubal ligation (female sterilization) is performed at provincial and central level hospitals and by special arrangement at district hospitals, by a team from the respective provincial hospital. UNFPA provided support in three southern provinces: Saravan, Sekong and Attapeu and in Oudomxay to subsidize for female sterilization and an initial assessment indicated

strong support from community leaders and an overwhelming demand by couples who had reached their desired family size.

There are plans to introduce sub-dermal implants at the provincial hospitals to broaden the method choice. Initial awareness-raising activities by staff of provincial hospitals indicated there was an interest among women for long-acting methods for spacing pregnancies. Obstetricians and gynaecologists and hospital staff from some provinces have been trained on implants in 2014 and training will be extended to other provinces and services provided in the near future. The emergency contraceptive (EC) pill is not in the essential drugs list, but has been included in procurement. However, it is not available at provincial and district hospitals as administrators at these levels did not know EC had been procured at the central level.

Purpose of client's visit to the health facility

The clients who came to the health facilities were predominantly married women: those in their mid-twenties who married young and have two to three children (need for spacing) and those in the mid-thirties with four to five children who have achieved their desired family size (need for limiting). Re-supply was the main reason for visits; new users comprised approximately one-fifth of hospital and health centre clients. The vast majority were on short-term methods: oral pills and progestogen injectables methods were the most prevalent which is in line with the findings from LSIS. The providers reported that very few men and unmarried youth came for services.

Health staff usually provided women with the method requested. There was limited discussion on the reproductive goals, individual circumstances and lifestyles and available methods which would guide the woman/couple

⁶³ World Health Organisation and Ministry of Health (2012), Health Service Delivery Profile, Vientiane Capital Lao PDR.

to make an informed decision. Health staff also remarked that for some women from ethnic communities, visits to the clinics for contraceptives were contingent on the husband's approval. Providers tend to dispense three to four cycles of pills at each client visit for clients who had been on oral pills for at least one year. This is in spite of the fact that evidence shows dispensing 13 cycles during the initial visit is more effective. Most providers who had conducted IUD insertions reported that they were comfortable with conducting insertions.

Clients and providers noted that the majority of pill and injectable users "had no problems". Method switching was related to the supply and availability of contraceptives. Clients who were using the injectable would be put on the pill if injectables were not in stock. If the oral pill was not available, clients were asked to use condoms. On several occasions, clients were sent to the pharmacies (in the private sector) to purchase pills or injectables. However, in the reporting forms, health staff noted the numbers of clients who were given pills or injectables; and the fact that clients did not obtain their method of choice could not be recorded. This has implications for continuity of use, client satisfaction and last but not least, for contraceptive projection, procurement and availability.

The current method mix with its prominence of short-acting methods puts the national FP programme in a vulnerable position. Stock-outs could have a quick and detrimental effect on women's access to their method of choice, which could in turn increase their risk of unplanned pregnancy and unsafe abortion. Long-acting and permanent methods have been proven to have greater efficacy and cost effectiveness than short acting methods of contraception.

Accessibility

Economic accessibility (affordability) - Contraceptives are provided free of charge at public

sector facilities but in some facilities, clients pay a small fee - "registration" (operational) fees for services. UNFPA had provided a subsidy for women from the lower wealth quintiles who had at least four children to undergo tubectomy in three southern provinces and in Oudomxay. During field visits, health administrators and providers reported that many women who had an unmet need for limiting births, availed of the services. In Oudomxay province, it was noted that after the subsidy was withdrawn, the number of women who accessed this service was reduced eight-to-ten-fold. However, in Saravan province using the provincial budget, the Provincial and District Health Departments cooperated with the provincial and district hospitals to continue the service through outreach mobile teams.

Access requires that services be non-discriminatory, affordable, and physically accessible, and includes access to necessary contraceptive information. Adolescents and youth, particularly the unmarried, feel discriminated in accessing services in the public sector and opt to visit pharmacies. Measures for physical accessibility are not in place in most facilities. Access to information is discussed in Section 4.6.

Acceptability

Attempts are made to offer culturally appropriate services particularly in districts where ethnic minorities reside. There is an effort to recruit staff from ethnic groups who share the same socio-cultural background to overcome cultural and communication barriers. Similarly, volunteers from the same ethnic groups residing in the same village cluster are recruited as community-based distributors (CBD) to offer information and services in a culturally sensitive manner. Cultural factors such as gender role inequality, deference to family or physician authority, difficulties in discussing sexual health issues, and beliefs about decision-making autonomy influenced decisions on health seeking behaviour.

The services offered were not always sensitive to life-cycle requirements. Clients requested for and were provided with oral pills or injectables as both clients and providers were familiar with these two methods even though some clients had long-term needs for spacing and limiting.

Quality of care

Quality of care was assessed with the elements described in the Bruce-Jain framework⁶⁴.

Table 4.7.1 Assessment of quality of FP services

Element	FPSA Finding
Choice of contraceptive method	The narrow method choice and method switching has been described earlier.
Interpersonal relations	The relationships appear satisfactory although there is a courtesy bias.
Information given to clients counselling	This was limited to the method requested. Availability of materials, i.e. posters, brochures and leaflets was limited. Most of the health facilities had the Decision-making Tool for family planning clients and providers (DMT), but this was not used at every client-provider interaction.
Technical competence	Satisfactory, but the observations during the FPSA was limited to short-term methods.
Mechanisms to ensure continuity	The clients were given a date to return for supplies. Stock-outs affected the continuity of method use. If injectables were not available, some women would switch to the oral pill; and if this was also out-of-stock, the women were told to purchase the commodity from a private pharmacy.
Appropriate constellation of services	The clients were provided contraceptives and there was no screening for RTI/STI etc. A system is not in place for obtaining patients' opinions and feedback for quality assurance mechanisms.

Accordingly, overall assessment of quality of FP services is low to intermediate. However, clients appear to be satisfied with the services received which meets their expectations, which could be due to limited awareness of clients' rights and their value systems.

FP service delivery environment

At the clinics visited during the FPSA, the overall FP service delivery environment (medical examination areas, cleanliness, lighting, and privacy) was variable; some basic infrastructure for FP services, such as running water and hand washing bowls were limited in many

health facilities. However, health centres in "model villages of the Three Builds" were refurbished and had piped water supply and were well-equipped and fully-staffed. FP services were provided five days in a week in most health centres and at the provincial and district hospitals, services were provided on two fixed days each week.

Supplies and logistics management

Most of the facilities that reported usually providing a particular FP method were found to also have it in stock at the time of the visit, but some facilities also reported experiencing

⁶⁴ Bruce, Judith. 1990. "Fundamental elements of the quality of care: A simple framework," *Studies in Family Planning* 21(2): 61-91.

stock-outs during the previous year. Overall, all the facilities visited had injectables, oral contraceptive pills (OCPs) and condoms in stock. Facility observations showed that most of the hospitals and health centres had organized recording systems. The health staff also completed the records and reporting forms adequately (RH Commodity Security is discussed in Section 4.8 and LMIS in Section 4.9).

The majority of the health facilities visited have the basic infrastructure for provision of short acting methods and IUD (and implant insertion at district and provincial hospitals).

Human Resources

Many health workers in health centres are low-level health staff/auxiliary nurses with limited pre-service training. Reports have also noted the inadequate numbers and skills of different categories of health personnel, with limited regular supervision and their motivation often a problem. Distribution of staff is often inequitable, with many staff reluctant to be posted to remote and rural areas. During the interviews it was noted that nearly half of the providers had participated at the five-day-course on family planning jointly organized by MCHC and the respective Provincial Health Departments to improve counselling and clinical skills on FP. Despite the in-service training to strengthen-communication skills, providers made little effort to understand the client's background, reproductive needs and preferences.

Capacity strengthening

Family planning is included in pre-service training programmes in medical universities and technical schools for nurses and midwives and in-service training for continuing medical education for doctors and nurses and midwives. However, the teaching methodology relies mainly on lectures and provides little opportunity for supervised clinical practice. The central and provincial MCHC conduct annual in-service training courses on FP counselling, record keeping and reporting and procurement

for district and health centre level providers. Where providers have been trained, a system to provide technical oversight, mentoring or supportive supervision of service delivery has not been well-established.

However, as the MoH progresses with implementation of its first National Health Personnel Development Strategy 2009-2020, a number of these deficiencies begin to be addressed. For instance, the decree on incentives for civil servants posted to rural areas, approved in 2011, will contribute to reduction of the urban-rural imbalances of health workers. Under the MNCH package of services, the capacity of the health centres and district hospitals to provide emergency obstetric care will increase in conjunction with deployment of midwives who have been trained on FP. Nevertheless, there is still scope for overall health system improvement.

Post abortion family planning

Post abortion care includes emergency treatment of complications of miscarriage or abortion and family planning counselling and services. The number of hospital admissions for abortion is about one tenth of deliveries at district and provincial hospitals. Counselling and oral pills are routinely prescribed after the evacuation of retained products of conception.

Postpartum contraception

Postpartum contraception is usually provided when women and their babies come for their postnatal visit at six weeks post-partum. Many women breast-feed for a prolonged duration and women use either the condom or progesterone-only pill for contraception. However, LSIS reported that less than 40 per cent of women are seen after delivery or within 2 days and 93 per cent did not have postnatal care (PNC) at any time after delivery. In comparison, a higher percentage of women receive antenatal care at 54 per cent of women while 42 per cent delivered with a health professional. Therefore, information and services on

FP should be provided at both AN and PN visits.

LSIS (2012) reported that exclusive breast-feeding is 40 per cent while predominant breast-feeding is 68 per cent. When exclusive breast-feeding is promoted, the role of Lactation Amenorrhoea Method (LAM) in high fertility, high unmet need countries with social stigma around FP, is programmatically very important. LAM has a failure rate of approximately 2 per every 100 users during the first 6 months postpartum if practiced correctly. LAM incentivizes non-traditional FP providers to incorporate FP counselling into MNCH visits, especially post-partum care – “Gateway” method – allows discussion on FP.

Furthermore, high levels of unmet need for spacing suggest efforts are needed to reach women during postnatal/infant care. High levels of unmet need for limiting suggest the need for a review of contraceptive method mix to determine if adequate and effective options exist immediately postpartum and thereafter. Another promising high-impact practice⁶⁶ is “Offering family planning information and services proactively to women in the extended postpartum period during routine child immunization contacts”.

Services for Young people

Young people constitute a large proportion of the population with nearly 60 per cent of the population below 25 years, and more than 30 per cent between 10 and 24 years. The Adolescent and Youth Situation Analysis noted that early marriage is still common and early childbearing not perceived as unusual. As there are a significant percentage of first births for women age 18 years and under, there is an opportunity to promote healthy timing and spacing to delay second and subsequent births. Currently there is inadequate access to

services by adolescents and youths and health facilities providing youth-friendly services are virtually non-existent with the exception of projects targeting young people in major cities. Youth centres were set up with an ASRH purpose in mind, and these are supposed to combine SRH information and services with recreational activities to attract young people, as well as providing vocational and educational components (see Section 4.6).

Mobile outreach services

Different approaches have been used to ensure access for underserved and hard-to-reach populations through outreach activities from fixed clinic sites in the district and health centre. Other strategies to reach couples in communities are through the Community Based Distribution agents and ensuring that contraceptives are available in the Village “Drug Box”.

However, staff reported that there were limited outreach activities even though health Centre staff are mandated to conduct outreach visits to each village or clusters of village four times a year, usually combined with immunization and nutrition programmes. The number of visits is variable affected by the staffing and funds for travel.

Community-based distribution of contraceptives

Community-based distribution of contraceptives broadens the contraceptive method mix available to clients and brings information, contraceptives and supplies to communities with limited access to clinic-based services. Since they are from the communities they serve, they understand the local issues around family planning and can remove barriers to acceptance caused by misconceptions. However, it was noted that some CBDs are not seeking new clients but replenishing supplies of current users.

⁶⁶Good evidence exists that these interventions can lead to impact; more information is needed to fully document implementation experience and impact. These interventions should be promoted widely, provided that they are implemented within the context of research and are being carefully evaluated both in terms of impact and process.

The CBD agents became the key FP service providers in remote and difficult to reach communities in ten districts in Sekong, Saravan and Attapeu, during 2008 through 2011. They were trained on: Screening and counselling of clients, injection safety and waste disposal; and given clear guidelines for referral (long-acting methods). Some CBD agents had previously worked as Village Health Volunteers and in selected districts, they are trained by the District Hospital to provide injectable contraceptives. Most CBD agents do not receive regular supervision as they work in hard-to-reach areas (Rural without roads) and thus training and refresher training courses are the few learning opportunities for them.

Statistics from annual reports and evaluations suggest that contraceptive use increased and contributed to reducing maternal and neonatal mortality and morbidity. The CBD modality was regarded as appropriate for community-based MNCH-N package delivery, and a CBD plus approach is carried out in selected provinces. The CBD model is currently supported in Savannakhet, Oudomxay, Phongsaly and Luang Namtha by UNFPA.

For the sustainability of the CBD programme, the CBD agents need support for travel and consistent supplies. The MoH plans to include CBD functions in the responsibilities of the VHW. In Saravan district, supplied with contraceptive commodities from the district health administration, two CBDs were able to continue their functions. The district administrator said that they could not provide remuneration but made sure their work was acknowledged and lauded at health events.

In summary, community-based distribution is an effective way to get services to hard-to-reach, rural populations but needs to be more widespread to have an impact on increasing access in rural areas. As the method choice provided by CBD agents is somewhat limited, outreach strategies and communications con-

tent must be designed to facilitate free and informed decision-making about the use of contraception, supported by an effective localized referral system.

Family planning services in the private sector

According to the LSIS, 26 per cent of current users reported that their modern method of contraception was obtained from the private sector, which includes pharmacies and private clinics.

Pharmacies

Pharmacies with their convenience, anonymity and cost-savings (compared to private physicians) are an important source of products and information particularly in areas with high unmet need for FP, health worker shortages and inadequately stocked facilities. Modern contraceptive methods oral pills, condoms, progestogen injectables, and emergency contraceptive pills are widely available through private pharmaceutical networks, although mostly in urban areas.

Pharmacies stock of three to four different brands of combined oral contraceptives that are sold at 3,000 to 6,000 kip per blister pack, the progesterone only pills at 4,000 kip and three monthly progestogen injectables at 4,000 kip per vial. Emergency contraceptive pills are sold at 8,000 kip (One USD is currently around 8,000 kip). The majority of the clients come for oral pills and smaller number buy injectables. Condoms are usually bulk-purchased by hotels and guest-houses. Most of the pharmacies did not sell Misoprostol (Yachine) even though they had heard about it. The pharmacies serve women, men and young people with contraceptive supplies. The shopkeepers do not usually provide any information on how to use the methods, side effects, continuity and they assume that clients are already aware of these facts. Evidence shows that with appropriate training and support, pharmacy and drug shop staff can facilitate the use of modern contraceptives especially in rural areas.

General practitioners

Doctors who are retired from the public sector usually set up private clinics and those who are still employed in the government sector, practice outside regular work hours. Commodities that are in high demand, i.e. different brands of oral pills, progestogen injectables and emergency contraceptives are stocked at these clinics. Women often purchase pregnancy tests and men with STI symptoms request medicines commonly prescribed for STIs. The price of contraceptives is comparable to the pharmacy, however clients receive information on side effects, continuing use, etc. At present, continuing medical education activities for general practitioners are not conducted on a regular basis.

The expanding role of the private sector

The Law on Health Care has been revised and has been passed by the National Assembly in 2014 and is awaiting approval by the President. Following the approval, a ministerial decree has to be passed and will be prepared by the Department of Health Care. This will further define what services can be provided in private sector, including for FP. Currently, general practitioners can provide pills, injectable and condoms. Decision-makers interviewed during FPSA were of the opinion that additional FP services offered should be dependent on the competency of health care providers to perform certain procedures. It was noted that many doctors practising in the private sector are public sector staff, so some have already been trained on IUD insertion and removal.

As the number of contraceptive users increases, the need is often most marked among those least able to pay for services. At the same time, there could be decreases in donor funding for family planning. Public-sector resources are often not sufficient to address the family planning needs of an entire population. Shifting users who can afford to pay from the public sector to the private sector can reduce financial pressures on governments, donors

and other partners.

Challenges in implementing rights-based quality services

Clients, providers and the programme face considerable challenges in implementing rights-based quality services. These can be summarized as follows:

- While public sector administrators and providers are cognizant of quality of care, they are less familiar with concept and framework of rights-based approaches. Availability of services and quality of care are addressed through public-health approaches.
- Skewed method mix towards short-acting methods, with pills, condoms, and injectable progestogen being the most prevalent contraceptives. These methods require regular re-supply, hence successful use requires access to a consistent supply of the product.
- Provider bias and misinformation for IUDs and limited experience with contraceptive implants. Although LARC may have higher initiation costs than short-acting methods, because they can be used without resupply for several years, they are often less expensive per year of use.
- Maintaining an adequate supply of contraceptive commodities at health facilities to meet clients' needs, to prevent stock outs and to ensure contraceptive security.
- Inadequate numbers and inequitable distribution of providers who have the appropriate knowledge, skills, supervision, and support to provide safe, effective, acceptable FP services.
- Geographical terrain as a barrier limiting access to health facilities
- Socio-cultural norms including male dominance among ethnic groups
- Inadequate access to youth-friendly information and services by young people
- Weak public-private-sector partnerships in the FP services area

Issues related to RH commodity security and the logistics management information system are discussed in Sections 4.8 and 4.9.

4.8 Availability and Reliable Supply of Quality Contraceptives

The launch of the 2009-2015 'National Strategy and Planning Framework for the Integrated Package of Maternal, Newborn and Child Health Services' (MNCH package)⁶⁷ provided a framework for the inclusion of reproductive health and family planning as an essential component of maternal and child health services. From 2009, Lao PDR joined the UNFPA GPRHCS and was designated as a Stream 1 country, which meant that Lao PDR was amongst a small number of countries provided with multi-year funding⁶⁸. At the national level since 2009, the vertical system for management of supply for contraceptive commodities is now designated to the Medical Products Supply Centre and Food and Drug Department⁶⁹. While the logistical process and management for RHC supply is now integrated with those of the T.B. and malaria programs, reporting is shared with the MCHC. There are clear indications that systems and roles are being embedded to meet national standards and international commitments for equity in access to reproductive health commodities, challenges remain to bridge the gap in unmet needs for RH services and contraceptive methods.

Issues with Reporting on Stock Availability and Reliability

The stakeholder discussions for the FPSA and review of literature co-authored by government and development partners confirmed that there is strong commitment within Government to increase equity and efficacy of the supply chain. However, the 2014 annual Stock Availability Survey (SAS) report would suggest otherwise as it finds that only "only 11 percent of facilities reported to have all the methods they offered in stock" (pg. 23)⁷⁰. This is in contrast to the 2013 SAS finding in which "88.8 percent of facilities reported to have all the methods they offered in stock" (pg. 17)⁷¹. On closer examination, the two reports have the same stated criteria, and yet no explanation of the large difference in these figures was provided in the 2014 SAS. Conversely, the 2014 SAS found the stock-out issue of modern contraceptives occurred in 89 percent of all facilities surveyed on the day (inclusive of female condoms and IUD)⁷². When female condoms and IUDs are excluded this is only slightly improved to 76 percent (pg. 25) of facilities surveyed. However, the 2013 SAS reported that the stock out rate of FP commodities was 11.2 per cent (pg. 17) of facilities surveyed. In the material reviewed, the disparity between these figures could not be reconciled.

However, according to discussions with clients and service providers, the issue of stock out was examined in terms of what clients and service providers did to mitigate the problem

⁶⁷ Ministry of Health (2009), Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services 2009 - 2015, Vientiane Lao PDR

⁶⁸ UNFPA (2010), The Global Program to Enhance Reproductive Health Commodity Security: Annual Report, DOI: http://www.unfpa.org/sites/default/files/pub-pdf/Global_Report_2010_RH_2_0.pdf

⁶⁹ Chounramany, K. (2010), Integration of MNCH, T.B., Malaria and HIV/AIDS Commodity Supply System in Lao PDR, presentation, Bangkok Thailand.

⁷⁰ Indochina Research Limited (2014), Facility Assessment For Reproductive Health Commodities And Services In Lao PDR Survey Report, UNFPA and the Ministry of Health, Vientiane Lao PDR.

⁷¹ Bock, A., and Bausell, L. (2013). Facility Assessment for Reproductive Health Commodities And Services Report, UNFPA and the Ministry of Health, Vientiane Lao PDR.

⁷² SAS 2014, page 24, Table 5.

when it occurred. At each site visited, there was congruency in the decisions clients took when their choice of method was not available. They either changed methods or abstained for the duration that their method choice was unavailable. This suggests clients and their providers were consulting and proactively managing their choices to space or limit births – albeit in non-ideal circumstances.

On the other hand the reports both identify three reasons for which stock-outs occurred. They are:

- poor re-supply practices indicating issues with forecasting and ordering;
- delays in distribution related to transport costs; and
- A lack of trained staff, medical equipment and supplies to perform procedures such as IUD insertion and male and female sterilization.

Poor Forecasting and Ordering Issues: During the fieldwork, it was confirmed that service providers only recorded information when clients were provided with a contraceptive. However, if a method was out-of-stock, it was not recording that the client did not receive the requested method or if the client was referred to obtain that method from another provider. Since contraceptive orders are based on the information recorded, the service delivery point will continue to order that stock even when using the provided formulas and recommended buffer amount. As a result service delivery points will continue to be at risk of stock-outs.

Delays in distribution related to transport costs: To date, there had been no cost-effective and manageable solution to cover the cost of transportation from central to provincial warehouses and district service providers. Stakeholders explained that they would use opportunities

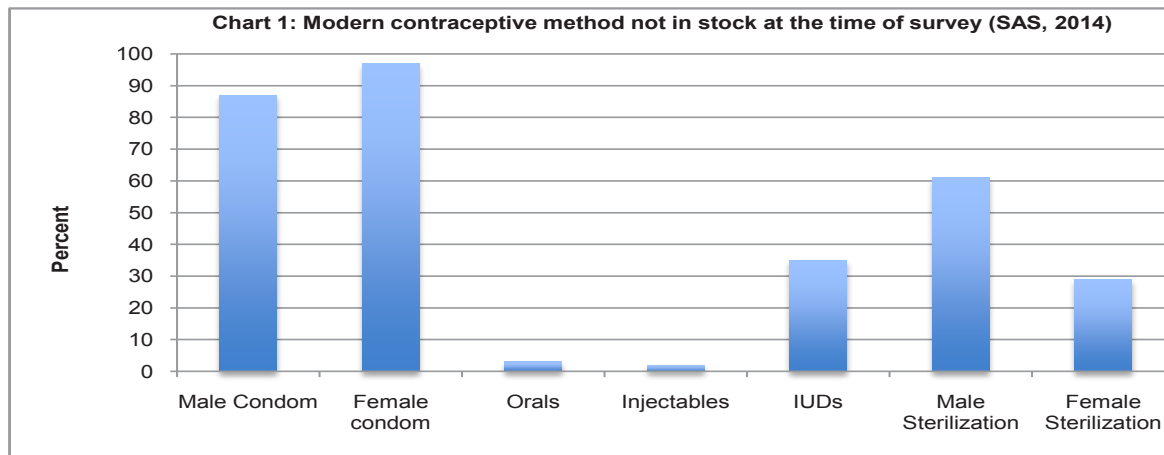
such as travel to meetings to get stock or rely on colleagues who were attending meetings at either central or provincial levels. As meetings may be unplanned, it is difficult to ensure predictability of supply by employing this transport strategy.

Lack of trained staff, medical equipment and supplies to perform procedures such as IUD insertion and male and female sterilization: While the critical shortage of health workers is well documented⁷³, the fieldwork highlighted that the staff who had been trained did not continue to make use of their training materials. Therefore, retention of information on process or technical and skills content was observed to be generally low.

The above findings are particular to rural and remote community settings. The experience of stock-out of contraceptive methods was familiar enough for the interviewed service providers and clients that each location was prepared with alternative measure to breach the short-term gaps. Risk mitigation could be seen in the form of health centres buying the same contraceptive from private providers, providing advice to clients on other methods and changing to another short-term method.

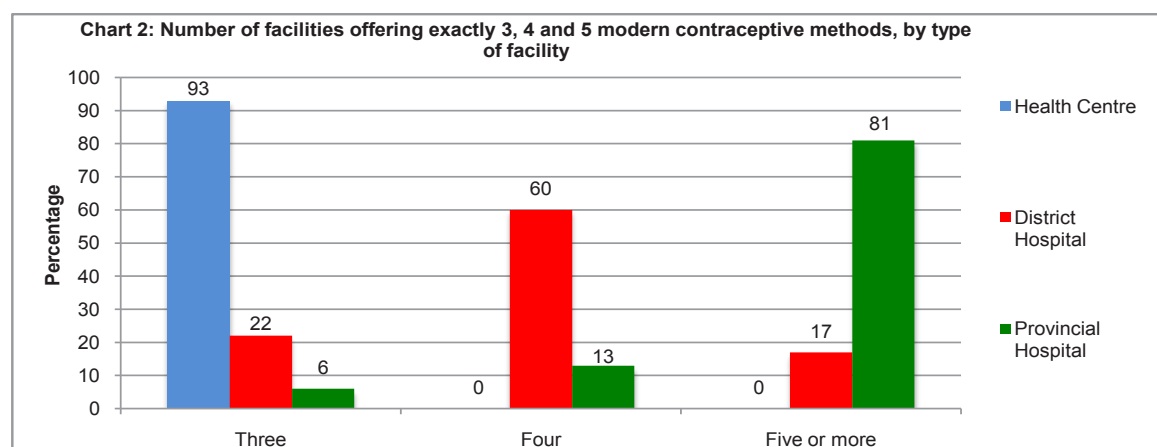
Interviews with service providers and clients confirmed that clients were familiar and trustful of the short-term methods namely injectable and oral contraceptive pills. This is also verified in the SAS report, in which the injectable and oral contraceptives had the least rate of stock-out (Chart 1). This suggests that demand creation for long acting and permanent methods should be increased to promote the appropriate method mix for short to long-term methods.

⁷³ WHO and MoH (2012), Health Service Delivery Profile Lao PDR, Vientiane Lao PDR.



In accordance with the MNCH Package⁷⁴ and GPRHCS guidelines⁷⁵ the SAS report looked at primary, secondary and tertiary service delivery points and the minimum number of methods offered at that facility⁷⁶. This is illustrated in Chart 2. These results show that health centres and Provincial Hospitals are on track to providing the recommended minimum number of methods for that facility level. The results also indicate that more improvements at the District Hospital levels are needed with 60 per cent of those facilities able to offer the minimum of four contraceptive methods. As the supply and logistics systems are maturing, overall the facilities are offering the minimum number of methods as per national and international standards.

Based on the fieldwork conducted, the following conclusions can be made. Firstly, lead agencies for managing the supply and logistics system have a window of opportunity to ensure continuous improvement and expansion of availability for LAPM methods as well. Secondly, clients have a deep understanding of the benefits of healthy timing and birth spacing and therefore they are taking responsibility to obtain contraceptives. Lastly, the family planning projects under the MNCH Package and the GPRHCS giving clients in rural and remote areas the opportunity to learn about family planning options and access contraceptive commodities if they choose it. In other words, the risk for shifting support away from providing contraceptives will be borne to the fullest extent by populations in isolated areas.



⁷⁴ Ibid Ministry of Health (2009).

⁷⁵ UNFPA (2013), Global Programme to Enhance Reproductive Health Commodity Security Annual Report, New York, USA. DOI: http://www.unfpa.org/sites/default/files/pub-pdf/GPRHCS%20Annual%20Report%202013_web.pdf

⁷⁶ SAS (2014), Table 4, Page 23.

Continuous Improvement

The situation analysis was also able to learn about current initiatives being piloted to improve the supply and logistical management of reproductive health commodities namely the use of the inventory control software mSupply. It is being trialled in three locations. Initial results show that the system is functioning well at the sites of Phine District and Savannakhet Province and Khammouane Province warehouses. While this initiative signals that more changes are on the way to improve the system, the consultants observed that moving towards a total market approach (TMA) for RH commodities would merit consideration.

The family planning typology for Lao PDR can be characterised as follows: insufficient government budget to provide free FP services to the whole population, trend for reduced donor funds, increasing demand for family planning services and users in selected contexts have the ability to pay for services and products. This aligns with conditions present in Vietnam, under which the Government prioritized free or subsidized contraceptives for poor or vulnerable groups and increased social marketing and contraceptive sales through the private sector⁷⁷. According to Drake et al (2010), the CPR in Vietnam for modern methods is 68 per cent as a result of shifting to the TMA. While there are significant distinctions to be made between Lao PDR and Vietnam such as population size, geography and health literacy, experiences gained in using this approach may provide valuable guidance for the Lao PDR. Further, PSI, a partner with MoH and UNFPA, also has extensive experience in the area of social marketing, market facilitation and health franchising⁷⁸. Under the GPRHCS TMA is supported and the case of Vietnam is used to demonstrate the TMA may also be appropriate for

Lao PDR.

4.9 Information Systems Pertaining to Family Planning

Within the past five years alone, the national health information system has seen the culmination of long standing efforts by the GoL and development partners to unify the information management system for services and products. A key initiative in this regard has been the development and implementation of the first National Health Information System Strategic Plan for 2009-2015⁷⁹. While the Health Information System (HIS) and the Health Management Information System (HMIS) have been functioning for a number of years, the Strategic Plan for the Health Information System focuses on strengthening and improving the HMIS by supporting policies and resourcing data systems and personnel, rationalization and integration of health indicators, improve quality of recording, analysis and use of health information. The FPSA examines the health information system from the perspective of all the actors in the system that report and utilize SRH data in the broader health system.

As previously discussed, the lack of accurate data on utilization of family planning services and products has ramifications in forecasting, procurement, distribution and paves the way for stock-outs to occur. The findings for this section are indicative of the broader challenges in the overall health information system. The first finding relates to the linear orientation in the flow of information. The second finding discusses the reporting landscape at each level of service provision. The third finding examines information storage and risks for loss of data.

⁷⁷ Drake, J.K., Thanh, L., Suraratdecha, C., Thu, H., & Vail, J. (2010), Stakeholder perspectives of Total Market Approach to Family Planning in Vietnam, *Reproductive Health Matters* 2010; 18(36): 46-55 DOI: [http://dx.doi.org/10.1016/S0968-8080\(10\)36529-3](http://dx.doi.org/10.1016/S0968-8080(10)36529-3)

⁷⁸ Population Service International Website <http://www.psi.org/approach/social-franchising/#about>

⁷⁹ Ministry of Health (2009), National Health Information System Strategic Plan 2009-2015, Vientiane, Lao PDR. DOI http://www.who.int/healthmetrics/library/countries/HMN_LAO_StrPlan_Final_2009_03_en.pdf
Ibid Ministry of Health (2009)

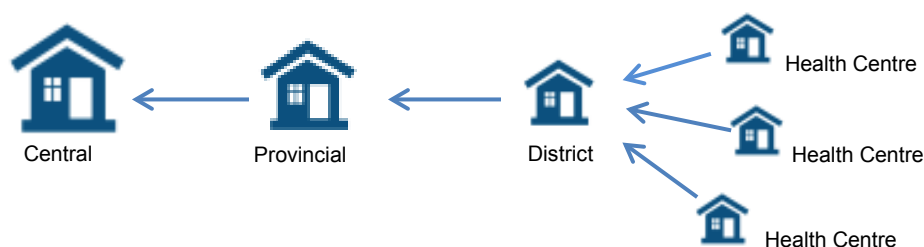
Findings and Analysis

Information and Reporting flows in one direction

Under the MNCH Package, there are two reporting systems concerning the National Immunization Program and the Contraceptive Supply System. These reporting and management mechanisms are under the function of MCHC with Provincial and District MCH each contributing quarterly and monthly service reports. The Statistics Division in the MoH and corresponding Statistics Units at the Provincial and District levels are also lead agencies in being the depository for statistical information on the health system including data on family planning. It should be noted that reporting forms for family planning data from the Statistics Division and MCHC have a different structure even though some of the indicators collected are the same. Service providers at provincial and district hospitals and health centres were observed to be completing in the daily records for clients accessing family planning services. Consistently the district level service facilities explained that they compiled written monthly reports and submitted them to the Provincial MCH. The Provincial MCH stakeholders explained that they would compile these as quarterly reports. The reports are sent to the next level of administration. Service providers reported that they do not receive any feedback

on the information they provided. This information flow is illustrated below in the Diagram 1: Flow of Reporting. As information appears to go in one direction, there will be limitation on how service providers (particularly at District level) can use the information to monitor and plan for service provision.

Another related issue is that information collected is oriented towards MDG indicators and donor requirements. This means that the drivers for improving the information system will always be from external partners rather than from within the information management system for continuous improvement. The health information system inclusive of family planning information is strongly orientated to informing policy directions. While that is important, the health information system also needs to support services providers in robust monitoring of health services including family planning services. The final issue is that the data is orientated towards measuring progress at the strategic level. Provincial and District health staff rarely access these reports perhaps because the Lao version is not available to them in their workplace or motivation to engage with these materials is limited.



⁷⁹ Ministry of Health (2009), National Health Information System Strategic Plan 2009-2015, Vientiane, Lao PDR. DOI http://www.who.int/healthmetrics/library/countries/HMN_LAO_StrPlan_Final_2009_03_en.pdf
Ibid Ministry of Health (2009)

Reporting Burden for Service Providers

This finding stems from fieldwork observations and interviews. It must be acknowledged that there are initiatives and actions taking place to harmonize the systems for collection, validation, analysis and presentation of health statistics. The District Health Information Software 2 (DHIS 2) is one example. In practice, however, service providers are facing multiple reporting burdens, which lead to many errors and inaccuracies in reporting information. For instance there are a number of reporting forms to be used. Each programme within the MNCH Package required separate reporting forms (for different donors). Some service providers were using out-of-date forms as well. As another example, DHIS 2 form used by the Statistics Division has a different format to the MCH form used by service providers at Provincial and District facilities. The lack of consistency between forms could mean that data may not be congruent and reporting becomes inaccurate and ineffective.

Related to the above issue is how questions are framed. The DHIS 2 form asks for both the amount of contraceptive distributed and amount wasted within the same column. The fieldwork showed that at all levels including the CBD agents, no provider had recorded the number of clients who were unable to receive a contraceptive method. As stated in previous sections, this has implications for forecasting and re-supply. In this instance, the burden is due to a gap in the information that is needed to help improve service provision.

Furthermore, as the Statistics Unit and MCHC at Provincial and District levels are also collecting data on the similar if not the same indicators, the time has to be spent to check the information for accuracy and for any discrepancies in the reporting. In order to address the risk of errors in reporting, District and Provincial level

centres have tried to ensure accurate data entry by having one staff member complete the reporting. This is a high-risk strategy as all the institutional knowledge is retained with one staff member.

Modes of Information storage and risks for loss of data

The current reporting and information system observed during the fieldwork is largely paper-based. Several of the facilities were able to replenish the forms, but some were observed to be using out of date MCH forms. In terms of maintaining orderly written files, many facilities could readily retrieve and show the folders containing the summary reports for contraceptives issues and daily records of clients attending family planning services.

A few facilities are using Microsoft Excel application for data entry. It was observed that no facility had backed up their electronic files. Furthermore, the use of Excel was limited to data entry and use of simple functions. The Excel files were not utilized to generate analysis of the data entered. More often the health staff had not had any basic Excel training. Any plans to transition the health information system from paper to web-based must be cognizant of the need to ensure that health staff are properly equipped to interact with the new technologies.

Transitioning to an electronic system was raised at the start of the fieldwork by UNFPA. However, the sites for the data collection did not include the districts using mSupply (pharmaceutical supply chain software) and although one province was engaged in the pilot, stakeholders were not informed about the status and effectiveness of the system. At the central level, the MoH noted that mSupply was working well in Khammouane Province, Savannakhet Province and Phine District.

The FPSA acknowledges that initiatives are underway to harmonize the health information system. However, the current gaps within the information management has implications for capacity development and provides significant challenges to achieving an effective health information management system.

5

Recommendations

Action in several areas were identified with the objective to reduce unmet need for family planning and improve CPR through voluntary, good quality family planning services; and they are prioritized with respect to the timeframes in which the recommendations can be completed with a period defined as Short, Medium and Long-term recommendations. The expected outcomes for these recommendations however will have long lasting impacts.

Short-term recommendations

1. Develop a costed implementation plan based on the National Family Planning Action Plan and FPSA recommendations

The recommendations of the FPSA and the actions proposed in the National Family Planning Action Plan for 2014-2015 and beyond⁸¹ will need to be considered to develop a costed implementation plan which will detail the activities and budgetary requirements and the funding gaps for key requirements such as commodities, training, behavioural change communication and services.

2. Support revision of the National Reproductive Health Policy to incorporate rights-based approaches

Overarching guiding principles such as human rights, equity, non-discrimination and mechanisms for sustainability were not adequately addressed in the 2005 National RH Policy and the revision of the Policy to deliver universal access to rights-based family planning in the context of overall approaches to SRH will complement the National Action Plan on Family Planning.

3. Conduct evidence-based advocacy on sexual and reproductive health and rights

Evidence-based advocacy needs to be sustained to increase commitment of key policy-makers from the Ministries of Health, Planning and Investment and Finance; and representatives of the National Assembly and National Committee for the Advancement of Women about specific RH/FP issues and to influence the budget allocation process. A group of committed individuals and like-minded partners who are willing to plan and coordinate the advocacy activities will need to be identified. The national capacity to analyse and repackage data to conduct evidence-based advocacy strengthened; and negotiation, effective communication and other skills of MCHC and country office staff improved for advocacy and policy dialogue.

⁸¹ Accelerating progress in family planning in Lao PDR: National Family Planning Action Plan for 2014-2015 and beyond (2013)

4. Incorporate family planning in national development plans and frameworks

The package of services under the Decree on free delivery and free health care for all children under five years decree should be extended to cover post-partum visits and contraception. MCHC and partners will need to follow-up on the inclusion of family planning in the basic package of MCH services as defined in the Health Sector Reform Framework and advocate for its inclusion to be covered under Universal Health Coverage together with a budget-line for FP commodities, equipment and supplies.

Medium-term recommendations

1. Tailor communication strategies to target populations

Employ a targeted and segmented approach for social and behaviour change for vulnerable populations, e.g. couples in remote areas, men in ethnic communities, youth and adolescents both in urban and rural areas and for communities where unmet need is high. Youth focused NPAs, such as student service centres at tertiary institutes (public or private) or youth focused NPA (such as Youth to Youth Peer Workers in Health Education and Development Association) or local volunteer groups (KhaoNiaw Theatre Group and FLAMES Youth Group) can be engaged to support targeted communication strategies. Whether through the use of traditional forms of communication or social media, these strategies should be developed to be culturally sensitive. Further, the targeted interpersonal communication strategies should address misconceptions and uncover women's needs and barriers to using LARC.

2. Support the provision of quality rights-based FP services

Apply the principles of rights-based approaches during training and service provision and improve quality of care by broadening the method mix to include emergency contraception and generate stronger demand for long-

acting methods that are underutilized (IUDs) or new (implants). Integration of FP services during antenatal, postnatal, following post-abortion complications and during routine childhood immunization contacts will increase access and convenience for clients. Provincial and district planning processes should engage the vulnerable and disadvantaged populations.

3. Advocate for and expand youth-friendly ASRH health services

In addition to advocacy on the information and service needs of adolescents and youth, the concerned government departments in partnership with INGOs, NPAs and youth representatives will need to expand the good practices established in Vientiane Capital and Savannakhet to other cities where there are many internal migrants or university students. It is imperative that information and services include FP topics and services too. Flexible, culturally sensitive approaches to respond to the needs of the youth who live in diverse social and cultural contexts will need to be developed.

4. Diversify to other channels for service provision and marketing

- *Public-private partnership*
The partnership between the public and private sector for training of public health sector staff on IUD provision in combination with demand generation activities should be expanded to other provinces and considered for training on sub-dermal implants.
- *Social marketing*
The distribution of a range of contraceptives and promotion of healthy contraceptive behaviour through social marketing should be initiated with partners such as PSI.
- *Pharmacy staff*
Pharmacy staff can be trained and supported to provide a variety of family planning methods and information and pharmacies can serve as an outlet for pills and con-

doms that are promoted through social marketing.

This includes investigating the feasibility of a total market approach for FP commodities for Lao PDR. The TMA engages public, commercial and community based stakeholders to increase services and uptake of health products such as reproductive health commodities. Various strategies employed and partners included prioritizing access to poor and vulnerable groups for health services and products free of charge or at a subsidized cost, while using social marketing to engage clients who are willing and able to pay for services and products.

5. Foster exchange opportunities with NPAs and INGOs

Organise information sharing and exchange opportunities with INGO and NPA partners on policy related MCH and family planning. These organisations may include (but are not limited to) World Vision Laos, Plan International, Learning House for Development and the Gender and Development Association. The INGO Network is an effective starting point to engage with INGO and NPA partners. In terms of private stakeholders, the FPSA did not identify suitable private enterprises that operated outside of providing modern contraceptives, although private colleges may be another potential stakeholder group.

6. Invest in capacity building of FP focused NPAs in other provinces

Mentorship and capacity building of the Promotion of Family Health Association has been started. This should be taken further by working to expand NPA or volunteer groups in other provinces to be enabled to not only be a service provider but to also be able to mentor other community based groups to promote FP goals.

Long-term recommendations

1. Develop comprehensive communication strategies

Comprehensive communication strategies for behaviour change, which are culturally appropriate, will need to be developed and implemented by CIEH, MCHC, INGOs and partners to increase awareness and demand for FP. The health communication initiatives at all levels should be closely linked to provision of services and the overall performance monitored.

2. Support the strengthening of FP services through institutional development

MCHC, Department of Health Care and other partners will need to further strengthen existing services through: (i) institutionalizing pre and in service training of service providers on rights-based provision of services; strengthen counselling and interpersonal communication skills and clinical competencies in accordance with best practice guidelines; (ii) provide support for infrastructure and organizational set-up to improve service quality. The equitable deployment of health staff and task shifting will serve to strengthen work force in hard-to-reach areas. In high volume public sector facilities, the placement of dedicated counsellors or providers of LARC, to supplement the work of regular staff should be considered.

Among the building blocks of the WHO Health Systems Strengthening Framework, the National Health Sector Reform strategy has focused on service delivery, health workforce, information, medical products, financing and leadership and governance; which will need to be further strengthened to address the deficiencies in the system and to ensure access to rights-based family planning. The public sector will need to forge partnerships with the public sector and NGOs for expanded and innovative service delivery mechanisms.

3. Conduct formative research

Formative research to determine and address myths and misperceptions about fertility and contraceptives and social norms about family planning and family size; behavioural data on sexual and reproductive health of adolescents

and youth; and factors influencing health-care seeking behaviour and policy decisions on FP and SRH. Policy briefing papers can be prepared from the research findings and the report can be used in policy dialogue with decision-makers.

4. Utilise multiple data sources to better define and understand issues with RHSC

A rigorous consideration of multiple sources of information and various dimensions of issue will help to better define and understand RHSC issues. The programming implications and impacts will be largely on communities who already lack family planning information and services. Specifically in addition to using the statistical and quantifiable measures from the SAS process, include qualitative frameworks to investigate how providers and clients are mitigating the issue of stock outs.

5. Continuous improvement and capacity building for information systems

With respect to information systems, the FPSA recognizes that improvements in this area require time, adjustment and long-term commitment to be effective.

- *Personnel*

Continue to conduct refresher or in-service training with emphasis on understanding data entry, monitoring, corrective actions and follow up. Establish practical tools to reinforce good practices for information management for example, provide glossaries to explain indicators, develop data storage and reporting flow charts. Lastly, ensure that information reported for key indicators is displayed and kept up to date at the service facility.

- *Recording and reporting processes*

Expedite the harmonization of reporting forms across departments while revising and clarifying ambiguously worded questions and headings on data collection forms. Furthermore, ensure that health staff at all levels and in particular at the District Hospitals and Health Centres can access collated information and reports.

- *Information technology*

Provide adequate timeframes for information systems to transition to web-based systems. Further support personnel by establishing an on call IT support for the new web-based systems. Lastly equip providers at service delivery points with sufficient levels of training to improve IT skills and computing literacy.

6

Conclusions and transferable lessons

The Family Planning Situation Analysis took a long-term view with respect to analysing policies supporting reproductive health and family planning. However, with respect to review of programmes the focus was on those that were implemented more recently. The document review and interviews at the central level were corroborated by findings from the field which were biased towards the provinces visited.

From 1995 when the Birth Spacing Policy was developed, family planning activities made a tentative start which gained momentum under the overarching National Reproductive Health Policy (2005). Various activities and programmes on family planning and maternal and child health were conducted, while other aspects were not covered as comprehensively as envisioned in the Policy. In general, women and men are knowledgeable about family planning; they know many types of modern methods, where to get different methods at the public facilities or private sector. Along with greater acceptance and increased knowledge about family planning, a fuller range of modern methods has become more available through public and private sector outlets.

Among the development partners, UNFPA was the key player for reproductive health programmes and the main partner for procure-

ment of contraceptives and other reproductive health commodities. However, with the strong economic growth in the country and commitments to universal health care by 2020 - the focus of development partners is shifting more to governance, sector plans and sustainable development. MoH and the MCHC will need to address issues such as insufficient government budget to provide free family planning services to the entire population, the trend for reduced donor funds and the increasing demand for quality rights-based family planning services. In a comprehensive approach to improving reproductive, maternal and child health, the critical role of family planning and its' relationship to development goals must be underscored. Improvements will be necessary in both the coverage and quality of services, particularly for the vulnerable and underserved populations. These include increased investments in all aspects of health systems: the physical infrastructure to provide services, capacity of providers, commodity logistics systems, health management information systems and BCC programmes at the individual and community levels.

Finally the FPSA would like to present three "good practices" as examples to guide future programming.

1. Factors contributing to sustainability of the CBD project in Saravan

After the CBD project came to an end following five years of support from UNFPA, in Saravan district⁸² due to the commitment of the provincial and district health authorities, two CBD agents were able to continue their functions within the same village clusters.

The following contributed to the success of the CBD project:

Participatory process involving key stakeholders

The participation of the provincial and district health authorities during the project generated commitment and built ownership and ensured that the issues are considered from multiple perspectives and decisions are reached collectively about how to proceed in the specific local context.

Relevance of the intervention

The intervention was relevant along several dimensions. It addressed an important RH need and had the potential for significant public health impact. It was based on sound evidence and feasible in the local settings where it was implemented.

Tailor the intervention to the sociocultural setting

The intervention was built on existing patterns of social organization, values and local traditions which led to it being accepted. It is therefore important to design interventions in such a way that they are consistent with community values and social institutions. There is often a close working relationship between CBD agents and Village Health Committees, and the selection of a CBD agent by a committee which includes the village chief indicates tacit approval for their roles and responsibilities.

Keep the innovation as simple as possible

The CBD agents responsibility was to provide

information on FP and contraception, offer pills and condoms (and where trained, injectables) and refer the couple to the health facility for long-acting and permanent methods. The simpler the interventions the more easily they can be implemented in the future. The complexity of the innovation must match the capacity of the implementing organization.

Assess and document the process of implementation

In addition to the focus on health outcomes and impacts, it is equally important to assess and document the process by which interventions are implemented in the course of the pilot or other programmatic research. Documenting what steps were taken to achieve results will help determine what needs to be done to implement interventions on a larger scale later on.

An Evaluation noted the relevance and effectiveness of the intervention, but cautioned that CBD clients, mainly women using oral contraception, are highly vulnerable to interruption of contraceptive supplies and a transition/exit planning is essential before abruptly ending UNFPA support for CBD programmes. It was recommended that UNFPA Lao PDR should continue to support these programmes with the understanding that current problems (stock outs, delay in payments, limited training and supportive supervision field visits, and insufficient household visits) are addressed⁸³.

Pilot projects and other programmatic interventions in which health innovations are tested on a small scale often show impressive results. However, their influence tends to remain confined to the original target areas and their results are often not sustainable. The requirements of sustainability (and large-scale implementation) need to be taken into account at

⁸²During the FPSA, Saravan was the only site visited among the three southern provinces, so the observations are confined to this district.

⁸³Report for an Evaluation of two UNFPA Lao PDR Programmes: Community Based Distribution (CBD) and Individuals, Families, and Communities (IFC) Final Draft 0.3 15 January 2014

the time of pilot- or field-testing.

2. Information and services for young people in Vientiane Capital

The Vientiane Health Centre for Youth and Development was set up in 2001 to provide gender-specific clinic services, telephone hot line, and outreach activities for youth. There has been a gradual increase in the numbers of young people seeking advice over the hotline and contraceptive use among clients, both at the clinic and during outreach⁸⁴. Since 2008, partnerships and linkages have been established, with the assistance of brokering services from UNFPA, with such institutions as the Centre for HIV/AIDS and STI (CHAS), the Mother and Child Health Centre/Ministry of Health, Mahosot and Setthathirath Hospitals, non-profit organizations such as CARE, FHI, PSI etc., telephone companies, Ministry of Education and the Vientiane Health Department. These organizations and agencies are sources of technical assistance, referrals and commodity supplies upon request.

It took time for the community to accept the necessity and concept of youth-friendly services. To set up innovative and complex interventions on an issue regarded as sensitive, projects may need to go beyond the typical three to four-year project time to try out implementation with only minimal support (initially). The success of the Youth Centre clearly demonstrated the need for adolescent and youth services; the efforts of a national association that advocated, coordinated and represented the youth clinic, enthusiasm and dedication of personnel, and acceptance by users.

3. Diversify service provision through new partnerships

The private-public partnership whereby MCHC, obstetricians and gynaecologists,

UNFPA and PSI collaborated to re-introduce IUD has highlighted that a method that is not traditionally popular could gain acceptance by the community through targeted BCC strategies using interpersonal communication agents to create demand and ensuring that facilities were ready to provide services through skills-based training and supervision of different categories of health providers. Through new partnerships MCHC could harness the expertise of PSI on BCC approaches and experiences on training. A few NPAs are still in their infancy and through assistance from development partners to strengthen their capacity and expand their portfolio, innovative approaches for vulnerable populations could be further explored.

⁸⁴ Evaluation Report - Lao Womens' Union Vientiane Capital, Vientiane Youth Centre for Health and Development (201184)

Annexes

i. Terms of Reference

Introduction

Over the past years, UNFPA Laos has been implementing a diverse range of family planning activities. However, in order to adopt a more integrated approach, adapted to the country context and in line with the global Family Planning strategy Choices not Chance, an assessment of the broader situation of family planning in Lao PDR is needed.

With the aim to leverage best practices in family planning, to accelerate program implementation and, ultimately, to increase modern contraceptive use and decrease abortion rates, UNFPA Laos is hiring two external consultants; one national and one international, to conduct a Family Planning Situation Analysis (FPSA).

The purpose of the FP situation analysis will be to assess the current situation of family planning, its determining and influencing factors, and to develop an evidence base to inform UNFPA's support, as well as the Government's future programming in the area.

The intended audience and users of the FP situation analysis are the UNFPA management in the Country Office as well as UNFPA staff, government counterparts in Laos, and other development partners.

Purpose

To provide a status of the country situation on family planning, including an analysis of related policy documents

The Assessment has to fulfil the following objectives;

1. To conduct a mapping of stakeholders relevant to FP in Lao PDR, including state, civil-society, donors and beneficiary stakeholders and the relations between them;
2. In consultation and collaboration with government and national partners, to

conduct a situation analysis and create a country family planning snapshot. The FP snapshot is a picture of the current situation of FP highlighting key indicators and trends demonstrating how family planning is integrated and mainstreamed.

3. To identify the main causes of critical issues such as unmet need and discontinuation of use of family planning methods, bottlenecks for method mix, and limited access to contraceptives information and services among adolescents and youth;
4. To assess the relevance and adequacy of national family planning related policies, legislation, programmes and plans, the extent to which they are implemented, as well as the extent to which they facilitate or represent barriers to accessing FP services;
5. To assess capacities (financial, programme, human resources and other elements of health systems) inside and outside the Lao PDR Government, to address family planning issues effectively;
6. To contribute to a better understanding on the issues related to family planning in Lao PDR, including dynamics and trends (including among adolescents and young boys and girls), the family planning situation, and its relation to gender equality, equity and the empowerment of women, and the ways in which these are interrelated with the overall economic development of the country, particularly well being of the poor;
7. To create an evidence base for advocacy and programming;
8. To provide recommendations for strategic actions responsive to the family planning needs of Lao PDR citizens and the identification of priorities for UNFPA support to national family planning programmes.

The FP situation analysis is expected to address the 5 Outputs of UNFPA FP strategy

2012-2020 Choices not Chance, which are:

1. Enabling environments for human for human rights-based family planning as an integral part of sexual and reproductive health and reproductive rights
2. Increased demand for family planning according to clients' reproductive health intention
3. Improved availability and reliable supply of quality contraceptive
4. Improved availability of good quality human rights-based family planning services
5. Strengthened information systems pertaining to family planning.

The consultants will work in a participatory manner, recording the strategic vision of the Government at various levels. The FPSA requires continuous advocacy and engagement with government and national stakeholders to ensure that the final product is developed under government leadership and is nationally owned. Relevant stakeholders in the Government of Laos will be involved in all phases of the evaluation, from the design, through the field phase and data collection, until the presentation and the provision of comments on the findings and recommendations.

The FPSA team is expected to identify lessons from past interventions in the FP sector, both the UNFPA's and other partners', which highlight the intervention strategies that adequately addressed root causes and those that did not. The findings of the situation analysis constitute the basis for selecting priorities and priority areas in the fields of family planning in the future. The document must specify why certain areas of cooperation were selected from the larger group of identified challenges within the country.

To promote Gender and Human Rights, the analysis should foster an understanding of which population groups are deprived of access and attempt to determine the reasons behind that deprivation at national and subnational levels.

Expected deliverables

- **Inception report** – Consultants are requested to submit a paper describing the design and the methodology proposed for the exercise, with details on the data collection strategies, requirements and timeline, with a possible reference to any similar exercises undertaken in the past.

- The **in-briefing and debriefing presentation** using PPT to be presented and discussed with the CO other key stakeholders, including the TWG-MCH during the in- and debriefing meetings at the beginning and the end of the field phase, synthesizing the methodology, main preliminary findings, conclusions and recommendations;

- Published and disseminated **Country Family Planning Situation Analysis** (maximum 50 pages plus annexes) that addresses the five Outputs of Choices not Chance, based on comments on draft report.

- As a result of the situation analysis, a **Country Family Planning Snapshot** will be developed, which is a picture of the current situation of family planning as part of sexual and reproductive health. It highlights key indicators, shows trends demonstrates how family planning is integrated and mainstreamed within the health and other sectors, and identifies gaps and remaining challenges to fulfil the national family planning strategy/plans. The snapshot will thereafter be updated yearly by the UNFPA CO, in coordination with its government partners, and will be useful to continuously monitor the progress in the area of FP in Lao PDR. The final FP situation analysis, as well as the FP snapshot must be delivered before the end of June 2015.

All deliverables will be drafted in English, and translated into Lao language.

ii. Inception report

The inception Report has been submitted separately

iii. List of persons met

List of persons met	
List of persons present at briefing meeting, Ministry of Health	
Dr. Toumlakhone Rattanavong, Deputy Director, Department of Planning and International Cooperation,	Ms. Sisamone Phandanouvong, Mother and Child Health Centre, MoH
Ms. Khamla Boupbabanya, Sexual Reproductive Health Unit, MoH	Mr. Saykeo, Department of Planning and International Cooperation, MoH
Ms. Phonthong Phouxay, Nursing Division, Department of Training and Research, MoH	Dr. Many Thammavong, Medical Products and Supply Centre, MoH
Ms. Phitsamay Vongxay, Finance Division, Department of Training and Research, MoH	Dr. Khonsavanh Inthavong, Medical Products and Supply Centre, MoH
Ms. Ketsaphone Sethahak, Finance Division, Department of Planning and International Cooperation, MoH	
List of persons present at briefing meeting, UNFPA Lao PDR	
Mr. Hassan Mohtashami, Representative, UNFPA Lao	Ms. Sally Sakulku, UNFPA Lao
Ms. Rizvina de Alwis, Deputy Representative	Dr. Sengsay Siphakanlaya, UNFPA Lao
List of Persons met in Vientiane Capital	
Dr. Kaisone Chounlamany, Dy Director General, Department of Hygiene and Health Promotion, MoH	Dr. Bounsou Keohavong, Chief, Drug Control Division, Food and Drug Department
Dr. Phasouk Vongvichit, Deputy Director, Department of Planning and International Cooperation, MoH	Dr. Somchanh Xaysida, Acting Director General, Department of Training and Research
Dr. Khampiou Syhakhang, Director, Mother and Child Health Centre	Dr. Sengmany Khambouhneheung, Head of Undergraduate Division, DTR
Dr. Kopkeo Souphanthong, Deputy Director, MCHC	Dr. Thanom Insal, Medical Products Supply Centre
Dr. Sengchoy Panyavarong, Director General, Department of Health Planning	Eric Seastedt, Regional Adviser, PSI Asia
Dr. Khampasong Theppanya, Head of Division, Department of Health Planning	Thongdy Phommavongsa, Health Services Manager, PSI
Dr. Visany Vonsavalin, Technical Officer, Department of Health Planning	Dr. Frank Haegeman, Lao Lux
Dr. Luexay Phadouangdet, Statistician, Department of Planning and International Cooperation, MoH	Dr. Eunyoung Koh, Technical Officer, WHO
Dr. Somthavy Changvisommid, Director General, Food and Drug Department	Mr. Bounlerth Yuandongchanh, Deputy Director, Social Affairs Department, National Assembly
Mr. Nakhonsaeng Phimpachanh, Deputy Director, Division of Social Development Planning, Department of Planning	Ms. Chansoda Phonethep, Director, Lao National Committee for the Advancement of Women
List of Persons met in Oudomxay Province	
Dr. Sounthone Douangsaysy, Deputy Director, Oudomxay Provincial Health Department	Ms. Soulay, MCH health officer, MCH Unit, Houn District Hospital
Ms. Chansamone Oulayseng, Chief, Oudomxay Provincial Mother and Child Health Centre	Mr. Sikhamb Keokhamlup, Supervisor, Navang Health Centre
Dr. Souvanthong Senvannakham, Director, Oudomxay Provincial Hospital	Mr. Somthiane, Officer, Navang Health Centre
Dr. Douangchay Sisouthammony, Chief, Mother and Child Health Unit, Oudomxay Provincial Hospital	Ms. Bounthan, Officer (Midwifery), Navang Health Centre
Mr. Somphanh Chaleunxay, Director, Houn District Health Office	Mr. Somphone Keophasert, Supervisor, Naxiengdy Health Centre
Ms. Thongsay Douangdapanh, Chief, Houn District MCHC	Ms. Phengynai Khanthavong, Officer (Midwifery), Naxiengdy Health Centre
Ms. Chantha Soukchantha, Officer (Statistics), Houn District MCHC	Mr. Khaxong, Medical officer, Naxiengdy Health Centre
Mr. Thongpha, Village Chief, Mai Village	Mr. Xiaxeng, CBD Worker, Dongnong Village Cluster
List of Persons met in Vientiane Province	
Dr. Soukphathay Sopaseuth, Director, Provincial Health Department	Dr. Southta Vanxeuse, Owner, Private Pharmacy

List of persons met	
Dr.Viengmany, MCH, Provincial Health Department	Dr.InponeManiseng, Fuong District Hospital
Nurse, Provincial Health Department	Ms. BounthanSaiyarath, Medical Assistant, Fuong District Hospital
Dr.ThongvinhXamouty, Ob Gyn, Provincial Hospital	Nurse, Fuong District Hospital
Dr.Konthieng, Medical Officer, Provincial Hospital	Mr. KhamnangInthasone, Director, Pha Sang Health Centre
Ms. Phommesonmena, Nurse, Provincial Hospital	Ms. KhamphanBaobohtai, Hygiene Promotor, Pha Sang Health Centre
List of Persons met in Savannakhet Province	
Dr.KeovilayvanhPhomsavanh, Deputy Director, Savannakhet Province Department of Health	Dr.KhampanhSinorlath, Deputy Head, Thapangthong District Health Office
Dr.KaenchanhSithithai, Savannakhet Province Mother and Child Health Centre	Ms. SouderneKeomanysay, Supervisor, Mother & Child Health Unit, Thapangthong District Hospital
Dr.PhalamaKhomsonlasinh, Savannakhet Province Mother and Child Health Centre	Ms. PeurngKeokhampasong, Health worker, Mother and Child Health Unit, Thapangthong District Hospital
Dr.BouagneunInthalangsy, Head, Mother and Child Health Unit, Savannakhet Provincial Hospital	Mr. KhambernPhadernthone, Supervisor, XeKeu-Phommaly Health Centre, Thapangthong District
Dr.KidouangNorlasing, Head, Kaisone District Health Office	Ms. HomphengKeoboungheung, Nurse, MCH, XeKeu-Phommaly Health Centre
Dr.PhetlamphoneKhambidok, Supervisor, Youth Counselling Centre, Kaisone District Hospital	Mr. Khambo, CBD worker, Mongkay-Mai Village Area
Clients (3), n/a, Mother and Child Health Unit, Savannakhet Provincial Hospital	Dr.PanomPhongmany, Director, Savannakhet Provincial Health Department
Client (1), n/a, Youth Counselling Centre, Kaisone District Hospital	Dr.OunKanyavong, Directors, Champhone District Hospital
Ms. ChansamoneKeovongkot, Deputy, Student Welfare Unit, Savannakhet Technical Training Institute	Dr.KhampouvanhThongsavath, Supervisor, MCH - Family Planning, Champhone District Hospital
Ms. Malinda Norlasaen, Supervisor, Administration Department, Savannakhet Technical Training Institute (Coordinator for UNFPA project)	Ms. KhammanychanhKethavongsa, Supervisor, Nonglumchanh Health Centre, Champhone District
Clients (3), n/a, Nonglumchanh Health Centre, Champhone District	
List of Persons met in Saravan Province	
Dr.KhasermSoukVongsothi, Director, Saravan Provincial Health Department	Mrs. KhammanySavanmixay, Health Worker, Senevang Health Centre
Dr.SomchitBoualavong, Head, Saravan Provincial Mother and Child Health Centre	Mr. BountheungChommalyvong, Head, Vapy District Health Office
Dr.BoukongXaysombath, Deputy Head, Saravan MCH	Mr. DalaPhommalyxay, Deputy Head, Vapy District Health Office
Dr.SommayKeomany, Deputy Director, Saravan Provincial Hospital	Ms. SounvanthaSengsavangphouthai, Officer, Vapy District Mother and Child Health Office
Dr.VilavanhKhomavong, Head, Saravan Hospital Mother and Child Health Unit	Ms. KhanthalyMeuangchanh, Officer, Vapy District Mother and Child Health Office
Mr. SengdeurneMeuangchan, Head, Saravan District Health Office	Mr. ViengsavathBouathaphongsy, Supervisor, Khonexay Health Centre
Mr. KhamphanSilipongsavath, Head, Saravan District Mother and Child Health Office	Ms. KhanthaSavangsengphouthai, Health Worker, Khonexay Health Centre
Ms. PouangmalaChamphakham, Officer, Saravan District Health Office (former MCH)	Ms. ThamphanPhavathsady, Health Worker, Houaykhon Health Centre
Ms. SomphitSihalath, Officer, Saravan District Health Office	Ms. KhankongLalimthavixay, Health Worker, Houaykhon Health Centre
Mr. NokkeolInthasene, Supervisor, Senevang Health Centre	Ms. BoualaChanlavong, Health Worker, Houaykhon Health Centre
Mr. SomphoneSivixay, Deputy Supervisor, Senevang Health Centre	Ms. OlathaiPhoutkeo, Health Worker, Houaykhon Health Centre

iv. Workplan

Week 1 - Katherine and Vimala in Vientiane Capital and Oudomxay Province			
Monday 20 April	09:00-12:00	Briefing with UNFPA country office Overview of travel and logistics plan	
	13:30-14:00	Meeting with Ministry of Health	DHHP
	14:00-15:00	Cabinet Dr.Bounfaeng	MOH
	15:00-16:00	Department of Health Care Dr.BounackSaysanasongkham, Deputy Director	DHC
Tuesday 21/04	11:20-12:20	Depart for Oudomxay (ODX)	Flight no. QV501
	14:00-15:00	Interview with ODX Health Department and MCH	ODX PHD
	15:15-16:30	Interview with ODX MCH provincial hospital	ODX Pro hospital
	16.30 -18.00	Interview private pharmacy staff and private practitioner	
Wednesday 22/04	07:30-09:30	Travel to Houn District	
	10:00-11:00	Interview with District Health and MCH district hospital	HuneDist Health
	13:00-16:30	Interview with Health Centre staff and clients	NavangHC
Thursday 23/04	08:00-09:30	Interview with Health Centre staff and clients	NaxiengdyHC
	10:00-11:30	Interview with CBD provider and clients (ii)	Dongngone village
Friday 24/04	12:40-13:30	Depart for return to Vientiane	Flight no. QV502
Week 2	Katherine in Vientiane Capital and Vientiane province (presented below)		
	Vimala in Savannakhet Province and Vientiane Capital (presented below)		
Week 3			
Sun. 03/05		Team travels to Pakse, Drive to Saravan	
Mon. 04/05	08:30-09:30	Interview with SRV Health Department and MCH	SRV PHD
	09:30-10:30	Interview with MCH of SRV Provincial hospital	Provincial hospital
	13:30-14:30	Interview with SRV District Health and MCH	SRV district office
	15:00-17:00	Interview with Health Centre staff and clients	Khuaset HC
Tues. 05/05	08:30-09:30	Interview with District Health and MCH	VapyDHO
	10:00-10:45	Interview with Health Centre staff and clients	KhonexayHC
	11:00 - 11:45	Interview with Health Centre staff and clients (ii)	HouaykhonHC
	13:00	Travel to Pakse (overnight stay)	
Wed. 06/05	12:30-13:45	Depart Pakse for return flight to VTE	
Thurs. 07/05	10:00 - 12:00	Debriefing meeting with UNFPA CO	
Fri. 08/05	08:30 - 13:00	Debriefing meeting	
Week 2 Katherine in Vientiane Capital and Vientiane province			
Monday 27/04	08:30-09:15	Mother and Child Health Centre	MCHC
	09:30-10:15	Food and Drug Department	FDD
	10:30-11:30	Department of Hygiene and Health Promotion	DHHP
	13:00-13:45	Department of Training and Research	DTR
	14:00-14:45	Medical Products Supply Centre	MPSC
	15:00-15:45	Department of Planning & International Cooperation	DPIC
	16:00-16:45	Department of Health Personnel	DOP
	17:00-17:30	Department of Planning & International Cooperation	DPIC
Tuesday 28/04	08:00-08:45	Promotion of Family Health Association	PFHA
	09:00-10:00	Vientiane Youth Centre	VYC
	11:00-11:45	Department of Finance MOH	MOH
	13:00-13:45	PSI	PSI
	14:00-14:45	WB	WB
	15:00-15:45	LUX Development	LUX
	16:00-16:45	WHO	WHO

Wednesday 29/04	08:00-09:00	Travel to Vientiane Province	
	09:30-10:30	Interview with Vientiane Province Health Department and MCH	VTE PHD
	10:30-11:30	Interview with MCH Vientiane Provincial hospital	VTE PH
	14:30-15:30	Interview with District Health and MCH + hospital	
Thursday 30/04	08:00-12:00	Interview with Health Centre staff and clients	Pha Sang HC
	12:00	Lunch and return to Vientiane Capital	

Week 2 Vimala in Savannakhet Province and Vientiane Capital			
26		Travel to Savannakhet	
Monday 27/04	08:30-09:30	Interview with SVK Health Department	SVK PHD
	10:00-11:00	Interview with SVK MCH	MCH office
	11:00-12:00	Interview - MCH services SVK provincial Hospital	SVK Pro Hospital
	13.30 - 14.30	Youth Friendly Services Centre interview clients	Kaisone Dist. hospital
	14.30 - 15:30	Youth Friendly Services Centre, interview clients	TTI Counselling room
	15:30	Travel to Thapangthong (TTG) District	
Tuesday 28/04	8:00 -10:00	Interview MCH + District Hospital	TPT district Hospital
	10:0 -11:00	Interview clients in facilities	TPT district Hospital
	10:0 -12:00	Interview HCs and Clients (i)	XekeuieHC
	13:30 - 16:00	Interview HCs and Clients (ii)	ThapheeHC
	14:00	Travel to Champone and stay overnight	
Wednesday 29/04	8:30 - 10:00	Interview MCHC + District Hospital	Champone District
	10:00 - 12:00	Interview with Health Dispensary staff and clients	NonglamchaneHC
	15:30	Travel back to Vientiane	
Thursday 30/04	10:00-11:00	Division of Social Development Planning	Dept of Planning
	14:00 - 15:00	Social Affairs Department, National Assembly	National Assembly
	15:30 - 16:30	Lao National Committee for Advancement of Women	Prime Minister's Office

