



Study on Gender and Ethnic Issues that Affect the Knowledge and Use of Reproductive Health Services in Six Ethnic Villages of Lao PDR

Lao/02/P05 – Promotion of the National Population and Development Policy and Integration of Population Variables into Development Planning

Lao/02/P06 – Establish Population and Development Studies and the Population Studies Center at the National University of Laos



The views and opinions expressed in this report are those of the authors and do not imply necessarily the expression of any opinion of the government of Lao, Committee for Planning and Investment, the National University of Laos and the United Nations Population Fund.

**Study on
Gender and Ethnic Issues
that affect the knowledge and use of
Reproductive health Services
in Six Ethnic Villages of Lao PDR**

Study conducted in August 2005

**Committee for Planning & Investment -
Department of General Planning
National University of Laos -
Population Studies Center**

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The study team would like to express special thanks to the ethnic research assistants and local government staff who facilitated the community-level information gathering and validation process. Without their participation, the Study would not have been able to communicate with the community members, and the wealth of information collected by the Study would not have been possible. The value of their contribution to the Study cannot be overstated.

Extensive information gathering was conducted at community and district levels, involving a large number of community members, along with village, district, and provincial staff. Each of these made an important contribution to the wealth of information collected, along with discussion and analysis. The Study would have been impossible without their participation, insight, and support. Community members stayed home from their regular livelihood activities for up to two days to participate in the information gathering and validation process. Further information gathering was conducted with key individuals at the provincial levels. The study team would like to express their special thanks to each of these persons who volunteered their time to participate in the Study.

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The study team would like to express their special thanks to the CPI and NUOL senior staff for initiating and overseeing the study process. Their ongoing support, both by releasing their staff from regular duties for an extensive length of time, and by providing vehicles, was an important factor in the successful completion of the field work. Finally, the team would like to express their sincere thanks to UNFPA for their vision, consultation, and ongoing support throughout the Study.

The team hopes that the information gathered will be useful to all organizations and individuals interested in supporting reproductive health initiatives in the Lao PDR. It is our hope that the Study will provide valuable information which will help the various stakeholders identify priorities and lay groundwork for pilot initiatives which address the reproductive health needs specific to the various ethnic groups.

The study team gratefully acknowledges the contributions of all involved. We have tried to faithfully represent the opinions and views of each of the communities and stakeholders. The information presented in the study report represents the perceptions of the study team, and possible misinterpretations or misunderstanding may have been the result of interpretation errors, and are the responsibility of the Study Team.

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ABBREVIATIONS

ADB	Girls' Education Project
AIDS	Acquired Immuno-deficiency Syndrome
CPI	Committee for Planning and Investment
CT	Central Team (Study team, comprised of 5 government staff and 2 consultants)
EED	Enfants Et Development (NGO which previously supported mother-child health care in ethnic communities)
EPI	Expanded Programme of Immunization (the national immunization program)
GoL	Government of Lao
GRID	Gender Research Information and Development
HC	Health Facility
HIV	Human Auto-immune Virus
IEC	Information, Education, and Communication
IFAD	International Food and Agricultural Development Agency
IV	Intra-venous
LWU	Lao Women's Union
LYU	Lao Youth Union
MCH	Mother and Child Health
NCA	Norwegian Church Aid (NGO working in Meung and Beng Districts)
NFE	Non-formal Education
NGO	Non-government organization
NUOL	National University of Laos
NSDP	National Socio-Economic Development Plan
P02	LWU reproductive health project supported by UNFPA third country programme
P04	Ministry of Education project supported by UNFPA third country programme
P05	CPI project supported by UNFPA: "Promotion of National Population and Development: Policy and Integration of Population Variable into Development Planning"
P06	PSC project supported by UNFPA: "Establish Population and Development Studies and the Population Studies Center at the National University of Laos (NUOL)"
PSC	Population Studies Center of NUOL
RA	Research Assistant, (research assistants from the local level, usually members of the ethnic groups studied)
RH	Reproductive health
RTIs	Reproductive Tract Infections
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendants ¹ (including those trained and those untrained)
UNFPA	United Nations Population Fund
VHV	Village Health Volunteers

Abbreviations of Villages (used in charts)

BN	Bong Nam Village (Ta 'Oy Ethnicity), Ta 'Oy District, Saravane Province
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¹ Lao: 'maw tam nyae' but this differs between provinces. In some northern locations, e.g. Oudomsay, 'maw tam nyae' referred to master of ritual ceremony (Lao: 'Maw Phon'); in the south both terms referred to traditional birth attendant. Government training programmes specify that TBAs should be female.

HNG	Huay Ngua Village, (Katang Ethnicity), Ta ‘Oy District, Saravane Province
HNK	Huay Namkha Village, (Lahu Na Ethnicity ²) Meung District, Bokeo Province
KSV	Kiusangvanh Village, (Hmong Ethnicity) Beng District, Oudomsay Province
M	Mang Village, (Khmu ³ Ethnicity) Beng District, Oudomsay Province
PS	Phonesavanh Village, (Akha ⁴ Ethnicity) Meung District, Bokeo Province

² Alternative name: Museu Dam. For the sake of this report, the term ‘Lahu Na’ will be used.

³ Alternative names: Kmhu’, Kmhou, Kmhou’

⁴ Alternative names: Akha, Iko, Ikoh. For the sake of this report, the term ‘Akha’ will be used.

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EXECUTIVE SUMMARY

OVERVIEW

The purpose of the study “Gender and ethnic issues that affect the knowledge and use of reproductive health services in six Ethnic Villages” was to gather information concerning gender and ethnic issues which relate to the understanding of reproductive health services, and impact community access to these services. The Study was funded by the United Nations Population Fund (UNFPA). It is important to qualify that the information gathered was specific to the six ethnic communities surveyed, and cannot be generalized as representative of these ethnic groups as a whole. Further in-depth studies would be needed for each ethnic group to achieve that purpose.

The Study was the first experience in qualitative information gathering by the counterparts at both central and local levels. It was also the first attempt in each of the locations for government and communities alike to participate in systematic information gathering by locally trained ethnic persons using the local languages. None of the central team or research assistants, and few of the local authorities, had any previous exposure to this type of participatory information gathering. The village feedback and district review sessions held in each location, was also a new experience for the central team members.

Objectives of the Study:

- Pilot a qualitative study process which is designed to be sensitive to gender and ethnicity issues, and which can be implemented by Lao government staff and local counterparts;
- Study the local perceptions and health seeking behavior in six ethnic villages in three provinces in the Lao PDR with special emphasis on the effect of gender and ethnic issues to accessing reproductive health services.
- Make recommendations to the relevant partners for the improved quality, appropriateness, and implementation of ethnic and gender sensitive programmes in the reproductive health field;
- Strengthen the capacity of technical officers at both central and local levels concerning gender and ethnically sensitive information gathering; and
- Disseminate the findings locally and internationally.

The Study was successful in meeting its objectives. Information was gathered from the community level on a wide range of topics, especially concerning traditions, practices, knowledge, and gender issues related to reproductive health and access to reproductive health information and services.

METHODOLOGY

Process

The study process included:

- Gathering information concerning the perceptions of ethnic males and females population (youth, married, unmarried) at the community level concerning local perceptions and knowledge of reproductive health issues and health seeking behavior and access to quality reproductive health services; and
- Joint analysis of findings towards the goal of improving the appropriateness of existing reproductive health programmes, and finding new approaches, with special focus on their access to information and quality reproductive health services and gender issues

which determine health-seeking behavior and decision-making concerning reproductive health issues.

The Study was designed as a survey and did not attempt to conduct in-depth research. Two days were allotted for community information gathering per village. As the villagers' livelihood is based on subsistence agriculture, they could not afford to be absent from their fields for any longer period of time. Information gathering was accomplished through building a pool of local researchers, and analysis and validation was accomplished through district level workshops in each of the three locations which were attended by all relevant stakeholders.

Study Team

The Study was undertaken by a team of five government staff from Vientiane, (the Committee for Planning and Investment (CPI) department of general planning allocated two persons; and the National University of Laos (NUOL) Population Study Center (PSC) three persons, together with provincial, district, and community partners, with the support of two outside consultants. Both consultants were fluent in Lao and English language.

Target Sites

The selection criteria specified that the villages were located within the 47 most impoverished districts in the country which in the Lao PDR are generally the remote, mountainous regions populated by ethnic peoples. In addition, the villages selected were located in districts where the UNFPA is supporting projects, in order to gain insight into their target areas. All villages studied were located within walking distance (defined as three kilometers) from a health center or district hospital.

Information Gathering

Semi-structured interviews were conducted with community members over a two-day period in each of the six ethnic communities, including feedback sessions with participating villagers. In order to accomplish this, ethnic research assistants both male and female, received training and experience by field testing and revising the interview tools for 4-5 days before conducting the 2-day community assessment. Care was taken to select research assistants from a different village whenever possible so that the interviewers were not known to the villagers in order to facilitate candid discussions, especially due to the sensitive nature of the subject.

Concurrent with these interviews of community members, the Lao-speaking central and provincial team members conducted interviews with 39 village authorities and relevant partners in the community, including Traditional Birth Attendants (both trained and untrained), health center staff and village health volunteers.

The validation meetings at the village level were followed by district review workshops held at each of the three districts centers in order to review the findings, identify issues, and discuss new approaches and solutions.

As few of the villagers could speak Lao, the role of the ethnic research assistants was the key to the success of the information gathering and community-level verification feedback session on the final day. The effectiveness of the training local ethnic youth and community members to conduct interviews in their own languages, many of which are unwritten, along with the wealth of candid information gathered in this rapid assessment process, exceeded expectations. A total of 164 female villagers and 122 males were interviewed, representing the

various sectors of the population (unmarried male/female, young married male/female, older married male/female; mothers of newborns).

Secondary data was also gathered from the various government sectors related to reproductive health at the provincial and district levels, as well as local authorities, in order to provide the scenario for understanding the situation of reproductive health in each village. The target sites and interviewees are summarized below:

Table 1 Target Sites and Interviewees

Provinces	Districts	Villages (6)	Ethnic Groups	Village Authorities, TBA, VHV, HC, etc.	Community Members Interviewed
Saravane	Ta'Oy	Bong Nam Huay Ngua	Ta'Oy Katang	4 (1 female) 6 (3 females)	51 (29 females) 39 (19 females)
Bokeo	Meung	Phonesavanh Hua Namkha	Akha Lahu	6 (1 female) 6 (2 females)	49 (29 females) 49 (29 females)
Oudomsay	Beng	Kiusangvanh Mang	Hmong Jua Khmu	10 (1 female) 7 (1 female)	49 (29 females) 49 (29 females)
TOTAL				39 (9 females)	286 (164 females)

FINDINGS

The Necessity for Locally Appropriate Programs

Reproductive health projects for ethnic minorities must be tailored to the situation and needs of the local people, using their own languages, with extension workers who are of the same ethnic groups.

The current system uses uniform approach and materials for the various ethnic groups, and has resulted in villagers misunderstanding the health messages and confusing them. Findings clearly showed that when reproductive health messages were conveyed in their own languages, the people clearly understood the messages and could repeat them correctly. This was the case for the Hmong in Kiusangvanh and the Khmu in Mang villages. Nearly all of the Hmong and many of the Khmu listened to the regular radio broadcasts transmitted from Luang Prabang in their own languages. Males and females alike had a clear understanding of the HIV/AIDS and family planning messages. Those who did not have a clear understanding of these reproductive health issues were those who did not listen to the radio. Villagers in the other 4 villages had quite a limited understanding of HIV/AIDS, with the exception of students (usually secondary school males) who had learned about HIV/AIDS and reproductive health from school. These students in turn told their peers. Findings showed that if a few youth attended school and learned these messages, others in their family or among their peers also had some basic knowledge of reproductive health issues. These points to the importance of bottom-up processes for project planning and monitoring, which are flexible and adapted to

the local situation. Training local ethnic youth and community members to use creative means to conduct reproductive health extension on a limited number of key topics would be an effective solution.

Close Relationship of Spiritual Forces to Reproductive Health

All of the ethnic groups studied held animistic beliefs, and perceived sickness and well-being as being related directly to spiritual forces. Thus practices and rituals are prescribed by the spirit world, and must be performed to ensure the well-being of the entire family. Animistic beliefs influenced all facets of reproductive health, including premarital sex and courtship, pregnancy and delivery, post-natal beliefs and the care of infants. More details are given below.

Inappropriate Immunization Policies

Policies for immunizations need to be flexible in order to address the situation of ethnic groups. Current policies call for females aged 15-49 to receive tetanus immunizations (i.e. females of childbearing age), and children less than 1 year old to receive the full immunization series. Those over 1 year only receive the measles and polio immunizations. The Study found a need for a more flexible policy concerning age, along with improved extension and logistics if coverage in ethnic and remote areas is to be realized:

- Tetanus
 - None of the 164 females interviewed in the 6 villages knew what the tetanus immunizations were for. Few knew how many immunizations were in the series. None of those being immunized knew why they should complete the series.
 - Many ethnic female youth of reproductive and marriageable age (generally age 12 or 13 and up, depending on the areas) have never heard of the immunizations.
- Children's Immunizations
 - In many of the ethnic groups, the father must give permission for the baby to be immunized.
 - Many respondents in the Northern provinces (e.g. Kiusangvanh Village) said they waited for the infant to be older before immunizing. However due to infrequent visits of the EPI team, in some cases the babies were too old for immunizations when the team came.

Language and Cultural Barriers

Language and cultural barriers are primary factors impacting the villagers' access to reproductive health information and services. Males and females community members in all target villages had minimal or no oral Lao language skills. The commonly heard statement from the authorities that many of the villagers could speak Lao language did not match the situation in the villages.

It is a priority to increase the number of trained male and female ethnic district health staff, as well as the number of ethnic staff in partnering organizations [Lao Women's Union (LWU), Education Services, Lao Youth Union, etc]. Due to improved education services, there are currently a number of ethnic youth completing their basic education who could be earmarked for scholarships to government training programmes, or participate in specially designed training workshops to become peer trainers in reproductive health.

A Lack of Networking, Coordination, and Monitoring

Networking to share materials and approaches designed for ethnic groups within the country and the region was weak. Coordination between various local partners involved with

reproductive health programmes appeared weak, and roles not clearly defined for inter-sectoral projects. Monitoring did not include spot checks or community consultation.

RECOMMENDATIONS

Many of the following recommendations arose from the review sessions in each of the respective districts: Ta 'Oy, Meung, and Beng. The study team wishes to endorse these as well as include additional recommendations prepared after reviewing the information compiled from the six villages and the three district review sessions. Any organization wishing to support reproductive health initiatives among the six ethnic groups studied, or in the three target districts, would find the detailed reports of the findings and review sessions both useful and of interest. In addition, they would find it beneficial to work with the pool of local persons trained through the Study.

- 1) Tailor reproductive health programming to the specific needs of ethnic groups and local realities, and pilot new approaches. This includes:
 - Male and female members of the ethnic groups from the target villages on the teams developing the activities and projects;
 - Using local language and field-tested materials;
 - Conduct information gathering specific to gender and ethnic situation prior to developing materials and approaches; conduct community feedback sessions of pilot materials/approaches for each ethnic group;
 - Involving community groups including ethnic village health volunteers and self-help groups in project planning, implementation, and monitoring;
 - Increasing ethnic and gender sensitive materials, and including issues related to young people and male involvement; and
 - Exploring innovative and participatory approaches to include the local population in design and implementation of programmes. These approaches should be flexible and adapted to the local situation.
- 2) Trained ethnic people, male and female, should be used to provide services.
- 3) Strengthen health service delivery. This includes:
 - Integrated outreach services, including regular ante-natal clinics at village level conducted by skilled midwives;
 - Home delivery with skilled medical attendance and strengthened links to skilled services;
 - Delivery practices which take into account traditional positive practices, and allows involvement of family during delivery
 - Monitoring which includes regular community consultation as well as 'spot checks';
 - Reviewing the current health center system; and
 - Enabling impoverished patients to receive free services.
- 4) Conduct community-level awareness raising and training of assistants for home delivery for all relevant family members (including husbands, parents, and youth).
- 5) Introduce flexible age limits for immunization policies and improve information flow.

- 6) Extend and strengthen sexual and reproductive health information. Recommended approaches include
 - Formal and non-formal education systems; and,
 - Media: radio, illustrated IEC materials, and videos in local languages.
- 7) Equip community members to provide health education in local languages.
- 8) Promote girls' education, both enrolment and progression.
- 9) Improve coordination and integration of reproductive health efforts at provincial, district, and local levels.
- 10) Improve qualitative and quantitative systems for gathering reproductive health data, including disaggregating by sex and ethnicity.
- 11) Conduct ethnographic studies and participatory social research, which includes the involvement of ethnic groups in design and implementation.
- 12) Build on the Study: pilot initiatives and implement recommendations in the three target districts.

CONCLUSION

The Study succeeded in training a pool of local ethnic researchers, gathering information, facilitating analysis, and developing recommendations with the relevant partners. This in turn provided opportunity for the district authorities and heads of the different district services to be presented with the Study findings, and form working groups to discuss issues and seek solutions. In the words of the Beng district governor:

“I am proud that we have this opportunity to develop the ethnic persons here, especially concerning reproductive health issues. I see that you have used this opportunity here to really invest your time and efforts for nearly two weeks in our district. The capacity building process as well as the information that you have gathered are very valuable and useful for us.”

It is the hope of the study team that both the localized study process and the findings and recommendations resulting from the Study will be useful for further participatory information gathering, towards the goal of strengthening ethnic and gender-sensitive approaches to reproductive health project and policy development. This in turn would increase the level of understanding and access to services by all sexes and age groups in the ethnic communities, and in particular, the vulnerable groups within each community.

It is the hope of the study team that the model of the localized study process will be followed by other organizations for further local information gathering, in order to inform development initiatives, and in particular, those related to reproductive health.

It is also the hope of the study team that the results of the Study will be disseminated to the participating communities and districts through local workshops, resulting in small pilot projects and initiatives which are tailored to community needs. If taken forward with further action, the findings and recommendations resulting from the Study should prove useful

towards the goal of strengthening ethnic and gender-sensitive approaches to reproductive health project and policy development. This in turn would increase the level of understanding and access to services by all sexes and age groups in the ethnic communities, and in particular, the vulnerable groups within each community, which is in keeping with the GoL's stated goal in relation to ethnic communities as stated in the National Socio-Economic Development Plan (NSDP) 2006-2010, as follows:

“... improve and expand the programme of education, health care, culture and information for ethnic group. Increase people's awareness on preservation and promotion of cultural values and traditions of all ethnic groups, Sustain and develop spoken languages and written characters/alphabets. Teach ethnic dialects in schools where ethnic characters/alphabets already exist.”

The recommendations of this Study report emphasize this need for special approaches which are tailored to the needs of ethnic communities. Contained in this report are tangible and concrete suggestions for relevant approaches which support the government's NSDP 2006-2010 plan to improve and expand the education, health care, culture, and information for ethnic groups, as stated above.

Study Report
Volume 1

1. INTRODUCTION

1.1 Context

The Lao People's Democratic Republic (Lao PDR) is a small, landlocked country that shares long borders with the Kingdom of Thailand to the west and the Socialist Republic of Vietnam to the east. It also has borders with Myanmar and the People's Republic of China to the north, and the Kingdom of Cambodia to the south. The Lao PDR is among the world's least developed countries. However, the government aims to exit this classification by 2020, and has embarked on strategies to address poverty reduction, which include efforts to extend social services to the marginalized areas.

According to the 2005 Census by the National Statistics Center (NSC), the population of the Lao PDR is approximately 5.6 million. Eighty percent of the population lives in rural areas, mostly dispersed in small villages that are difficult to access. Over two-thirds of the country is mountainous, and significant urban-rural and lowland-upland, along with disparities in terms of socio-economic status exist. Poverty is much more wide-spread in the mountainous and rural areas where most of the ethnic groups live, as compared to urban and lowland areas⁵.

The annual population growth rate is estimated at 2.1 percent (2005) as a result of high fertility and declining mortality. If the population growth continues at the current rate, the population will double by 2040. Compared to other countries in the region, the total fertility rate is relatively high at 4.5 children per woman. However the fertility rate has steadily dropped over the last 20 years, at 7.1 in the early 1990s, and 4.9 in 2000⁶, or 4.5 according to some government sources. The Maternal Mortality Ratio (MMR) is the highest in Southeast Asia, at 405 deaths per 100,000 live births⁷, and results from the Lao Reproductive Health Survey 2005 suggest that MMR is even higher among women living in Northern and Southern regions. About 16.8 percent of adolescents have started childbearing between the ages of 15 - 19, a rate that is extremely high when compared with other countries in the region⁸. The Infant Mortality Rate (IMR) is 70 deaths and the under five mortality rate is 98 deaths per 1,000 live births⁹. Contraceptive prevalence rate of all methods was about 38.4 % according to the 2005 statistics, and 35 % for modern methods¹⁰. Compared to 2000 data, there is growing evidence that there is an emerging positive trend for the use of modern contraceptives.

1.2 Gender situation

Lao's Gender Empowerment Measure is among the lowest in Asia, reflecting relatively low female representation, especially at all levels of the government and within institutions. Despite efforts towards ensuring gender sensitive policy development and planning at the national level, gender specific issues are not well integrated into sectoral and local development plans. There is still a weak understanding of key gender development issues, and commitments and budgets for implementation of gender specific actions are often limited. A lack of opportunities is also a concern, particularly for poor girls and women in rural and

⁵ Source: Millennium Development Goals Progress Report Lao PDR, jointly prepared by the Government of the Lao PDR and the United Nations, January 2004.

⁶ Source: "A Country Gender Analysis and Profile of the Lao PDR", Gender Research Information and Development, supported by the World Bank.

⁷ Source: "Results from the Population and Housing Census 2005" National Statistics Centre/ Committee for Planning and Investment

⁸ Source: Lao Reproductive Health Survey 2005, National Statistics Centre/ Committee for Planning and Investment.

⁹ Source: "Results from the Population and Housing Census 2005" National Statistics Centre/ Committee for Planning and Investment.

¹⁰ Source: Lao Reproductive Health Survey 2005, National Statistics Centre/ Committee for Planning and Investment.

remote areas, especially those from the many ethnic groups which have low education levels and limited understanding of the Lao language

Women, especially between the ages of 10 and 29, have increased health risks. Access to essential health services is limited, and this places women at a disadvantage. Rural and ethnic-women face significant reproductive health concerns, including limited access to family planning and safe delivery services, and high levels of malnutrition. Gender dynamics that limit girls and women's ability to have a decision making role in marriage, as well as negotiating sex, make women especially vulnerable. They risk unwanted pregnancies, having too early, too soon and too many pregnancies, as well as increased risk of abuse, sexually transmitted infections, and HIV/AIDS.

1.3 Ethnic Groups

The Lao PDR officially recognizes 49 ethnic groups, classified in four ethno-linguistic families¹¹: Lao-Tai (Tai-K'dai)¹², Mon-Khmer, Sino-Tibetan¹³, and Hmong- Mien¹⁴. Members of the latter three ethno-linguistic families (i.e. the non Lao-Tai speaking people) comprise about half of the country's population. For the purpose of this report, the term 'ethnic groups' and 'ethnic peoples' (i.e. the English equivalent to the Lao term commonly used) will refer to these non Lao-Tai ethno-linguistic groups, which were the focus of the study.

The largest of these non Lao-Tai ethnic groups in the country is the Khmu (Mon-Khmer ethno-linguistic group), numbering approximately 500,975 persons¹⁵ (over 11% of the total population), followed by the Hmong. The other ethnic groups have relatively small population numbers¹⁶. Linguistic mapping and analysis has not yet been conducted throughout the country to determine the numbers of languages in the country. Thus different villages may be categorized as the same language, even though they may not be mutually intelligible.

These non Lao-Tai ethnic groups generally occupy the more impoverished and geographically remote mountainous regions of the country, and constitute the majority of the population in 10 of the 18 provinces.

Many of the non Lao-Tai ethnic people, especially women, are unable to speak or read and write the national language, Lao. Most of these ethnic groups do not have written materials available in their own language. The following chart¹⁷ prepared by the Ministry of Education (2000) presents the literacy rates, disaggregated by ethno-linguistic family and sex. Disparities can be clearly seen between ethno-linguistic groups as well as between male and female. In some groups (e.g. Hmong) the males are over five times more likely to be literate than the females.

¹¹ classifications and numberings vary greatly according to the source.

¹²Officially referred to the Lao-Tai group within Laos, generally referred to as Tai-K'dai by linguistic sources

¹³the Study focused on the Tibeto-Burman Family within the Sino-Tibetan Ethno-Linguistic group.

¹⁴ also known as Hmong-Yao or Hmong-Iu Mien

¹⁵Source: 1995 census, results of 2005 census not yet published

¹⁶ The 2005 census, which has not yet been published, will provide figures for their respective populations, although it is important to keep in mind that language mapping has not yet been conducted.

¹⁷ Source: Country Report on Non-formal Education and Functional Literacy for Indigenous in Lao PDR, Department of Non-formal Education, Ministry of Education, October, 2000.

Table 2 Ethnic and sex disaggregated data on literacy rates

Ethnic Group	Literate Males	Literate Females	Overall Literacy Rate
Lao-Tai	84%	63 %	73%
Mon-Khmer	56%	20%	37%
Hmong-Mien	46%	8%	27%
Tibeto-Burman ¹⁸	22%	12%	17%
Others	61%	33%	47%
Total Population	74%	48%	60%

Source: MOE, 2000¹⁹

The ethnic people have the highest illiteracy rates, and experience the greatest challenges to accessing education and health services, including reproductive health care, extension, and information services. According to the Primary Health Care Expansion Survey in 1999, the data²⁰ on women aged 15 – 49 suggest that the women of the Lao-Tai ethno-linguistic group made greater use of district and provincial hospitals as a location of giving birth than did women from the other ethnic groups, who were more likely to give birth at home with the support of family or friends or with no assistance at all. In some ethnic groups, particularly those in the southern Lao PDR, women traditionally give birth alone, in the forest at some distance from the village, without any assistance. The situation of delivery without medical assistance is considered to be one of the main causes of maternal and infant mortality.

Table 3: Location of Delivery, by Ethnicity²¹

Place of Delivery	Ethnic Lao²² (%)	Ethnic Minorities (%)
District or provincial hospital	10.87	3.94
Health center	0.61	0.38
Private clinic	0.20	0.07
At home with ‘medical staff’ ²³	10.21	3.42
At home ²⁴ with traditional attendant	16.8	8.44
At home / with friends	54.98	70.90
At home ²⁵ without help	6.02	9.73
Other	3.11	

Source: GRID 2000²⁶

¹⁸ Of the Sino-Tibetan linguistic family

¹⁹ MOE, Department of Non-formal Education (2000). Country Report on Non-formal Education and Functional Literacy for Indigenous in Lao PDR. October 2000. Report presented at UNESCO APPEAL Conference held in October 2000, Kunming, PR China.

²⁰ Source: Primary Health Care Expansion Survey (1999), as cited in “A Country Gender Analysis and Profile of the Lao PDR”, Gender Research Information and Development (GRID), supported by the World Bank.

²¹ The figures are presented as they appear in the GRID publication. It is not clear why the totals do not add up to 100%.

²² It is unclear from the context whether this refers to Lao-Tai peoples in general, or specifically ‘lowland Lao’.

²³ The Lao term used is not clear. Likely it refers to anyone with some type of primary or secondary medical training, but not necessarily skilled in deliveries.

²⁴ The exact term is not clear for ‘at home’. This likely refers to ‘not at a health centre’ but may include a hut outside the family house. If there are friends or attendants it is likely within the village boundaries.

²⁵ The term is not clear. ‘At home without help’ likely refers to a variety of locations other than a health centre: either in the house, in a hut near the house but within the village boundaries, or in the forest outside the village boundaries.

1.4 Purpose of the Study

In keeping with the national priority of poverty reduction and expansion of social services to marginalized areas, the Lao government has placed a priority on extending services to the most impoverished regions and peoples of the country.

To reach this goal, and in order to improve the services for these most marginalized groups, it is important to identify and address the issues that contribute to the marginalization of ethnic groups, and in particular, women. These include the factors which impact their access to social services, including education and health. The disparity clearly shown in the available statistics demonstrates that ethnic women in particular seem to have limited opportunity to benefit from these services.

For this reason, the Lao Government commissioned the Committee for Planning and Investment, and the Population Studies Center from the National University of Laos, to conduct a Study on “Gender and ethnic issues that affect the knowledge and use of reproductive health services in six ethnic Villages”. This study was supported by the United Nations Population Fund (UNFPA).

The Study would aim to gain more information related to the ethnic villagers’ understanding of, traditional beliefs and attitude towards sexuality and reproductive health, and in particular, how this relates to the respective roles of men and women in relation to their access to reproductive health information and services.

1.5 Objectives of the Study

The objectives of the Study were as follows:

- To pilot a qualitative study process which is designed to be sensitive to gender and ethnicity issues, and which can be implemented by Lao government staff and local counterparts;
- To study the local perceptions and health-seeking behavior in six ethnic villages with special emphasis on the effect of gender and ethnic issues to accessing reproductive health services;
- To make recommendations to the relevant partners for the improved quality, appropriateness, and implementation of ethnic and gender sensitive programmes in the reproductive health field;
- To strengthen the capacity of technical officers at both central and local levels concerning gender and ethnically sensitive information gathering; and
- To disseminate the findings locally and internationally, including presenting findings at the 3rd Asia and Pacific Reproductive and Sexual Health Conference in Malaysia in 2005, and sharing with relevant partners in the Lao PDR.

Integral to the Study was the on-the-job training and capacity building for the study team members, both central and local government staff and ethnic research assistants, in order to build their skills in gathering information which was sensitive to gender and ethnicity.

²⁶ GRID Center, Lao Women’s Union (2000). Marriage and Family in the Lao PDR: Data from the Pilot Survey on the Situation of Women. Vientiane, Lao PDR.

2. METHODOLOGY

2.1 Overview of Methodology

The Study methodology was designed to enable candid information gathering, with community members' information disaggregated by age group, sex, and marital status, and their perspectives recorded separately from that of the village authorities and service providers. The community interview results were treated as primary information from the community, while the perspectives of outsiders (service providers, authorities, and officials) concerning the communities was treated as secondary information.

Please refer to the annexes for further information on the following:

- List of study team Members and Research Assistants (Annex 1);
- Field Schedule (Annex 2);
- People and Institutions Interviewed (Annex 3);
- Community Interview Tools in English (Annex 4).

2.2 Scope

The Study was planned as a “Rapid Assessment”, and did not attempt to conduct thorough research. This was due to the fact that both the central and local (Research Assistant) research teams were receiving on-the-job training, and lacked prior background and field experience in qualitative research as well as in the field of reproductive health. In addition, time and budget constraints allowed for only 8-10 days per province, which necessarily included the local training and tools testing process in addition to actual field work and district review sessions. Thus the Study was designed to progressively develop the central team research capacity throughout the 6 weeks of the field study, and to develop local research capacity at each of the three districts, through on-the-job training. This proved to be a very ambitious and challenging task for all involved. The role of the local ethnic research assistants cannot be overstated, as without them it would not have been possible to communicate with the ethnic villagers, the majority of whom had little if any Lao language skills. These newly trained research assistants should prove an important resource for any further studies. The ‘rapid assessment’ has identified topics for further investigation concerning reproductive health in relation to gender and ethnicity, which are presented in the section Research and Implementation.

2.3 Study Team

The central team was comprised of five Vientiane-based government staff, selected by their institutions, namely the Population Studies Center of the National University of Laos (3 staff), and the National Committee for Planning and Investment (CPI)'s Social Economic Development Unit (2 staff), and two consultants. In each of three provinces, the central team was accompanied by 2-3 provincial counterparts from relevant departments of Health, the Statistics & Planning, and the Lao Women's Union. The plan called for participation of a Provincial Health representative in each province; however this was accomplished only in Oudomsay Province, largely due to logistical reasons. Provincial Health representatives in two of the three locations were not able to join the study team as planned. In each district, two or three government counterparts including Health services and LWU joined the team. Selection of team members was made by the local authorities (provincial and district), with priority given to speakers of ethnic languages. Each of the three districts provided local ethnic staff for the team, and Oudomsay Province was able to provide two provincial ethnic staff for

the team, including the Mother and Child Health (MCH) director who was a woman of the Khmu ethnic group.

Research Assistants

Key to the success of the process was the central role played by ethnic research assistants in information gathering and interaction with the ethnic communities. The original research plan called for 5 research assistants per ethnic group, three females and two males. The research assistants were selected by the district from the best educated local community representatives from each ethnic group, with priority given to local villagers, students, and recent graduates. When sufficient numbers of literate ethnic community members were not available, district and provincial ethnic staff acted as research assistants. Generally the education level of the male research assistants was far higher than that of females, ranging from lower secondary graduate to teacher training college and medical doctor. The females' education levels ranged from scarcely literate (level 2 of Non-formal Education, or NFE; and primary grade 2) to lower secondary completion. Whenever possible, Research Assistants were recruited from a different village so as to be an 'outsider' to the community studied, in order to facilitate more candid feedback. This was not possible for one ethnic group (Lahu Na, or Black Lahu²⁷) which consisted of only one large consolidated village in the target district. This village also had an exception to the general criteria that research assistants are from the respective ethnic group, due to the extremely limited number of literate Lahu Na females and males. Thus after the initial trial, it was determined that only one Lahu Na female and no Lahu Na males were able to serve as research assistants. Additional research assistants were selected from educated females and male district staff who spoke a closely related language variety, Kuei (sometimes referred to as White Lahu).

Both of the consultants were fluent in the Lao language, which greatly facilitated the entire process. However, neither the central team members nor the consultants could speak ethnic languages. Most of the central team had limited experience in ethnic villages. Since neither the central nor local research assistants had previous exposure to qualitative information gathering, on-the-job training was built into the entire process, which was supported by the two outside consultants.

Preparation

Village Selection

The Study aimed to include as wide a range of ethnic groups as possible. From among three provinces selected by the Government together with UNFPA (Bokeo, Oudomsay, and Saravane), villages were selected by the provincial and district officials in consultation with the study team, based upon the following criteria:

- Located within the 47 most impoverished districts in the country (which in the Lao PDR are generally the remote, mountainous regions populated by ethnic peoples);
- Within Zone Zero of a functioning health center (defined as within three kilometers);
- Within a district where UNFPA supports programmes; and
- Representation to as wide a range of ethnic groups as possible, from both the north and south of the Lao PDR.

In order to gain insight into the disparities in as wide a range of ethnic groups as possible, villages were selected from among the non Lao-Tai ethnic groups. Thus the government

²⁷ Also commonly known in Laos by the term *Museu Dam*

representatives selected ethnic villages from each of the three ethno-linguistic groups, in both northern and southern areas of the country, towards the objective of gaining insight into gender and ethnicity in a range of ethnic villages.

The six ethnic villages were each from a different ethnic group, and represented all three major non Lao-Tai ethno-linguistic groups, as follows:

Table 4 Ethnic Languages and Groups

Ethno-linguistic Classification	Ethnic Groups in the Study
Mon-Khmer	Katang, Ta ‘Oy, and Khmu
Hmong-Mien	Hmong Jua ²⁸
Sino-Tibetan	Lahu Na ²⁹ , and Akha ³⁰

Only two days were allotted for community information gathering per village. As the villagers’ livelihood is based on subsistence agriculture, they could not afford to be absent from their fields for any longer period of time.

The study team provided on-the-job training for a pool of local ethnic researchers, gathered disaggregated information from local community members concerning reproductive health using local languages, and gathered secondary information using the Lao language from authorities and service providers. In addition, the team facilitated a day-long analysis session with all relevant partners, held at the district level. This provided an opportunity to inform the district authorities of the findings, and to discuss problems and solutions. The varying perspectives of the communities, the authorities, and service providers were discussed and analyzed at these sessions through working groups. Participants reviewed findings, identified issues, and discussed creative solutions, with special attention to gender and ethnic issues.

Preliminary Planning Trips

Preliminary planning trips of approximately 3 days were made to each of the three respective provinces and district centers in order to select which locations and ethnic group would be the focus of the study. health centers and villages were included in the preparatory trip when possible, as in the case of Meung district (Bokeo Province) and Beng district (Oudomsay Province). The central team conducted the first provincial preparation trip (Saravane) as one overall team, and divided into two smaller teams for the subsequent preparation trips to the two northern provinces. The purpose was to meet with provincial and district staff in order to present the objectives of the study, and to select the ethnic groups, districts, and villages to participate in the study. The criteria for local ethnic research assistants and participating district and provincial team members were also discussed, with priority given to speakers of local ethnic languages. Based upon this preparation trip, the local authorities were able to take responsibility for selecting the districts, ethnic groups, and specific villages which would participate in the study. This step was added to the research proposal, based both on experience and various socio-economic research reports which stated that lack of preparation at the local level, especially to address the challenge of communicating with women of ethnic minorities who did not speak the Lao language, had compromised the research³¹.

²⁸ Alternate names: Green/Blue Hmong, Hmong Lay, Striped Hmong

²⁹ Alternate names: literally ‘Black Lahu’, or Museu Dam.

³⁰ Alternate names: Ikoh, Koh, Hani

³¹ The UNESCO-supported ‘Gender and Ethnicity in Education’ Study reported that a serious limitation of their study was that they succeeded in interviewing only one ethnic minority female, despite the title of their study being ‘gender and ethnicity’.

Training

A primary specific objective of the Study was to strengthen the capacity of technical officers at central and local levels concerning gender and ethnically sensitive information gathering, including the members of the central team (CT) from the Committee for Planning and Investment (CPI) and Population Studies Center (PSC) of the National University of Laos (NUOL) and teams of local Research Assistants, including provincial and district counterparts from related government services (including MCH, CPI, Education Services, LWU,) with an emphasis on the ethnic Research Assistants from the specific ethnic groups to be studied.

The goals of the training were to train both central team and research assistants (approximately 10-13 persons per province) towards the goal of establishing a pool of government staff experienced in reproductive health information gathering. The training was designed to give them basic understanding and experience in the areas of:

- i) Qualitative research skills;
- ii) Field testing, sharing lessons learned, and revising tools and approaches; and, iii) Analyzing findings.

All ethnic research assistants, as well as provincial and district study team participants, participated in an initial training session of four to five days in each location. This included guided field practice and field testing and adapting the interview tools for the specific ethnic group before conducting the actual community survey.

The research assistant training sessions were all held at the district level, with the research assistants from each of two ethnic groups per district participating. The length of the training were shortened to the absolute minimum due to budget constraints as well as the time pressure to complete the survey before the roads were impassable due to rainy season. Following the joint training, the central team, Provincial and district counterparts, and research assistants divided into two teams in order to conduct field testing of questionnaires and tools concurrently, followed by a joint feedback session and revision to tailor the tools to the specific ethnic groups. The field testing provided an opportunity for screening research assistants as well as providing them with field training before conducting the actual study. The exercise enabled the central team to assess the research assistants' skills, identify and follow-up on coaching needs, and determine their respective roles on their interview teams, whether recorder or interviewer. In one location, Meung district, the field testing exercise revealed that two Lahu Na (referred to by the team as Museu Dam) Research assistants had insufficient literacy skills to fulfill the task. Thus they were replaced by ethnic Kui district staff that was able to communicate with the Lahu Na villagers.

During the training, the ethnic research assistants had guided practice in order to understand both the content of the interviews as well as methodology. The study team depended on these ethnic research assistants to orally translate the tools into their own languages, conduct field testing, and revise them as appropriate for the respective ethnic groups.

Initially, both semi-structured focus group discussions and individual interviews were planned. However, as both the research assistants and villagers had no prior exposure to qualitative information gathering, the focus group discussions were changed to semi-structured group interviews during the guided practice in the first province originally. Thus, the main tool was the semi-structured interview, which was prepared in advance using colloquial Lao-language. Community interview tools are included in English translation as Annex 4.

The ethnic research assistants worked as 2 person teams whenever possible, with one person interviewing in the local language, and the other recording in the Lao language. Interviewing and recording skills were practiced both in a classroom and village setting before conducting the information gathering. Thus the training sessions were critically important for equipping them with the necessary understanding of the questions and basic interview skill. As none of the central level study team members could understand the local languages, the highest educated research assistants helped monitor that the guidelines were being used effectively.

Interview Tools

Primary information tools used with villagers were questionnaires for Semi-Structured Group Interviews and Individual Interviews. The ethnic research assistants conducted this information gathering through the use of the local languages, with male research assistants talking with male villagers and female research assistants talking with female villagers. Research assistants were trained to use two types of tools with villagers: semi-structured group discussion and individual interviews. The research assistants were trained to use the Lao questionnaires as a basis for posing questions using the local languages.

All tools were prepared in colloquial Lao-language, and field tested and further revised for each of the six ethnic groups in an effort to make them easily understandable for each location and ethnic group. The research assistants in turn translated the tools orally into their own ethnic languages, practicing the questions in both a classroom and field setting before conducting the information gathering. Translation was oral for all the ethnic groups with the exception of Hmong, as the Hmong research assistants happened to be literate in their own language.

2.4 Information Gathering

Process

The central team spent an average of nine field days at the district and village level in each of the three provinces, consisting of:

- i) Training for local counterparts and research assistants (3 days);
- ii) Field testing in ethnic villages followed by revising the tools and questionnaires in order to tailor them for each specific ethnic group and locality (2-3 days);
- iii) Actual field work including both information gathering and participatory feedback meeting (2-2 ½ days)
- iv) Presentation workshop at the district level. The latter included group discussions with relevant district departments in order to verify findings, identify and discuss issues, and brainstorm appropriate local solutions (2 days).

The two teams conducted information gathering concurrently for the two respective ethnic groups, followed by participatory feedback sessions at the village level. This process was repeated for each of the three target districts. The actual study was always conducted in a different village than that of the field testing exercise, with the exception of the Lahu Na village, which conducted the study in a different section of the village. The fieldwork was followed by a joint workshop at the district level, for presentation and verification of findings from the two ethnic villages, followed by discussion, analysis, and conclusions.

Interviewing Community Members

All semi-structured interviews with the community members were conducted in the local languages, by the newly trained ethnic research assistants. The latter were selected from different villages so that they were not known to the interviewees in order to facilitate candid discussions. The entire process generally required a total of two days, with 1 ½ days spent on interviews, and the final half day for a feedback session to validate the answers recorded with the community members. A total of 286 villagers (164 females, and 122 males) were interviewed in the six villages.

The Study took care to interview males separately from the females, ensure that interviewers were of the same sex as those interviewed, and hold interviews in confidential settings away from the listening ears of other villagers and the local authorities and service providers. The latter were interviewed concurrently in different location from the community members. This was in order to gather candid answers that were not influenced by the interviewer or presence of different members from different strata of society, such as the local authorities and service providers.

The villagers interviewed were selected by the village chief, and categorized according to marital status and sex, such that disaggregated information was gathered for males and females for seven categories: never married (male and female), young married under 35 years of age (male and female), and older married over 35 years of age (male and female), as well as mothers of infants. Generally eight villagers were interviewed per category, four of whom were interviewed individually, and four in a group. Since many of the villages were quite small, ranging from about 22 to 50 households, often the majority of villagers in each category were interviewed. The majority of those interviewed were of reproductive age, which was defined differently by each locality and ethnic group, ranging from age 12 to 49 years for females and 15 years and up for males. Care was taken to ensure that interviews were held in local languages and by persons of the same sex, in a location where privacy could be ensured. This was important due to the sensitivity and personal nature of the topics discussed, which included practices and customs concerning courtship, menstruation, sexual initiation, childbirth, sexual practices, family planning. In addition, questions were asked about risky behavior and outside pressures to the traditionally isolated communities concerning HIV/AIDS, STIs, and potential of exploitation and recruitment into the commercial trade. Males and females were asked questions on the same topics, although the interviews for females included more details, e.g. concerning pregnancy, delivery and infant feeding.

It is important to stress that the topic of sexual activities and reproductive health is sensitive and rarely talked about in Lao society. Thus these questions were purposely interspersed with more general questions of a less personal nature, usually concerning access to information and services related to reproductive health. Interviews were generally held in empty classrooms or meeting rooms, or in the school field under the tree, with assistants keeping constant guard to send away children or others attempting to listen to the discussions and interviews. While individual and group interviews covered the same range of topics, the group interviews were more general in nature, with fewer personal questions, in order to facilitate more candid responses.

Ethnicity

The Study took care to gather data in the local language, disaggregated by sex and age. This was an important part of the approach, as it enabled documentation of the perceptions of the ethnic males and females from different strata within the community social structure. In all of the locations visited, this was the first time that male and female community members' perspectives had been gathered and recorded. In order to gather information concerning ethnicity and gender in relation to reproductive health, a range of questions were asked on the following topics:

- Traditions, beliefs, and practices concerning courtship and marriage, pregnancy, delivery, family planning, and post-partum care of mothers and infants;
- Roles in the family and decision making in relation to the above, especially in relation to referral of mother and infant for necessary medical care during pregnancy, delivery, and the post-partum period;
- Access to information and reproductive health services; and
- Changes and pressures on traditional society which impact sexuality and reproductive health.

Interviewing Village Authorities and Health Service Providers

An underlying principle of the methodology was the assumption that information gathering would be most effective if ethnic community members (Research Assistants) communicated directly with villagers using ethnic languages, while civil servants gathered information from local civil servants, and that the Lao language could be used for effective communication with government civil servants and local authorities.

Therefore, concurrent with community interviews, the Lao-speaking study team members (government staff from central, provincial, and district levels) conducted interviews with the various community partners involved in reproductive health service provision or community leadership. This enabled the government staff on the study team to conduct interviews for other civil servants and village volunteers rather than interacting with the community members, which facilitated candid information gathering.

The Lao-speaking government staff on the team was matched with relevant partners for the respective community, and did not gather information from the villagers themselves. They conducted semi-structured interviews with the village authorities, traditional birth attendants (both trained and untrained), village health volunteers, health center staff, private mobile medics, and teachers. These interviews were not personal in nature, but concerned access to information, services, and treatment in relation to reproductive health. The difference in perceptions between the civil servants and the communities concerning access to and knowledge of reproductive health services is highlighted and discussed throughout the report.

Secondary Information Gathering

In addition to the information gathering at the village level, secondary data was also gathered from the various government sectors related to reproductive health at provincial and district levels, in order to provide the scenario necessary for understanding the situation of reproductive health in each village. Background information for the provincial, district, and village profiles varied greatly, depending on the availability of statistics and personnel in the

government office on the day allotted for this secondary information gathering. In addition, the central team had no previous experience in this type of information gathering and strengthened their skills throughout the process. Thus there are gaps and variation in the information and level of detail collected for the synthesis of the various provincial, district, and village profiles. As the central team's information gathering skills improved throughout the process, so did the quality and relevance of information used for the profiles. Examples of the more complete and structured profiles are Mang and Huay Ngua villages.

District Review Meetings

In addition to training a pool of local ethnic researchers, gathering reproductive health information using local languages, and gathering secondary information, the Study also facilitated a day for analysis with all relevant partners, which provided opportunity to inform the district authorities of the findings, as well as to form working groups to discuss problems and solutions.

A summary of locations and community members and local persons involved in the Study:

Table 5 Overview of Persons Interviewed

Province name	District name	Village name	Ethnic Groups	Village Authorities, local service providers interviewed ³²	Total Village population	# Houses (families)	Total villagers interviewed ³³
Saravane	Ta'Oy	Bong Nam	Ta'Oy	4 (1 female)	298 (141 females) Ta'Oy	40 houses (41 families)	51 (29 females)
		Huay Ngua	Katang	6 (3 females)	466 (219 females) Katang	N/A ³⁴	39 (19 females)
Bokeo	Meung	Phonesavanh	Akha	6 (1 female)	238 (117 females)	43 houses (49 families)	49 (29 females)
		Hua Namkha	Lahu Na ³⁵	6 (2 females)	967 (514 females)	112 houses (210 families ³⁶)	49 (29 females)
Oudomsay	Beng	Kiusangvanh	Hmong Jua ³⁷	10 (1 female)	462 (238 females)	N/A ³⁸	49 (29 females)
		Mang	Khmu	7 (1 female)	385 (149 females)	59 houses (68 families)	49 (29 females)
TOTAL	3 districts	6 villages	6 ethnic groups	39 (9 females)	2,816 (1,378) total females	N/A	286 (164 females)

2.5 Analysis

Information gathered by Research Assistants was disaggregated according to the following categories: never married males/females, married males/females (divided by age into two categories: under 35, and over 35), and mothers of infants. Topics included: courtship and marriage practices, pregnancy, childbirth, food rules, knowledge and practice concerning family planning, risky behavior, immunizations for females and infants, breast feeding, infant care, and HIV/AIDS and STIs. Gender issues and cultural factors were explored which influenced the health-seeking behavior and decision-making concerning reproductive health. Disaggregated data is found in Annexes 5-7.

³² the total number is given, followed by number of females in brackets

³³ both 'never married' M/F and 'married' M/F

³⁴ The village has 75 houses (95 families), which includes an unknown number of Lao households. The Lao population is 39 persons (20 females).

³⁵ All interviews for males and half of interviews for females were conducted in Lahu Shi, which is a related, but different, dialect

³⁶ A married daughter always lives with the parents, thus two families per household

³⁷ All interviews were conducted in White Hmong, which is a related, but different, dialect

³⁸ Kiu Sanvane is a mixed village of Khmu and Hmong, total population 709 persons, including 361 females and 348 males, with 101 houses (125 families).

Gender

Due to the difficulties associated with understanding and translating the concept of ‘gender’, the Study chose to focus on gaining insight into gender and ethnic disparities, and cultural and gender issues which impact reproductive health. The team found that the main gender and ethnicity issues impacting reproductive health at the community level are as follows:

- Decision making (who decides concerning prevention and treatment for a woman’s reproductive health needs, going for help, etc.)
- Access to information (usually women are less educated, have less language skills, flow of information is through males and the women don't get the message, etc)

Cross checking of the information gathered from primary and secondary information sources has emerged as an important issue for analysis. Much more consultant and central team time would have been needed to analyze and assess the information from each village, district, and province adequately. The study team noted the differing perceptions and information provided by the various partners at village level provides different information related to the same topic, which makes cross-checking very difficult. For example, the reproductive health information gathered from the HCs was conflicting. The district and HC also generally provided quite different information from that given by the community. An example is the Beng district and HC reporting that they give immunizations for women and children 3-4 times per year, while the Kiusangvahn village has never heard of immunizations for women, many have never seen the HC staff in their village, and they repeated that the district health teams comes about once a year to provide immunizations for children only.

2.6 Reflection on the Study Methodology

Information gathering depended primarily on interviews, with no direct observations. The Study generally had two days or less for each of the six villages. There was no literature review or quantitative information gathering, both of which are necessary for any comprehensive research.

Due to the lack of experience of the interviewers, the Focus Group Discussions actually resembled group interviews. None of the central team members or consultants knew the ethnic languages, and had to rely on back-translation to Lao in order to spot check interviews and compile the findings. The success of the information gathering relied upon the success of training the research assistants, as well as using the more educated research assistants to provide technical backstopping.

The qualitative study approach was new to all of the study team members and local partners. None of the provinces had prior experience in training local ethnic research assistants to gather information from community members. The village feedback and district review sessions held in each location for information verification and joint analysis was also a new experience for the central study team members, although familiar to many of the provincial and district participants. Despite efforts to train local research assistants for each of the respective ethnic groups, in three of the locations the dialects spoken in the villages were different than those spoken by the research assistants.³⁹ Since none of the central team or

³⁹ In Saravane, the female Katang Research Assistants spoke a different language variety than the target village; In Bokeo, the research assistants were Lahu Shi (White Lahu), although they could speak Lahu Na (Museu Dam); in Oudomsay, the

consultants could speak the ethnic languages, they relied on back-translations of interviews to check findings. Thus the findings of the Study, although very informative, must be considered preliminary rather than conclusive.

The study team had underestimated the difficulty of gathering statistics concerning reproductive health at the local levels. They found a general lack of disaggregated data by gender and ethnicity at provincial, district, and health center levels. In addition, the village-level data collection varied greatly. As is common in developing countries, the various provincial and district services were highly compartmentalized, both within their own sector and between the various sectors. Thus a number of individuals needed to be interviewed from the district health office in order to gather information concerning their various programmes within the health sector, whether Mother Child Health, Traditional Birth Assistant training, and Health Education.

In addition, the various district services (e.g. health, education, LYU, Lao Women's Union) were not always aware of what the other organization was doing in relation to reproductive health, even in joint projects. Reproductive health is implemented by a number of partners. For example the various HIV/AIDS Prevention projects are implemented jointly by LYU, LWU, MCH, MoE, Ministry of Culture radio, TV, and other donor agencies (e.g. GTZ). It was not possible for the team to identify and meet all of these within the scope of this Study.

One of the potential limitations which were successfully addressed was the communication problem with ethnic communities. This potential limitation was successfully overcome through the Study process, which included local on-the-job training for ethnic research assistants, both male and female. This is the primary limitation usually encountered by such studies in the Lao PDR, as the majority of the remote ethnic community members do not speak the Lao language. This is especially the case for ethnic women. Meanwhile, generally very few of the provincial government staff, and only a handful of district staff, speak the languages of the ethnic communities. The role of the ethnic research assistants was essential to the success of the information gathering and community-level verification feedback session on the final day. Despite the statement commonly heard from various levels that "many of the ethnic villagers speak Lao, especially the men", the study team found this not to be the case. Information gathering and communication with the villagers would not have been possible without the research assistants.

An additional constraint was the accelerated time line for the study as well as of staff with time dedicated to the Study. Reasons for the time constraint was the total budget available, the lack of time availability on the part of central team members (none were dedicated fully to this task, as all had on-going responsibilities in Vientiane), and the fast approaching monsoon season.

Too little consultant time was allocated to the process. None of the central team or research assistant had prior experience in qualitative information gathering, and for this reason, the Study was designed both as a capacity building as well as information gathering process. However, the capacity and time availability of the central team for the task were overestimated. Thus the two consultants did not have the time necessary to provide hands-on guidance for such a large team of central team staff, as they already were occupied with two teams of ethnic research assistants in each location.

research assistants spoke White Hmong and conducted the interviews in that language, although the villagers were Green/Blue Hmong.

Despite the limitations, the wealth and range of information gathered despite the language and cultural challenges was remarkable. A pool of ethnic community members, many of whom are youths, has been trained as research assistants in each of the locations. The successful mobilization of large numbers of community members, village authorities, and reproductive health service providers to meet with the interview team despite the busy agricultural season exceeded expectations. In most villages, the number of interviewees comprised well over half of the persons of reproductive age.⁴⁰ Information was gathered on a range of topics, primarily related to traditions, practices, and knowledge related to reproductive health, as well as access to reproductive health services. Quality information was gathered by the ethnic research assistants through interviews and discussions with villagers. Each district organized a review session of one or more days in which the study team reported the findings, and participants discussed the issues and creative solutions.

Lessons Learned Concerning Study Process and Methodology

Strengths

The Study was locally managed, due to the advance preparation trip which gave the local district and provincial authorities an important decision making role in selecting the sites and guiding the preparation and implementation phases of the project.

Ethnic Research Assistants: Key to the Process for Primary Information Gathering

The process of training local research assistants emerged as key to the success of the project. This was based upon the concept that having villagers speaking in the local language to other villagers is the most successful means of information gathering at the local level. Miscommunication is avoided by speaking in the local language which they understand, and responses are candid when interviews are conducted by persons of similar social position. During the preparation trips, the local authorities in most locations told the study team that the male ethnic villagers can communicate in the Lao language, but not the females. However, the study team found that even male ethnic villagers in all locations had limited Lao language skills. The interviews and information gathering would not have been possible without the use of ethnic Research Assistants.

The primary information gathering process paired research assistants with the interviewees from the target villages. Whenever possible, the research assistants were villagers themselves, although in each location it was necessary to recruit some from among the ethnic government staff. However, care was always taken to pair by gender, and whenever possible, according to age:

- Ethnic female research assistants with ethnic female villagers
- Ethnic male research assistants with ethnic male villagers
- Adolescent research assistants with ethnic youth (whenever possible)
- Research assistants were unknown, or ‘outsiders’, to the villagers whenever possible (although of the same ethnic group)

⁴⁰Each group defined the reproductive age for their respective village, generally about 13 years of age and up for females and 15 years of age and up for males.

Counterparts at the central, provincial, and district levels generally had some experience with quantitative studies, most of which are centrally planned and implemented. However they have little or no experience with qualitative studies.

Those who have experience testing tools have usually not tested them in a situation similar to the remote ethnic target village. Instead they are often tested in an easily accessible locality, and training sessions are usually held at the central or provincial level.

Questionnaires are generally administered in the Lao language, often translated by a local villager who has not have participated in the training sessions. Often the Lao language used for these tools is very literary rather than the colloquial, informal spoken language. The formal language often makes the questionnaires unclear even to the interviewer as well as the interviewee. Ethnic male translators are often locally recruited on an ad hoc basis. Due to the lack of experienced and trained ethnic females, male translators or interviewers are usually recruited. If the translator is known to the interviewees, and is a different gender, this may compromise the quality of information gathered.

Besides the unique focus on gender and ethnicity, this Study was the first of its kind in each of the three districts in many aspects:

- Qualitative research rather than quantitative
- Training held at district level, rather than at central or provincial level
- Guided practice and capacity building held in the field
- Training local research assistants from the ethnic communities, rather than relying on government staff to speak with communities
- Advance preparation trip to each district and village location, in order to facilitate local ownership, planning, and site and research assistant selection, rather than determining these key factors at central or provincial levels.
- Local field testing of tools, with revision and adaptation for each ethnic group
- The use of local languages for all information gathering with villagers, along with community feedback sessions
- Participatory feedback sessions for validation of data at the village level
- Participatory feedback and analysis session at the district level

The study team recommends the above process for any further studies. The decentralized, participatory process, using local research assistants and local languages, was the key to gathering the wealth of qualitative reproductive health information in the six remote ethnic villages.

Areas for Improvement

Additional Preparation Concerning Language of Communication

Even with the care to recruit ethnic research assistants, in three of the locations, the majority of the research assistants spoke a different language variety than that of the target village: Katang, Lahu Na, and Hmong. Although the situation was not ideal, it was vastly better than trying to communicate with the villagers in the Lao language. The lesson learned is that it is important for the preparation team to investigate the language of each target village, as detailed information is not available at the district level.

Challenges to Finding a Language of Communication with Villagers

The Katang dialects vary, thus the Katang research assistants (from The Katang village near the Ta'Oy district center) sometimes found it hard to communicate with the Huay Ngua villagers. The trial Katang village had been near to the district center, which was a different version of Katang than Huay Ngua 43 kilometers away.

In the Lahu Na village, the level of education was so low that the villagers recruited as research Assistants had to be replaced with district staff who spoke Lahu Shi (locally referred to as Kui), which is closely related to Lahu Na.

The Hmong target village of Kiusangvanh was of Hmong Jua⁴¹ ethnicity, whereas the Research assistants were from the Hmong Daw, or White Hmong ethnicity. Fortunately for the Study, the Hmong Jua villagers had learned the dominant White Hmong dialect since moving to the main road in 1999, as well as through listening to the Hmong radio broadcasts. However, the situation did not allow for the methodology of interviewing villagers in their own language variety to be consistently applied.⁴²

Capacity Building

Due to budget constraints, insufficient time was allocated for training and team building for the Central team both 1) prior to beginning the Study; 2) during the Study after each provincial field trip; and 3) during the write-up and analysis phase upon return to Vientiane.

In addition, the central team did not have sufficient time allocated to concentrate on the write up and analysis upon return to Vientiane. If the objective is to train them to conduct research, they need to be able to be involved in the entire process, and not have the distraction of other work responsibilities upon return to Vientiane.

Implications for Further Research

It is important that any future studies have an adequate time line and budget which allows for a greatly increased capacity-building component. This would benefit researchers from the central, province, and local levels. The experience of the Study demonstrated that the objective of building up a research team in such a short time period was not realistic. In addition, the central team had to return to their regular responsibilities upon return to Vientiane, and thus in reality the final analysis, synthesis, and reporting became the responsibility of the consultants. This was despite the original objective that the central team gain skills in conducting the entire process of a study from beginning through to completion.

To achieve the objective of building a central level team to conduct studies and research, the capacity building component needs to be strengthened to include:

- Pre-study preparation training, training of trainers, and team building for the central team
- Guided analysis and reporting immediately after field work in each province

⁴¹ Lao: 'Hmong Lay' or Striped Hmong

⁴² Despite preparatory field trips to the village level to select the target villages, as well as to recruit Research Assistants; this potential difficulty was not identified until the actual field work began. This was because the District office did not have information concerning the specific Hmong ethnic groups. The White Hmong Research Assistants who had already been recruited and trained thus conducted field interviews in their dialect, despite the target village being Hmong Jua.

- A team retreat for reflection and planning after each location
- Two weeks allocated for field work per province location (rather than 8-9 days in this study), followed by at least 2 weeks of analysis and reporting in Vientiane before continuing to the next field site.
- A minimum of two weeks (ideally one month) for guided analysis, preparing field reports, and identifying gaps in data after each provincial field trip. This would allow for identifying gaps in the data, as well as strengthening the skills of the team members.
- Sufficient consultant time for guided supervision of secondary data information gathering.
- Guided practice in writing the final report, over a period of one month.
- Adequate time allocated for analysis and reporting: the central team members need to be able to concentrate and focus on their research, free from regular job responsibilities, if they are to achieve the objective of trained researchers.

3. FINDINGS BY GROUPS

This section will compare some of the similarities and differences between ethnic villages surveyed concerning their reproductive health practices and beliefs. The reproductive health Study did not conduct an ethnographic study, but rather, a rapid survey concerning reproductive health practices and beliefs in 6 ethnic villages. In-depth research is needed to understand the relationship between beliefs and practices. Many of the practices noted have spiritual or ceremonial significance, which would need to be better understood before recommendations for reproductive health programmes could be made.

The following highlights have been extracted from the data gathered. Findings are presented first by ethnic group, and then by topic Village profiles, reviews of available healthcare, and other health related information can be found in the Annexes.

3.1 Finding by Ethnic groups of the 6 Study Villages

The groups which are related linguistically are grouped together in the following descriptions. Linguistic similarity does not necessarily lead to cultural similarity; however those groups living in close proximity such as the Katang and Ta'Oy appear to be both culturally as well as linguistically related.

The findings represent the six ethnic villages studied, but cannot be generalized to represent the ethnic group as a whole. Further, in-depth studies would be needed in order to order to develop an ethnic profile.

Information derived from interviews with the members of the community is separated from information derived from government officials, experts or other outsiders, (including Lao medical personnel based in Vientiane, and others who are not members of the ethnic village) which is indicated as such.

3.2 Katang and Ta'Oy Ethnic Groups

Mon-Khmer Language Family (Central Katuic Branch)⁴³⁾

The Katang and the Ta'Oy are closely related linguistically, and are both longstanding inhabitants of the southern Lao PDR. Most of the findings concerning the Katang and Ta 'Oy in this survey were quite similar, and thus are usually presented together in this report. The Ta 'Oy village in the Study, Bong Nam, had many cultural similarities to the Katang village, Huay Ngua. A more detailed study would need to be conducted to determine the similarities and differences between these two ethnic groups. The study team also found that the groups classified as "Katang" and "Ta 'Oy" were not always carefully defined, and referred to a range of dialects. The Katang living near the Ta 'Oy district center spoke a dialect which differed from the Katang of the Study Village of Huay Ngua.

Kinship and Gender roles

The Katang and Ta 'Oy organize families along patrilineal lines, with related families living in close proximity⁴⁴. Marriage may take place within or outside the village community, and

⁴³⁾Source for Linguistic classifications: Chamberlain, James R., Indigenous Peoples' Profile, Lao PDR. Care International, Vientiane, Prepared for World Bank Dec 1995.

women continue to have contact with their parents. Marriage ceremonies, which require a buffalo to be given to the wife's family, are paid for by the husband's family, and for this reason married men (among the Katang) express a desire for daughters. It is inferred that women move from their homes to their husband's residence upon marriage. Polygamy (men having several wives) may have been practiced in the past. The Ta 'Oy women interviewed indicated that wives were sexually subordinate to their husbands:

There are cases of newly married couples in which the husband wants to have sex many times in one night, and the new wife did not agree, in which case she can be questioned by her husband's parents. There have been cases of forced intercourse in which the woman was menstruating and did not want to have intercourse, but her husband insisted. Women do not initiate intercourse as they are afraid their husbands may be angry.

Source: Bong Nam Village interviews with married women.

However illegitimate (pre-marital) Centre of the man, see below.

Courtship and Pre-marital sex

Young Ta'Oy men said that

When young men go to visit girls in another village, or in their own home village, they need to spend money on the girl, or else buy gifts for her, depending on what she wants. You can leave some clothes with her, and then go redeem them, sometimes with gifts of money. Some boys talk with the girls in a public place, such as under the house, while others go to a more private place in the forest. The couple gets to know each other and agrees to marry, after which the marriage can take place.

Young people in the communities interviewed are free to choose their partners, although arranged marriages were the norm "in previous times". However, parents arrange and pay for the marriage ceremony, and therefore (due to the rules against pre-marital sex) exercise some control over choice of spouse. Marriage for girls may occur at or after age 13, and for boys at or after age 15.

Traditionally a period of time elapsed between a first wedding ceremony ("engagement") and a second, variously given as one year, one month and one day, three years, three months and three days and seven years, seven months and seven days, with consummation and moving to the husband's house only occurring after this second ceremony. This tradition seems to have declined along with the decline in arranged marriages.

Both the Katang and the Ta'Oy villagers interviewed described very strong rules against pre-marital sex⁴⁵. They believe that someone in the family will get sick or die if the youth have intercourse before marriage. If pre-marital sex does take place, ceremonies to appease the spirits must be performed by a spirit specialist, involving the sacrifice of an animal, which may vary from a chicken to 1 or 2 buffalos ('one white, one black' is the tradition for the

⁴⁴ Department of Ethnic Groups, *The Ethnic Groups in Lao P.D.R.*, 2005

⁴⁵ However observers have noted that a discrepancy exists between the strict rules and actual practice is well-documented in the literature.

Katang) which are purchased by the man, who is held responsible^{46[4]}. Girls would tell their parents in the case of forced pre-marital sex, resulting in a fine being levied.

Family Planning

Awareness and use of family planning covered less than half of the women interviewed. Its use was dependent upon consent by the husband. Preferred methods were pills and injections.

A Katang village chief observed that Katang families want many children to take care of them in their old age. Therefore they do not want to limit the number of children because due to the high child mortality rate, there may be no one left to take care of them.

The Ta'Oy women stated that until the first child is born, the husband and wife share a bed and sleep together. After the first child is born, the husband sleeps in a different place. This practice may help space births; however this issue was not explored further.

Pregnancy

None of those interviewed, either male or female, knew that pregnancy could occur after only one act of sexual intercourse, or, as stated in the interview question, 'how many times it was necessary to have intercourse, before getting pregnant'.

Food prohibitions are practiced during pregnancy. Reported prohibitions include: snakes, raw food, and rats which they have found dead in their holes (for fear of obstructed labor), beef, eggs, buffalo meat, sesame oil, peanuts and peppers. Pregnant women can eat chicken, ducks, domestic pigs, fruit and vegetables.

Women continue to work during pregnancy, including agricultural work, carrying firewood and water, and cooking. Men say that they nowadays often help the women with these tasks.

Common reported health problems during pregnancy include backaches and feeling tired. When they are sick, sometimes women go to the health center to buy medicine, but if they have no money, they cannot do so and have to bear it. Pregnant women usually don't go to the health center for pregnancy checks, but wait for the 'health day' campaign once every 3 months. They only go to the health center if they feel there is a problem during the pregnancy.

The health center records showed that two women had gone for treatment of vaginal discharge.

Delivery

Both the Katang and the Ta' Oy have very strict rules concerning who can assist during childbirth, and spirit ceremonies must be performed (by whom is not clear) if anyone outside the immediate family is to assist. However these ceremonies could be performed in time for outside assistance if necessary, as both the Huay Ngua health center staff and the primary medic of Bong Nam had attended or assisted with difficult births.

⁴⁶ It was interesting to note that they reported this as being the fine, but did not remember any occasions of it being enforced. The high level of the fine evidently emphasizes the seriousness of the offence. However, at least one case was cited in which the fine should have been levied, but the male who fathered a child was a transient male from outside the ethnic group who could not be located.

Traditionally both Katang and Ta' Oy women gave birth in the forest some distance from the village. Now delivery is in a small, newly built hut or extension near to the house, always with a bed built especially for the new mother. The birthing position is hanging on to a rope. Banana leaves are put on the ground to catch the fluids, and disposed of after the delivery. During and after delivery, the mother must lie on a newly-built bed, which has never previously been used (thus the health center beds are not acceptable).

Assistants are family members only: the parents of both husband and wife, and often husbands. When the woman is in labor before child birth, no one touches her, because they want her to be brave and be used to giving birth alone. The husband tries not to hold or support her, because for the next baby's birth, if she is alone with no one to hold her, she will need to be able to manage on her own

Decision-making concerning assistance during delivery is by parents and husbands. There is no decision-making role for women who are delivering.

Katang 'TBA'

Recently a UNFPA-supported project to train 'traditional birth attendants' was begun in southern Lao, and included the Katang village of Huay Ngua, despite their lack of tradition for TBAs.

The woman interviewed had been appointed as 'TBA' by the village chief one year ago due to a newly introduced reproductive health training project. She had never been a 'traditional birth attendant' before, and had not been consulted during the selection process, but rather, appointed without consultation.

In the past year she had 'assisted' with two deliveries. On both occasions she had stood outside of the birthing hut and called out to ask the persons inside if they needed assistance. She did not dare go into the hut as this was forbidden. Despite these precautions, she still became very ill on both occasions, and attributed this to the spiritual forces involved. Thus she fears that being a 'TBA' is dangerous to her health, and thus did not plan to continue in this position.

Source: Huay Ngua Interviews

Post-natal Beliefs and Practices

Both groups seclude the mother for a period of time after birth, due to a belief that she is ritually polluted or polluting at this time. Husbands and wives may sleep separately after the birth of the first child.

The Ta 'Oy interviewed said that only the mother cuts the cord. She uses sharpened bamboo, although now razor blades are sometimes also used. She does not put anything on the cord unless there is a problem. If the stump doesn't heal well, she takes an old mat, scorches it, and puts the charcoal on the cord. The married men added that if there is a spider web, that is also used on the freshly cut cord.

The Ta 'Oy women said that the wife is responsible for disposing of the placenta. The placenta is usually buried at the base of a tall tree or on a small hill ('phon'), which

symbolizes the child growing tall and large, or sometimes near a post. If the baby dies, that serves as a place for the child's spirit to rest.

The Katang interviewed said that a spirit ceremony is held 2 days after the woman's bleeding stops to welcome a new baby to the family.

Care of Infants

Like many Mon-Khmer peoples, the Katang believe that the baby of a woman who dies in childbirth will not survive because the mother's spirit will come back to get the child. There are also rules against anyone except an immediate relative breast feeding the child (as a 'wet nurse'). Thus if a mother dies in childbirth, it is generally assumed that the newborn baby will die.

Death of a newborn

In a fairly recent case of maternal death in the Katang village of Huay Ngua, the health center staff person said she encouraged the father to feed the newborn with formula if they could obtain it, and otherwise sweetened condensed milk which was available in the shops. The family followed her advice by giving sweetened condensed milk, but the baby died anyway.

Source: Huay Ngua Health Center Staff

Breastfeeding and supplementary feeding

The traditional belief of the Ta 'Oy interviewed is that colostrum should be discarded, because it is spoiled milk. However, this is starting to change due to health center and health extension. After delivery, the baby is breastfed after the cord is cut and it cries. The baby stays with the mother, and is breastfed, unless the mother is working in distant fields. In that case she leaves the baby with relatives and give specially prepared rice in addition to breast milk to the new baby after it is several weeks old. After the child can sit up, it is fed specially prepared rice, rice porridge with chicken eggs in it, regularly. After the child reaches one year, it can eat regular rice and whatever else it wants, including ripe fruit, such as bananas, and papaya.

None of the married women interviewed in the Katang village knew what colostrum was, however, many said they never discarded it. They breastfed the infant as soon as it cries, which is usually within the first 1-2 hours. Many breastfed the infants until 4-5 months, after which they start giving rice. The women of poor families have to return to their work in the fields soon after delivery. Therefore they wait about 5 days after birth, and start giving rice soup with mothers' milk only 3 times per day. The community members knew that this was not the best practice, and emphasized that this is the practice of only the poorest families, which comprised about a quarter of the families in the surveyed village. These mothers knew that the baby feels full from breast milk but not from the rice, because the baby cries when given rice but is satisfied when given breast milk.

Risks to reproductive health

Outside Exposure

The Katang village studied is located at a crossroads, which has brought an increased influx of men coming from other areas, especially with the newly improved roads. The improved

transportation links has also led to unmarried young men leaving the villages for work opportunities.

In the village surveyed, the Katang girls, often encouraged by parents, serve whiskey to male visitors for a fee (about 10,000 kip). Traditionally this must have parental supervision and only involve males from the same ethnic group. However, it has become popular for transient men, such as truck drivers and construction workers, to request the teenage Katang girls to serve alcohol for them. These men are from other ethnic groups, usually Lao. The truck drivers are from the big cities, and usually stay at least one week in Huay Ngua to measure logs before going to the sawmill in Champasak province. Many people are worried this will lead to pre-marital sex.

HIV/AIDS & STIs

Very few people had heard of HIV/AIDS or STIs, or knew much about them if they had heard of them. Some young men had information from their friends, and cited the local school and teacher as their main source of information.

Poor Health-Care Delivery

Immunizations

Immunizations have been given to mothers and infants, but most had not completed the series and none were clear on the reasons for immunization. It was generally believed that injections were only necessary for treating illnesses rather than prevention, and thus many people who believed they were healthy did not seek out the immunizations. Adverse reactions by infants, including pain and fever, also caused villagers to avoid giving them injections. Villagers also noted that often the immunization teams that visited the village did not provide sufficient advance notice of the immunization date. As many live in their distant fields rather than in the village, sufficient time must be allotted to allow for the message to be sent to them in their field locations and thus enable them to return to the village on the appointed day. Health center staff claimed that immunizations had taken place although villagers disagreed in a number of the locations, indicating that immunizations were not held regularly. Even in the Katang village of Huay Ngua, which had an unusually dedicated health center staff, the women did not know what the tetanus immunizations were for, although they had apparently completed the courses.

Restrictions on Health Care Training

Training for “Traditional Birth Attendants” was restricted to women only, and thus prevented the training of the actual primary health care deliverers: a local male medic trained during the French colonial era and the village spirit specialists (most probably male) who are called on to perform spirit ceremonies during and after birth. The respondents recognized the usefulness of traditional medicine for health problems, apparently including for treating STIs.

Culturally Inappropriate Services

Members of both the Katang and Ta 'Oy ethnic groups were reluctant to make use of hospital services due to the belief that women must give birth in a bed that has never been used, and that making use of a bed in which someone has previously been ill or died could have serious consequences to their own health.⁴⁷ Hospital staff members do not generally work as

⁴⁷ This belief may be a traditional means of ensuring hygiene, which may be difficult to ensure in the public health facilities.

outreach agents (i.e. to visit people needing medical care), as their job description is to provide hospital-based care. Several members of the hospital staff were of the Katang ethnicity, and thus understood these beliefs, however they were apparently unable to adapt policies and practices to attract more people to come to the hospital for treatment.

Vulnerability to epidemic diseases

A virulent form of cholera swept through Lao and ethnic villages in southern Lao PDR and north eastern Cambodia for several months mid-1999, with Ta'Oy district affected starting in June. Over 300 persons died in Ta 'Oy district, with about half of the deaths in the villages of the Ta 'Oy district center.⁴⁸ Villagers died within less than half a day of exhibiting symptoms. The water supply was contaminated, and thus the disease spread rapidly. During the epidemic, funerals ceremonies could not be held, as the traditional practice of drinking un-boiled water with the ceremonial rice wine was one factor that spread the disease rapidly, especially when people traveled to and from villages for funerals.

The cholera epidemic swept through the village Talum Lalao, which is a village adjacent to the district center composed of both the Katang and Ta'Oy ethnic groups, some of whom have intermarried. At least 40 persons died within a short time, affecting every household. In some families, all members were wiped out, leaving the houses empty. In others, all were infected but only a few died. Villagers date time to 'the Year of Cholera'. One of the female ethnic research assistants from a mixed Ta'Oy and Katang family explained, "I dropped out of school in the year of the cholera epidemic, as my father and my brothers died, and there was no one to work in the fields." She lost both her father and about half of her several siblings within one week.

The study team also learned from the Talum Lalao village chief that many parents do not want to use birth control. They feel they need to have many children to ensure that some are alive after disease or epidemics sweep through. The fear is that if they limit their family size, they will be left without any children to take care of them in their old age.

⁴⁸ Provincial Health Education Unit estimate. No one at Ta 'Oy district health could give figures on this as each person only knew their one specific area of work.

Additional Findings and observations:

- Both the Katang and the Ta 'Oy have strong beliefs concerning the relationship of spiritual world with health, sex, and delivery.
- Some observers say that the restrictions against pre-marital sex are more strictly enforced for the Ta 'Oy as compared with the Katang.
- The practices of creating a new birthing house and a new bed could promote good hygiene.
- Traditional practices for cutting the umbilical cord could entail a high risk of tetanus infection.
- Prohibitions against pre-marital sex are positive with respect to family supervision, but could have negative consequences for the youth as they could be falsely accused of pre-marital sex by the spirit specialists.
- Villagers practice secondary burial rites, burying and then digging up the bodies of the dead after 1-3 years to clean the bones and rebury. This may be a hygiene concern – a forensic medical opinion would need to be sought.

Akha and Lahu Na⁴⁹

Sino-Tibetan Language Family (Tibeto-Burman, Central Loloish Branch)

The Akha and Lahu Na are related linguistically, and both groups migrated from China within the last several hundred years. Villagers of the Lahu Na village Hua Namkha moved from China four generations ago.

3.3 Akha

Phonesavanh Village, of the Akha⁵⁰ (commonly referred to in Laos as the Ikoh) ethnic group, is situated 2 kilometers from the Meung district center. The village was established at this location in 1993, and has a population of 238 persons, of which 117 are females and 121 are males, with 43 houses and 49 families.

A total of 53 villagers (males and females, both married and unmarried) were interviewed individually or in focus group discussions. This comprised 22.26 % the total village population. A total of 29 females participated in the information gathering exercise, comprising 24.7 % of the total Akha female population. A total of 24 Akha males were interviewed or participated in the focus group discussions, comprising 19.83% of the total male Akha village population.

Kinship and Gender Roles

According to ‘The Ethnic Groups in Lao P.D.R.’, the Akha practice patrilineal descent. Interviews showed that a newly married couple establish a house next to the house of the husband’s parents. The dead body of widow or divorced women are not allowed to be buried by family or by any member of Akha group, they usually pay the outside workers or laborers from other ethnic groups to bury the dead. A divorced mother cannot keep her children if she remarries. She must give them to someone else, to raise in a different village.

Each village has a male who is the traditional ‘youth leader’, (serving as the gatekeeper in the village concerning the youth) whose decision they must all follow. Female youth stated that this youth leader may make decisions without consulting them, which they do not want to follow, however they have no option of refusing. For example, unmarried girls may be told to provide massage to visiting civil servants or other visiting men, and they cannot refuse even if they don’t want to participate.

Some of the men interviewed perceived that women do not have a heavy workload.

Pre-marital sex and Courtship

According to the married men interviewed, the custom of sexual initiation (*‘bong’*) for Akha girls by an older male relative before they reached puberty is still very strong in Phonesavanh Village where the study was conducted. They believe that if a girl has not had sexual intercourse she cannot begin menstruation, as the vaginal opening will be too small. In addition, her life will be shortened, and she will die by the age of 35. The district hospital reported a case in 2004 in which the girl had excessive bleeding and needed stitches and

⁴⁹ Lahu Na ethnic group, or Black Lahu, are also referred to by outsiders as the ‘Museu Dam’, a term given them by the Shan peoples meaning ‘black hunters’. The term ‘Lahu Na’ is used in this report

⁵⁰The terms ‘Akha’ and ‘Ikoh’ are used interchangeably in this report.

treatment at the district hospital due to this practice. The Akha boys also have sexual initiation with the practice of 'lok' which involves intercourse with a woman who has experienced sex before. The boy initiates this, and apparently the woman may not refuse. Courtship practices allow for pre-marital sex as well as changing partners. Marriage and childbirth occur at an early age (age 13 and up for girls).

Immunization

Phonesavanh is located in zone zero for the district hospital, thus the women go there for immunizations. Most of the women understand about immunizations and have completed the series. The women had a very high rate for tetanus immunizations compared to other villages in the Survey. Only one of the women interviewed had never had tetanus immunizations, saying she was afraid it would hurt. One other woman had received only 3 of the tetanus injections⁵¹, and understood that the health staff had told her that she had completed the series. district health statistics are as follows:

Target group age 15-45	Persons completed series	Persons who have started the series
46 women	32 persons/ 5 injections	14 persons / 1 injection or more

Family Planning

Unmarried youth had little or no knowledge of contraception or family planning. Married men and women were aware of the use of pills and injections for contraception, but none of the interviewed women under 35 used contraception. It was unclear what proportion of women over 35 used contraceptives. Some older men and women were aware of condoms but did not use them or understand their use.

Pregnancy

No one interviewed knew that pregnancy is possible after having sex only once.

According to the female youth, no stigma is attached to getting pregnant outside marriage.⁵² A relatively high number of women have attended the nearby district hospital for ante-natal care.

Married women said that they continue to do heavy work until the day of her delivery. Sex is also allowed until the delivery date. The most common problems during pregnancy are loss of appetite and feeling tired.

The following foods are 'taboo' for pregnant women: wild fruit that birds or rats have bitten or which are infested with worms, meat from animals which have died in the forest, pork from pigs which have never had offspring, animals which have had their foetus die inside them, or food left over after others have eaten.

⁵¹A series of injections is required, (previously 5 per series, more recently 6 per series) followed by booster shots

⁵²[10] According to 'The Ethnic Groups in Lao P.D.R.', one of the traditional prohibitions of the Akha forbids unmarried pregnant women from giving birth within the village.

All pregnant women under 35 years, and 1 over 35 years, reported going to the VHV to get 30 free vitamin/iron supplements. The women don't understand about having pregnancy checks when they are doing well and do not have any problems. Thus they only have pregnancy checks when the District Immunization team comes for Health Day and checks pregnant women along with giving immunizations. If the child stops moving, then they know there is a problem and go to the hospital.

Delivery

Married males interviewed said usually the husband, the woman's mother, and a TBA attended the woman while she is giving birth.

Married females described the birthing position and procedures as follows. The woman sits in a squatting position and holds onto a cloth or cloth rope. The person who helps her bathes her back with warm water.

The respondents gave different answers concerning who cuts the umbilical cord: those age 35 years and older said that only the husband cut the baby's cord. Women under age 35 said that the mother cut the cord by herself. They also said that the TBA brings a scale to weigh the baby and calls the VHV to write down the weight and birth date of the child. Bamboo is used to cut the cord, a piece of cotton thread is used to tie the cord, and the placenta is buried in the ground under the house at a location below the bedroom, with the location marked. Ashes are put over it, and hot water poured on it regularly for a period of 10 days. Some of the women said that they do not want their husband with them during delivery, for fear the husband will get in the way.

There appears to be a higher death rate among the infants of very young mothers as well as inexperienced mothers. The deaths appeared to occur more frequently among the first and second born infants, rather than the subsequent births.

Several of the Akha women have delivered at the nearby district hospital. They say practices differ in breastfeeding, which is delayed at the hospital as compared with home births, where breastfeeding begins very soon after delivery. Also, the placenta is disposed of by the hospital, rather than given to the parents for traditional means of disposal.

Post-natal Beliefs and Practices

Married women gave this account of post-birth practices:

As soon as a baby is born, two eggs are quickly boiled. One is given to the new mother and the other to the older brother or sister to eat. The eggs must be boiled in a hurry because it is important that no other baby is born before the eggs are eaten, which would be considered bad luck. Before the mother peels the boiled egg, she rubs the egg around her nipple and says "May I have a lot of milk in order to have enough milk for my child". After eating the egg, she touches the nipple to the baby's lip and says "I will raise you until you are tall and strong". The person who buries the placenta (usually the husband or relative) hurries back to the house to boil a chicken with salt and ginger. The new mother eats first and is given a larger portion than the others.

The family raises chickens⁵³ in preparation for the new mother to eat after delivery.

The Akha have a strong tradition concerning twins. They believe that one of the twins must be an evil spirit, and thus traditionally they are both killed at birth and the parents cast out of the village for one year. This means that the parents of the twins must immediately leave the village, live in a hut outside the village, and have no contact with the villagers for the period of one year. The practices are now changing concerning twins in the Akha village of the Study, (Phonesavanh village, Meung district) due to a campaign by the district government to eliminate this practice of killing twins. Incentives and presents are provided to help the Akha families raise their twins.

The Akha women follow dietary restrictions after delivery. Food which is prohibited includes pork from a pig which has had offspring, buffalo meat, and vegetables with yellow flowers. Some people consider all food except eggs, chicken and pork to be prohibited until the baby's umbilical cord is healed, after which there are no food restrictions.

The couple waits about four months after delivery before having sex. The tradition of a husband having other sexual partners during these four months is apparently an accepted practice in the Akha community.

Care of Infants

Breastfeeding and supplementary feeding

Most emphasized that breastfeeding begins soon after birth, as soon as the mother has been washed and the placenta is buried. The practice of touching the nipple to the infant's lips as soon as possible after birth described above, suggests that breastfeeding may begin even sooner.

Immunization

Immunizations were given to infants at the district hospital. It is interesting to note that the Akha village visited was close to a district hospital rather than a health center and had a much higher rate of immunization of both women and infants than all other groups studied. This may be due to increased awareness due to NGO projects in this village.

Risks to Reproductive Health

Outside exposure

Some young people have traveled outside the village, often to the provincial center for school or work, and even to Thailand for work. They travel directly by boat on the Mekong to the 'Golden Triangle' area.

Massage has been promoted in recent years as "Akha custom" when in fact there was never a tradition of young women providing massage for visiting males.

⁵³It is not clear if able to eat only chicken meat, or the innards as well (which are rich in iron, and vitamin A).

Akha Massage- New or Old Tradition?

According to the Akha tradition, each village has a male elder who is responsible for the youth. This person is responsible for all interaction between the male and female youth in the village, as well as between outside visitors and the village youth. He organizes the girls who provide massage for visitors. If a girl refuses, then he scolds them and their families. Thus the girls feel they cannot refuse. The village youth leader arranges the massage to be held under supervised conditions, and thus is confident that it does not lead to sex services.

Traditionally massage was provided for older people and relatives who had walked long distances to visit the village, and often it was provided by older married women. In more recent times, massage was provided for visiting soldiers, and more recently for civil servants. Local authorities say that massage is an Akha tradition, and some see it as a potential for income generation.

Some of the girls say that they don't want to do massage, because they work hard in the fields all day, and sometimes have to stay up past midnight to entertain and massage visitors. There is no fixed price. If they do get paid, sometimes the men touch them inappropriately by putting the money down their shirts or skirts.

Source: Female youth from 2 Akha villages near Meung district center
(Study village of Phonesavanh, and 'trial' Village)

HIV/AIDS & STIs

Many young Akha men but few young women had heard of HIV/AIDS, from district health personnel. Both married men and women said that they had heard of AIDS, but had never seen someone who was infected with HIV/AIDS, with the exception of one man who knew a man with HIV/AIDS. They understand that AIDS can be contracted through infected needles, sex, or infected nail cutting equipment. Married men were aware that condoms are effective in protecting against STIs.

Itching and burning sensations while urinating were reported by both men and women, and these were treated with penicillin or traditional medicine.

Health care delivery

A relatively high number of women had attended the nearby district hospital for ante-natal care.

Several of the Akha women have delivered at the nearby district hospital. Practices differ as described previously. Breastfeeding is delayed at the hospital as compared with home births, and the placenta cannot be disposed of by the parents in traditional fashion as it is disposed of by the hospital. Other women lacked confidence in the district hospital. One woman interviewed (under age 35) went to the hospital to deliver her baby, but following the delivery she had continued heavy bleeding. She said that the district hospital told her to go home and use traditional medicine. They told her that if the bleeding didn't stop, she should then go to

the Bokeo provincial hospital⁵⁴. Another woman described how she lost confidence in the district hospital: she had taken a child there for treatment, however, the child died instead of getting well. Thus she lost confidence in their health care, and never took her other 3 children to the hospital when they were sick.

Additional findings and comments:

- Nutritional practices for pregnant women seem positive.
- Non-sterilized bamboo used for cutting the cord raises the risk of tetanus.

3.4 Lahu Na

The Lahu Na⁵⁵ village is composed of three hamlets, of which two (Lo Saw and Ja Pheu) were the subject of the Study, with the findings presented below. The third hamlet, Ja Yaw, was used as the ‘trial’ village for field testing the tools and giving the research assistants practice with the questionnaires prior to the actual study. The findings presented below reflect the Hua Namkha villagers’ perceptions, and cannot be generalized to represent Lahu Na ethnic villages elsewhere in the country.

The total number of community members interviewed in Hua Namkha village was 49 persons, including 29 females. In addition, a total of 6 persons (including 1 female) were interviewed from among the village authorities, VHV, TBAs, and HC staff. Their comments are included as relevant, with the source marked accordingly.

It should be noted that many interviews took place in the related Lahu Shi⁵⁶ language, as Lahu Na speaking research assistants were available.

Kinship and Gender Roles

According to “The Ethnic Groups in Lao P.D.R.”, the Lahu Na do not practice paternal inheritance. Men move to their wives’ parents’ house until the next younger sister is married, whereupon the couple will make their own house. This suggests a matrilineal kinship pattern, which is consistent with the data below.

The Lahu Na girls in the Study village Hua Namkha lived in a separate house from their parents starting at about age 10. Boys and girls choose their own partner, and girls can initiate a relationship with a boy, and is encouraged to do so by her parents, as she needs to find a husband in order to join her family and help with the farm work. Those interviewed said that the parents prefer girls as they will live with them and take care of them in their old age. Boys usually have more opportunity to go to school than the girls, because the girls have too many household chores.

⁵⁴As Meung district is very remote, transportation to the provincial hospital is generally not available without hiring private vehicles at great expense.

⁵⁵Also known as the Museu Dam

⁵⁶White Lahu, also known as Kuei

Pre-marital sex and courtship

Pre-marital sex is allowed, usually between couples who have promised each other that they will marry. Although marriage is largely the choice of the couple, this process is not stress free: several cases of suicide over broken or forbidden relationships were reported.

The villagers described how a boy can conduct courtship. The boy goes to visit the girl at her house, following which they may pair up as a couple. If the boy promises to marry her, they can have sex. If she gets pregnant before marriage, or if he breaks his promise to marry (and she still wants to marry), he must pay a fine of silver equivalent to 660 baht, of which half goes to the girl and half to the village elders, as well as buying one pig for a village meal. The girl is obliged to pay a lower fine of 330 baht and a pig if she becomes pregnant before marriage and the father of the baby cannot be found to pay the fine (for example, someone from outside the village). If the boy and girl each find a new partner, then there is no fine. In some cases the girl may get engaged as early as age 10, but they wait until menstruation begins before having sexual relations. Usually girls are 15 years or older before getting married and bearing children, but some of the girls get married starting at age 13.

Marriage customs

The girl's parents or older relatives are the ones who go to the boy's family to make the marriage agreement for their daughter. The girl's family boils water for the boy's family to drink. Two pairs of candles are lit for the first time the couple sleep together in the boy's house. Then the couple comes back to sleep in the girl's house for one night. Again, two pairs of candles are lit. The following day they take one large basket of polished rice to the boy's house and sleep there one more night. Following this, they take polished rice from the boy's house to the girl's house and then set up residence with the girl's family. If the couple wants to go back to live with the boy's side of the family, they must wait about 4-5 years. If the couple separates and gets divorced, the boy must pay 600 Baht to the girl's family. An additional 60 baht for the village spirit ceremony, along with 1 pig must be given to the village elders to eat.

Immunization for women

Usually girls are at least 15 years old before getting married and bearing children, however, a number of girls get married starting at age 13. As the age for tetanus immunizations is 15, this means some mothers may not be covered by the immunization program. None of the young women interviewed knew what the immunizations were for or how many injections they needed, and many had stopped the series as they felt the injections were painful.

Family Planning

Most of the married women had heard about family planning. Pills are the most popular method. A number of the unmarried females had heard of the pill, but no other methods. Very few of them knew about condoms.

Pregnancy

All of the Lahu Na girls interviewed believed that it is not possible to get pregnant after having sexual intercourse only once. Some of the younger girls did not know that one of the signs of pregnancy is cessation of menstruation. Most boys believed that sex over a long period of time is necessary for pregnancy.

Pregnant women usually do not go to the hospital, health center, or TBA for pregnancy checks, or consult anyone besides their own parents. They do not have any food taboos when they are pregnant, but eat as usual according to the food that is available in each season. The only taboo is smoking tobacco and drinking alcohol, except for those who already smoke tobacco, who continue smoking as usual. The males say that when their wives are pregnant, they help by collecting firewood, carrying water, and pounding rice. They say they do not let their wives do the heavy work. Some of the women, however, say that they continue to do their heavy work while pregnant.

Delivery

Family members assist with birth, which usually takes place at home. As the couple lives with the girl's parents, they usually assist with the birth, and the boy's parents are present also if they are nearby. The husbands help with delivery by helping support the woman in a semi-upright position so that she can deliver the baby easily. Husbands also cut the umbilical cord, using a piece of bamboo which is not boiled.

The decision to go for assistance or refer to a health facility during delivery is made by parents of the couple, along with the husband. The woman delivering does not make the decision. Some of the families have the TBA help with delivery. If a woman has trouble in childbirth, the husband, parents, relatives, and TBA discuss what to do and decide among themselves if the woman is brought to the district or provincial hospital.

Post-natal Beliefs and Practices

After the delivery, the husbands help bathe the newborn, and boil water for their wife and newborn. After cutting the cord, nothing is put on the stump, which is tied with a cotton string. The placenta is buried under the household ladder.

Care of Infants

Immunization

Most babies have not been immunized. Mothers believe that small infants are still too young to get injections. Thus they may miss the first 'round' of immunizations for this reason, and then wait many months for the next visit by the district immunization team. Fathers make the final decision about immunizations for newborn, thus if they do not agree, the baby cannot be immunized.

Breastfeeding and Supplementary Feeding

The mother usually discards the colostrum because she thinks that it is unhealthy for the baby. Only a few of the mothers do not discard the colostrum: those who don't still don't know the value of feeding their infants the colostrum. All of the babies start nursing within the first hour after delivery, after the placenta has been buried. Many infants are exclusively breast fed until about 5- 6 months, when they start eating rice. However, poor families give rice to the baby before 5 months because the mother must go to work. Also, for those cases which the mothers do not have enough breast milk, or the mother has to go work in the fields, they start giving rice earlier.

Risks to Reproductive Health

Outside exposure

Parents are concerned about the recent influx of outside males requesting girls to serve whiskey at night without supervision. This is a recent problem which started late 2004, and is related to the influx of males for project work. Girls go in small groups to serve alcohol for visiting male workers in the project office after dark, against their parents' wishes, and are paid about 10,000 kip each. The project office is located on its own compound at the edge of the village, and thus outside of the parents' realm of supervision. Parents disapprove as this is happening with unknown males away from parental supervision. The parents say that they only give permission for girls if it is daytime. For this reason, the girls often don't let their parents know when they go to the project office in the evening to serve liquor. According to the traditional custom, if girls and boys drink alcohol, it needs to be in a place where the parents can see her, and with a boy known to the village community. The girls traditionally do have rights, and exercise them, it is generally understood that if a situation arises in which a man or boy touches her, and she is not willing to be touched, she can leave.

Lack of education

The education level is very low for Lahu Na girls and women. Almost none of the girls spoke any Lao, and very few interviewed went to school, even though the village has a large school with three teachers. Education about immunization and reproductive health is also lacking. The villagers described the following system for information dissemination in the village: relevant health information for women, infants, and children is given to the village chief in the Lao language, who in turn calls a meeting for the 'heads of family' (attended by males) held in the local language. The men in turn are told to pass the information onto their wives. The resulting level of reproductive health information of the married and unmarried females was low.

HIV/AIDS & STIs

HIV/AIDS: There is a very low level of HIV/AIDS awareness among all age groups and sexes, and even less knowledge of STIs. In the case of male youth, 6 out of 8 interviewees had heard of HIV/AIDS but felt that they did not really know what it was. They had heard of HIV/AIDS from the health center and the VHV. Of these 6 persons who had heard of HIV/AIDS, 4 persons knew that HIV/AIDS was a dangerous disease, contracted from unprotected sex. To prevent contracting HIV/AIDS, they should not have sex with service girls in the drink shops, and use condoms. They believed that females can become infected with HIV/AIDS more easily than males

Most of the girls have heard the term 'AIDS', but do not know what kind of disease it is. Only a few know how to protect themselves from HIV/AIDS, by not having casual sex, and using condoms.

Knowledge about HIV/AIDS

One woman in Hua Namkha village had heard from relatives in another Lahu Na village in the Nam Nyu Special Zone of Bokeo Province who, according to her source, died of HIV/AIDS. The Lahu Na girl had returned from living with relatives in Chiang Rai Province of Thailand. When she returned, she told people she had contracted AIDS, and that no one should have sex with her. She got very thin and died within 3 years. She had heard this story from a visitor from that village. Most of the Hua Namkha women, however, had never heard this story and most could not explain what AIDS is.

Source: Hua Namkha Field Testing ...
Interview Session(Trial hamlet)

One outside visiting laborer had been treated for STI symptoms at the district hospital, suggesting that the village is not isolated from this risk.

Health Care Delivery

The health center in the village studied does not have regularly assigned staff, and at the time of the field visit, it was not open regularly. Villagers stated that they usually did not go to the district hospital for cases when treatment was needed beyond what the health center could provide. Reasons included the lack of money (necessary for transportation, food and living expenses for both the patient and the family at the health facility, as well as medicines and treatment), the lack of transportation, and the difficulty giving up the labor in the family to accompany the person. For example, a male family member needed to accompany a woman or child to help them to translate. No funds were apparently available or known of to treat impoverished villagers.

Additional Findings:

- The matrilineal kinship pattern means that girls have increased support from their parents and control over their sexual behavior. However, they still have no decision-making role in whether to call for medical attention during delivery.
- Many local customs (prohibitions against alcohol and smoking for pregnant women, families attend birth, infants are breastfed) seem positive for reproductive health. The main problem appears to be one of inadequate outreach and education on issues such as immunization, colostrum, sterilization of the instrument used to cut the cord, etc.

3.5 Khmu

Mon-Khmer Language Family (Katuic Branch)

The Khmu⁵⁷ ethnic groups belong to the Khmuic branch of the Mon-Khmer ethnic group, and are longstanding residents of the northern and upland regions of the Lao PDR.

⁵⁷ While this document uses the term Khmu, as this spelling which is commonly used in the Lao PDR, the alternative spelling Kmhu' or Khmou' is technically correct phonemically and is the term the people use to describe themselves.

Ban Mang is situated 22 kilometers from the district center. It is comprised of the original section of the village which was established 33 years ago, as well as a new section of the village composed of households recently relocated to this site. The latter has been named “New Mang Section”. The information gathering was conducted only with the original section of the village. All of the villagers are of the Khmu ethnic group, and the villagers all speak the Khmu language. The total population of the data collection site, which is the original section of Mang Village, is as follows: 335 people in total, of whom 149 are females and 186 are males, totally 59 houses and 68 families.

The Khmu village in the Study, Mang Village, was located near Lue villages and appeared to have stronger Lao language skills than the other communities in the Study. However, it still was not possible to conduct interviews in the Lao language. The villagers had access to reproductive health care through the services of a private practitioner who had been trained as a medic in the military. They were the only village in the study that had this type of service provision. Mang Village has had a Reproductive health project since 1997, and it is possible that the relatively high level of understanding and access to services shown in the findings are related to the project.

Kinship and Gender Roles

Parents say that they prefer daughters to sons because they are more helpful with the household chores, while the boys tend to be ‘lazy’ and want to play instead of doing chores. Some of the males interviewed appeared to believe that they were not as physically as strong as females.

Pre-marital sex and courtship

Age of marriage for girls is generally 16 or 17 years or older, and males 20 years or older. Girls live with their parents until married. The age at marriage in this community is several years older than the other ethnic groups studied. Pre-marital cohabitation (and sexual relations) are acceptable for engaged couples, with the parents’ permission. Marriages are arranged by parents or through the couple’s choice – some girls said that even if they were not in love with the boy selected by their parents, they would marry them as the parents would go to a spirit doctor to get a love potion, and they expect they would love each other after getting married and having children.

Pre-marital pregnancy is punished with a fine of 150,000 kip, 1 jar of rice wine, and 1 chicken, paid to the girl’s older male relatives. If the boy does not marry the pregnant girl, the girl’s elder male relatives and village elders fine the boy. He has to pay the girl’s parents 500,000 kip, along with one large pig (measuring at least 4 ‘kam’⁵⁸), and one chicken, as well as paying child support until the child is 18 years old. If another boy wants to marry the girl, she can marry him.

Immunization

Of the female youth: 75% have heard of tetanus immunizations. (Of these, 50% heard from the school teacher, 25% heard from the health worker, 25% heard from the VHV. They understand that the injections ‘are to keep them in good health’). 25% have never heard of the immunizations and know nothing about them. Of those receiving injections (50%), they have

⁵⁸ ‘kam’ is a common measurement for animals in Lao, equal to the length of one fist

all received one injection and say they will continue the series. Of those never having received injections (four persons or 50% had not yet had injections), the majority said that when the health worker came, they were not old enough . Now they are old enough (age 15 and over), but the health worker has not come yet.

Married women said that information about immunizations was only given to their husbands, via the village chief. They complained about the HC staff, saying, “The HC staff come to give the injections, but when they come, they never explain the reason, they just give the injections and leave in a hurry”.

Only 31% of all women interviewed had completed immunizations, and 44% have not yet completed the series. The common problem is the immunization schedule- the women get the message too late, or if they are working in their fields, they don't get the message at all. One person explanted that the e injections were for: to have easy delivery, prevent measles, and prevent hurt eyes. She learned this from the health center.

Immunization Confusion

The worker from the health center said he goes to pick up the medicine for immunizations for women and children at the district hospital. He only gives one day's notice to the village, as he must first be sure of getting medicine from the district before telling the villagers to come for immunization day. The vaccines can only be kept on ice for one day. Therefore he must give the injections on the day after pick up. If any of the women have never received immunizations, he must add them to the plan for medicine to pick up. However, all three of the VHVs gave different answers to those of the HC. The VHV said that they themselves give all the village women two days advance notice of the immunizations, to ensure that they can all come on time to receive the immunizations, and that the district health staff send a message to the VHV concerning the date for immunizations. The study team interviewed the district health office but did not have opportunity to meet with the staff responsible for immunizations in order to clarify the information.

Source: Mang village interviews.

Family Planning

Women take the initiative to find information about family planning, and discuss the options with their husbands, who make the final decisions. The most popular methods are pills and injections, as well as a rhythm method (abstaining from sexual relations for 7 days after the woman has her menstrual period). None of the men over 35 had ever used condoms. Women knew about family planning from the HC staff and the VHV.

Pregnancy

Married men say that when their wives are pregnant, they help by doing heavy work (in fields, carrying water, carrying firewood) and caring for children and cooking. Pregnancy checks were relatively common for all married women, at 62.5% for females under 35 and 50% for females over 35 years. Reasons for not going for pregnancy checks included: lack of money, too far, didn't go since there are no problems. There are no food prohibitions when pregnant.

Delivery

Married Men assist by cutting the cord (using unboiled, sharpened bamboo), massaging their wives, and boiling water. Sometimes scrapings from the wooden pestle are put on the cut cord. Of the eight males over 35 years who were interviewed, five said their wives had no difficulty related to delivery, one had difficulties and called older relatives, one went to the hospital when experiencing difficulty, and one went to the hospital for delivery.

The married women interviewed said that none of the women interviewed had given birth in the health center or district hospital. The common birthing position in the village is sitting or squatting and holding onto a rope.

A sharpened, un-boiled piece of bamboo is used to cut the cord. The mother cuts the cord herself. Then she takes string to tie the cord, but does not put anything on the cut end.

Post-natal Beliefs and Practices

The placenta is traditionally hung up in a tree in the forest.

The Khmu in Oudomsay Province believe that if a woman dies in child birth due to obstructed labor, the unborn child must be removed and buried separately. She cannot be buried or cremated with the child inside of her, or she will return as a malevolent spirit known as '*phi phae*' to haunt the family and village. Mang village reported a number of deaths of pregnant women in recent years, but the cause is not clear.

After a child is born, the woman can eat black chicken, black buffalo, specific vegetables, and pork (from a male pig). She cannot eat the following food: white buffalo, meat from an animal that died (rather than was killed), fermented vegetables or spoiled food. Couples wait one to two months before having sexual relations after childbirth.

Care of Infants

Immunization of Infants

No information was available concerning immunizations. The immunization activities at Mang village are implemented by the mobile EPI team from the district and province health offices. The EPI team evidently did not share the results of the immunization activities with either the village chief or the HC staff. The study team attempted to get the information at the district hospital but were not able to access it. This illustrates the situation of weak documentation and sharing of information which is not unusual in remote locations.

Breastfeeding and Supplementary Feeding

The Khmu women interviewed described breast feeding practices in which they wait one or more days for their breasts to become engorged with milk before breastfeeding. In the meantime they often give the child cooked rice which has been masticated and then cooked in the fire, or sugar water. Colostrum is given to the infant, although only one woman was aware of the value of this.

Many of the mothers said they were afraid the newborn is hungry, so they give cooked, masticated rice on its first day after birth. Some sources indicated that this is because rice has ceremonial significance.

Confused Breast Feeding Messages

The health center staff had just returned from the provincial MCH training. When interviewed, he said he plans to conduct extension health education for mothers on breast feeding, with the message that the mother is to give the baby exclusive breastfeeding for 1½ years, before starting complimentary feeding. By coincidence, the study team member who interviewed the HC staff person was the Provincial MCH Director responsible for conducting the training session for the HCs. She had taught that the baby should have exclusive breast-feeding until six months of age, before starting complimentary feeding. Thus she was surprised and dismayed to find that he had misunderstood the content of the training.

Source: Mang Village HC interview

Risks to Reproductive health

Increasing Sex Trade and Outside exposure

Oudomsay provincial town is experiencing a rapidly growing demand for sex workers, who are usually recruited from the villages, although some girls are imported from China. This has not yet been reported in Mang village, but is reported to be a trend throughout the province.

A Beng district village girl near to the district town reported that an unknown man was recruiting “lovely young orphan girls” to sell fuel for him at his gas stations. He would only take girls with no relatives.

Some young men have left the village to pursue work opportunities. Factory recruiters have occasionally come to the village.

HIV/AIDS & STIs

HIV/AIDS: The primary source of HIV/AIDS information is Khmu language radio broadcasts from Luang Prabang, and a recently received Lao language VCD. Both males and females who listened to the Khmu language broadcasts understood the HIV/AIDS message correctly.

Most respondents, particularly young men, were aware of HIV/AIDS and understood some risk factors and preventative strategies, although both correct and incorrect information (in particular, many women had been told by health extension staff that HIV/AIDS could be caught from nail clippers) was in circulation.

Some men, but few women, were aware of STIs, and a number had experienced symptoms, particularly of vaginal discharge and syphilis, and gone for treatment. Their preferred source of treatment was the private mobile medic. It was reported that a traditional healer in the village had an effective treatment for vaginal discharge.

HIV/AIDS Misinformation from HC staff

The study team selected Na Hom village for the questionnaire trial for interviews and focus group discussions. It is a Khmu village which is about 700 meters from the Na Hom HC. One of the women in a focus group discussion group of 4 women said that she had heard of AIDS from the Na Hom HC staff. The other three women in the group said they had never heard of AIDS. Most of the other women also said they had never heard of AIDS.

The village woman who knew about AIDS often went to village meetings, and explained what she learned in Khmu language. One member of the study team, heard the villager explain that AIDS is a disease which destroys the woman's reproductive organs, and later spreads to the woman's abdomen. If a man has sex with her, he will become infected. If anyone in Na Hom village becomes infected, they will die, as they are poor. They will not have the money to go to Vientiane for treatment, because district and provincial hospital cannot treat them. She also explained that AIDS can be spread by not using toilets.

The study team members asked her where she got this information. She said that she learned this from the HC staff member who came twice to the village to do HIV/AIDS extension. She gave the name of the HC Staff person and the dates that he came to the village.

Source: Mang Village field notes

Health Care Delivery

In cases of childhood illness mother initiates treatment by telling father about the illness. The husband decides on the treatment or if going to a clinic is required, and mother takes to clinic. Unmarried teenage girls tell their mothers if they feel unwell, rather than their fathers, for fear the fathers will scold them and accuse them of being lazy.

The preferred health care is the private mobile medic, who makes house visits as well as provides follow-up. The health center was primarily used for family planning. Villagers suggested that the health center would be more useful to them if it could be kept open at regular hours. The HC Staff's account of his availability and extension activities was inconsistent with that of the villagers.

Additional Findings:

- The effectiveness of the Khmu language information (radio broadcasts) about HIV/AIDS demonstrates the usefulness of native language approaches to reproductive health information etc.
- Unclear and overlapping responsibilities between HC, VHV and DH appear to create confusion.

3.6 Hmong Jua

Hmong-Mien Language Family, (Hmongic Branch, Green/Blue Hmong⁵⁹ language variety)

The Hmong also trace their roots to China in recent generations, although no information is available concerning how many generations ago the ancestors of Kiusangvanh village moved to Lao. Their houses are built on the ground, as in China, and their strong male preference and marriage practices reflect Chinese influence.

Kiusangvanh village is located about 22 kilometers from Beng district center. The village was relocated here in 1999, from a mountainside about 2½ hours walk from the present village. The former village was called Kiu Nya Say. Kiusangvanh village has a total of 709 persons, including 361 females and 348 males. There are 101 houses, with 125 families. There are two ethnic groups in the village: Khmu and Hmong. The Hmong population in the village is 462 persons, or 65.16% of the entire village. The Hmong population totals 224 males and 238 females.

In Kiusangvanh, the total number of villagers (males and females, both married and unmarried) interviewed individually or in focus group discussions was 53 persons. This composes 11.47% of the total population of Hmong villagers. A total number of 29 females participated in the information gathering exercise, comprising 12.11 % of the total Hmong female population. A total of 24 Hmong males were interviewed or participated in the focus group discussions, comprising 12.90% of the total male Hmong population. (This does not include the village headman, VHV, and TBAs who were also interviewed.)

Kinship and Gender Roles

Hmong villagers cannot marry within the same clan, and the woman joins the man's family. The male Hmong from small villages with only a few clans need to travel to different villages to find wives. However, this is not the case in the Study village of Kiusangvanh as there are many clans. However, it may be a reason for the frequency of Hmong boys from other villages visiting the Kiusangvanh girls. A woman's offspring belong to her husband's family, and if he dies, his children belong to his parents rather than to his widow. She may have the option of marrying her dead husband's brother in order to stay in the family with the children, or to leave the children and remarry. However, widowed or divorced women need to pay back the bride price if they want to move out of in-laws house or back to their parent's home. A divorced woman cannot die inside of her parents' house; a small hut has to be built for her outside.

The married men prefer boys as children, as they will stay with the family and carry on the family line. However, married women would prefer to have a girl as the oldest child, in order to help in the house, because boys do not know how to help with housework. Many think it is not worthwhile to educate girls, as they leave the family to live with the in-laws. Thus sending them to school does not contribute to the parents' future livelihood.

Pre-marital sex and courtship

Marriage age is generally at age 15-16 for girls and 17-25 for boys. Traditionally the parents had an important role in choosing the mate, but this is changing. Premarital sex is apparently

⁵⁹[17] also called Striped Hmong

allowed if the couple promises each other they will marry. However, if the girl gets pregnant, and the boy does not agree to get married, he will be fined.

The male Hmong from small villages which contain only a few clans need to travel to different villages to find wives, as custom does not allow them to marry within their clans. However, travel to find spouses is usually not necessary in the case in the study village of Kiusangvanh as there are many clans represented within the village. However, it may be a reason for the frequency of Hmong males from other villages visiting the Kiusangvanh girls.

Village girls can be taken advantage of easily by the males from town who have cash to buy gifts (soap, etc.) for village girls, who are seen as quite naive. The girls think that the gifts are an engagement gift, when actually the boy has no intention of marrying.

On this topic, Hmong girls in Kiusangvanh say:

“White Hmong boys come from Oudomsay town to visit girls here. They like to visit but have no intention to marry. Generally they only talk and nothing more. The girls here are naïve and trusting. These boys come frequently, but usually new faces, not the same people. Thus we have never met them before.”

It is necessary for boys to pay a bride price to the parents of girls if they wish to marry. This was given as 1 pig and 50 ‘*manh*’ of silver.

Teenage Suicide

Village youth say that their parents in the White Hmong village of Phakeo (the trial study village) tend to go along with their teenager’s choice of a spouse, unlike in the past when they would sometimes arrange or forbid marriages. This is because about 10 years ago in the nearby White Hmong village on the mountain, a young couple died because the boy shot his girlfriend and then shot himself, as the parents did not want them to marry. Since that time, parents in this cluster of Hmong villagers tend to give their permission, as they are afraid that the youth might do something similar.

Source: Youth FGD, Phakeo Trial Village

Family Planning

Of the unmarried male youth interviewed, most knew the following methods for preventing birth: condoms, pills, and sterilization. They had learned this information from the school as well as from government health staff coming for health extension work in the village. The female youth however did not know about birth control, although some had heard of condoms.

Most of the married males interviewed knew about family planning from the Hmong language radio broadcasts. In addition, some knew from the extension work of the provincial and district health staff. The methods that they knew how to use were condoms and a rhythm method (counting fertile days). A small number of men preferred condoms, because they saw that their wives had negative health reactions to birth control injections.

Almost none of the married females interviewed had ever heard of birth control. Those who did had learned of it because they took the initiative to ask peers who knew about birth control.

Immunizations

No female youth or women had received tetanus injections, or even heard of them.

Pregnancy

In Kiusangvanh, 38.5% girls knew that it was possible to get pregnant after having sexual intercourse only one time. They said they had learned this information from their parents. 62.5% of girls did not know. 62.5% of the girls interviewed knew that if they were pregnant they would stop having menstrual periods, but the other 38.5% did not know.

- Male youth said that if a girl gets pregnant before marriage, then the girl should marry the boy. However, if the boy does not agree to marry, he will be fined one pig as well as 2,500,000 kip, after which the boy does not have any further responsibility for raising the child.
- Female Youth: If a girl gets pregnant and does not marry the boy, it is not possible to give birth in her parent's house or to go into parent's house for one month after birth. No one can help the unwed mother deliver the baby, or touch her for 3 days. She must deliver the baby herself in a hut outside the main house. The study team interviewed one unwed mother who had gotten pregnant twice (by different men) and delivered both babies herself, no one could touch her or the baby for the first 3 days after the delivery, and she had to wait 1 month to enter her parents' house. In both cases, a Hmong male had promised to marry her but broken his promise.
- Women continue working in their fields until the day of the delivery. They have health problems such as tiredness, back ache, aching legs, etc. Only 1 person had had a pregnancy check, because she had a difficult pregnancy. She was pleased with the quality of service and decided to have both of her babies at the district hospital.

Delivery

Delivery is inside the house, hanging onto a rope, assisted by the husband and his parents. Unmarried women deliver on their own in separate hut outside of their parent's house. Generally no one can assist her, and no one can touch her or the baby for several days after the birth.

Usually the woman gives birth at home. Two women had their babies in the provincial hospital. One of these was a woman who went to a pregnancy check at the provincial hospital, and decided to return to have the baby there. Usually the husband helps the woman in child birth, together with his parents. The husband holds the woman in a semi-upright position to help her deliver easily and to give her strength. The husband is also responsible for boiling water and bathing the baby, cutting the cord with scissors or a razor, some boil it first and others don't. Nothing is put on the newly cut cord, disposing of the placenta, cutting fire wood, and washing clothes for his wife and baby for one month after delivery.

Post-natal Beliefs and Practices

Couples wait at least 15 days after delivery before having sex, usually for one or more months.

The mother and baby stay at home for a period of about one month, while she recuperates, a period which is referred to in the Lao language as “*yu kam*”⁶⁰ Special care is taken to ensure that the spirit of the newborn does not depart. Thus there is a very strict tradition concerning keeping the baby at home for the first month. During this time, they cannot go for treatment if either becomes sick. There appeared to be a high infant mortality during this time period, with infants dying 1- 2 weeks after birth, or at about one month. Those under two weeks often had seizures, which may indicate tetanus. Often the causes were unknown, as they could not leave the house to seek medical care.

Many foods are forbidden for the mother for one month after delivery, the only food allowed being chicken, rice, salt, and boiled water. Hmong men help wives by doing household and farm chores, including washing clothes and fetching wood, for 1 month after delivery.

Care of Infants

The study team observed Hmong men actively involved in child care, although it is not clear at what age they begin to take care of the infants.

Mother and Infant Immunization

None of the mothers had heard of or received tetanus injections .The majority of children in the village were not immunized, because the injection team comes only once per year. The women were not in the village when the immunization team came, and by the time they arrived in the village the injection team had left. When they finally took their children to get injections, they were told they were ‘too old’ as they were over 1 year.

Breastfeeding and Supplementary Feeding

Only a small number of women did not discard the colostrum. The women who did give the colostrum to the babies did not know the value of it. Others discarded it as they were afraid that the child would get a stomach ache if they drank it. The women only gave breast milk for the first 6 months, and then started complimentary feeding. They began nursing shortly after delivery, after the disposal of the placenta.

Risks to Reproductive Health

Trafficking

A case of Hmong girls being trafficked to China for marriage was reported by a Hmong Research Assistant from the provincial town.

Where is She? Hmong Girls Abducted to be Brides in China

In 2004, a White Hmong teenage girl in Oudomsay town was befriended by a Hmong man from China, who invited her to go with him to visit the market at the border. The girl wanted to go, but was afraid to go alone. She asked if her friend could join, and he said fine. Thus they picked up the second girl at her village outside of Oudomsay on their way to the border. She took her woven basket along to the border market with her. When they reached the border, they crossed the border rather than staying in the market on the Lao side. This

⁶⁰[18] “ Yu kam” traditional ay of heating the body of mother after delivery

surprised the girls, but they were told they could go comfortably for a ride into China if they got into the large bus. They traveled a long distance, for 1 or 2 days. Then the Hmong man said he would go talk to his relatives for a minute, but he never came back. The girls were separated, and one was taken somewhere in China. However the girl with the basket happened to have a bad cough, and thus was not allowed to travel further. She found out that they had been abducted to be wives, (as there is a shortage of women in China), not for the sex trade. She realized she had been tricked and sobbed every day. Finally after one month, the man where she was staying told her that if she wanted to go home so badly, go cry at the police station, and they would send her home. She could communicate with him in Hmong. She went to the station sobbing, and the police were very helpful and arranged for her to return to Laos. She returned to Oudomsay one month later, still carrying her woven basket on her back. However the other girl has still not been heard from. If the other girl had not returned, they would have had no idea what happened to them. The relatives told the provincial police, but they said that it would be costly to try to look for the girl, so the relatives have no means of following up. The Provincial LWU and Provincial Youth had not heard of this case. The girl that has disappeared is a close relative of one of the Hmong Research Assistants.
Source: Hmong Research Assistant

Outside exposure

See ‘premarital sex and courtship’, for the potential for exploitation of courtship customs by males visiting from other villages or towns (e.g. from the White Hmong ethnic group).

Lack of education

Many think it is not worthwhile to educate girls, as they leave the family to live with the in-laws. Thus sending them to school does not contribute to the parents’ future livelihood. The boys in nearly every family of Kiusangvanh village attended school, with a number in lower and upper secondary school. Very few girls attend school despite the fact that it is located in their village. This past school year was the first to have female graduates (4 persons) from primary school. All four will continue to secondary school 3 kilometers away, including the village chief’s daughter.

Boys go to primary and secondary school, but girls have very low enrolment for both levels. Reasons are as follows:

- The girls’ families feel that investment in girls is wasted, since they will leave home at marriage and thus no longer contribute to their parent’s household
- The girls are needed for household chores and field work.
- Both the girls and their mothers perceived that girls did poorly in school compared to the boys, and that the girls learned more slowly and did not remember what they learned. (This may be related to the fact that the girls had much weaker Lao language skills than the boys, and school is conducted in the Lao language).

HIV/AIDS & STIs

There was a very high level of accurate knowledge among all persons interviewed (both sexes, all age groups). This finding was unique to the Hmong village studied. The source of information was the Hmong language radio broadcast which airs a daily HIV/AIDS radio drama, supported by UNESCO. All persons interviewed listened regularly to the daily radio drama.

There was a high level of knowledge among men concerning STIs, however, no women had heard of STIs. The men's source of STI information was the Hmong radio broadcasts, however, this information was evidently not in radio drama format, and the message was infrequent.

High Infant Mortality

A number of infants in Kiusangvanh village die between the age of about 10 days (the mothers report that the cause is usually from some type of seizures), and a little over 1 month (mothers report that this is often from breathing problems). This was confirmed by the village chief. One infant died due to boils that it had had for 2 weeks, and others died from unknown fevers. If an infant is ill, but still under one month of age, the mother cannot take it to a health facility because she cannot leave the village for the first month after delivery.

Health Care Delivery

- Immunization for both women and children has a very low level of understanding and use. Outreach service for children takes place once a year; however the villagers usually do not arrive in time as they live in distant upland fields near their old village site. None of the women had heard of the tetanus immunizations for women age 15 and over.
- People make no use of the health center nearby (3 km away). Instead, they go to traditional healers, private practitioners and the provincial hospital. They perceive both the health center and the district hospital as providing unacceptably low quality service, thus if they make the effort to leave the village for treatment, they go to the provincial hospital.

4. FINDINGS BY TOPIC

4.1. Close Relationship of Spiritual Forces to Reproductive Health

All of the ethnic groups studied held animistic beliefs, and perceived sickness and well-being as being related directly to spiritual forces. Thus practices and rituals were prescribed by the spirit world, and must be performed to ensure the well-being of the entire family. The following beliefs and practices concerning courtship, pregnancy, delivery, post-natal care, and care infants were common for all ethnic groups unless specified.

Pre-Marital Sex and Courtship

- Attitudes towards pre-marital sex varied between ethnic groups. In general, groups with matrilineal kinship and inheritance patterns are more tolerant of premarital sex than patrilineal groups. This may have good and bad consequences for each group: on the one hand, cultural rules against pre-marital sex may promote abstinence and hence reduce the threat of HIV/AIDS; on the other, cultures which place a greater burden of shame upon pre-marital sex may be less open to discussion of risks and acceptance of safe sex practices. More comparative research on the spread of HIV/AIDS and other STIs within different groups adopting different preventative programs (e.g. promoting abstinence vs. promoting condoms) is needed.
- In particular, pre-marital sex is strictly forbidden among the Katang and Ta 'Oy, for fear of illness or death within the household. Sacrifice is required to appease the spirits; otherwise someone in the household will become sick and possibly die. The sacrifice is one or two buffalos, purchased by the male. The village youth who are of courtship age are strictly warned by their parents concerning the consequences of pre-marital sex. If anyone in either household becomes sick, the girl is closely questioned as to whether her suitor has broken this rule. Enforcement varies between ethnic groups, with some observers saying that the Katang are less strict in practice than the Ta 'Oy.
- In most groups responsibility for pre-marital sex and pregnancy falls upon the male partner.

Pregnancy and Delivery

Early marriage, early child bearing, bearing many children, and short birth intervals were common in all the groups. The close relationship between spiritual forces and delivery influences many of the following traditional practices:

- Many of the ethnic groups believed that a particularly malevolent spirit was attracted by the blood and afterbirth associated with the delivery, and this belief in turn determined their practices.
- Spiritual ceremonies were often required when problems arose either during pregnancy or delivery. In southern groups, the rituals needed to be held prior to referral, while in some of the northern groups, they could be held concurrently or after the medical emergency was over.
- The locations and attendants during delivery were related to spiritual beliefs. The southern ethnic groups visited traditionally gave birth in the forest with no attendants, although this practice is changing. Usually birth is in a special hut not far from the main house. They continue to build a special bed for the new mother, believing that

she will become very ill if she uses a bed that has been previously used (Katang and Ta 'Oy).

- In all villages visited, once a health problem or emergency had already arisen in relation to the pregnancy or delivery, the pregnant woman or woman delivering was not the decision maker concerning whether to go for assistance. The problem was seen as related to influence from the spirits, and the primary decision makers were the parents on both sides (both her side and her husband's), along with the husband. Referral is often further delayed as in many of the ethnic groups as the spirits needed to be consulted in order to transfer the woman from their care to the care of a medical service provider.
- Many groups discriminate against unmarried mothers. An unmarried mother in the Hmong village was required to deliver in a special hut, and no one could touch her or the baby for three days following delivery.
- The practice of cutting the umbilical cord with un-sterilized implements is common and a high risk factor for tetanus.

Post-natal Beliefs and Practices

- Prompt burial of the afterbirth in a specific place is common: it is important to clean up blood which may attract malevolent spirits, and the location is important for ensuring the well being and growth of the child.
- Usually breast feeding could not begin until the placenta was disposed of and the mother and child washed clean from the blood associated with delivery.
- Ongoing ritual cleansing is often prescribed after delivery for a specific period of time, in order to prevent attracting the malevolent spirits associated with the blood from the delivery. The rituals and period of time varied by ethnic group, whether for the first days, weeks, or month after delivery. In addition to cleansing, specific rituals were often prescribed for ensuring the mother's and baby's well-being.

Care of Infants

- The death of an infant within the first several weeks of delivery was often attributed to 'the spirits taking it', in which case death was apparently viewed as inevitable and medical treatment of no use.
- No attempt was made to feed a newborn if the mother died in childbirth in at least one of the southern ethnic groups (Katang). They believed the infant would not survive, since the mother's spirit would certainly come to claim the baby to join her in the spirit world.
- Killing twins upon birth, and casting the parents out of the village for a period of one year, was traditionally practiced by one of the northern groups (Akha). This was due to the belief that twins are abnormal, and thus one of them must be a malevolent spirit, and the parents had been responsible for bringing the spirit into the village.
- Infant deaths among the Hmong generally occurred within the first two weeks of delivery, or at around one month of age. Rules preventing both the mother and infant from leaving the village for at least one month after delivery prevented any diagnosis or treatment.
- There appeared to be a higher mortality rate among the infants born to the young and inexperienced mothers.

4.2. Decision-making

- In all the groups studied, women lacked decision-making power concerning delivery, especially in regards to referral for emergency obstetrical care (the parents are the primary decision-makers, along with the husbands). Awareness of preventative health measures is lacking, although it appears that women often do have decision making power concerning preventative health measures, for example, they can attend ante-natal care if it is available within walking distance.
- Decision making concerning immunizations in the family, especially concerning newborns, was often made by the males. For example, the Lahu Na fathers said they wanted to wait until the child to be 9 months-1 year before being immunized. However, this current national immunization schedule stipulates that immunization starts with birth and finishes at about one year of age. Thus most of the families are told their babies are too old to complete the series when they are finally brought for immunization.

Ante-natal Care and Delivery Practices

- Awareness of preventative health measures was low in all locations visited.
- Most women only went to health facilities after a problem arose. Thus very few went to the health centers for ante-natal care if the pregnancy appeared to be trouble-free.
- Skilled birth attendants were usually absent. The general practice was home delivery with untrained attendants, and accompanied by family members. Skilled attendants, if available, were generally called upon only after a problem arose. However, usually the first course of action when a problem arose was to conduct spiritual rituals.
- Family members usually assisted during delivery. Many, but not all, of the ethnic groups call a spiritual specialist or Traditional Birth Attendant (TBA) if they need outside assistance during delivery.
- The southern ethnic groups studied (Katang, Ta 'Oy) did not have this tradition, and the TBA appeared to be an alien concept. Traditionally the woman gave birth alone in the forest, and more recently nearby the house but assisted only by close family members. The assistance varied from people being outside the hut to provide encouragement through calling out advice, or to actually going into the hut to assist with the delivery. The main assistance usually requested of an outsider, such as a health center provider, was to 'remove a retained placenta'^{61[19]}.

Breastfeeding

Colostrum

- Only a few women knew about the value of colostrum. Their source of information was usually the mobile district health team.
- The belief in many of the villages, passed on from mother to daughter, was that colostrum was sour milk that could make the baby sick, and therefore it should be discarded.
- Those who did not discard colostrum still did not know that it had value for the infant.

Exclusive Breast Feeding

- The Hmong practiced exclusive breastfeeding, but many of the other groups did not. Most groups started breastfeeding immediately after birth, the exception being the Khmu.

⁶¹ The same term seems to be used whether referring to a retained placenta or pieces thereof.

Supplementary Feeding

- Some of the ethnic groups began giving rice (gruel or masticated) to the infants soon after birth. The reasons varied:
- Babies of impoverished families had to be left with a family member at about five days after birth to enable the mother to return to work in their upland, although they knew the baby was not satisfied with the rice (e.g. the poorest families in the Katang village).
- The belief that the mother must wait until her breasts are engorged before she can breast feed (e.g. Khmu)
- The belief that breast milk should be supplemented with rice, as rice is perceived as helping the baby grow faster (e.g. Lahu Na).

Risk Behavior and Avoidance

- The transition from previously isolated villages to those with transportation and employment links greatly increases the exposure to HIV/AIDS.
- Many of the ethnic groups studied are sexually active from their early teens.
- Formal education is the single most important source for HIV/AIDS info for youth. Youth knew very little about HIV/AIDS, unless they heard from teachers or peers through the school program.
- Peer education among out-of-school youth was an important source of information. They generally had no knowledge of STIs.
- Broadcasts in the ethnic language were highly effective in raising awareness of HIV/AIDS
- Women were not informed about STIs, and have very limited knowledge of HIV/AIDS
- Men were better informed on STIs and HIV/AIDS
- Ethnic girls in Oudomsay province are being lured out of the villages for labor, sex trade, and marriage (human trafficking)
- Ethnic village girls appear to be the most vulnerable, with risks including:
 - Employment in hospitality services
 - An influx of outside males
 - little or no knowledge of HIV/AIDS

Changing Society and Outside Influences

Most of the villages studied had experienced rapid change in the past years. Several had been relocated to main roads, and road links had greatly improved. These previously isolated villages reported rapidly increasing contact with outsiders, usually from outside their own ethnic group, including truck drivers, construction workers, traders, government staff, and development workers. Unmarried girls in villages near major roads and crossroads are at risk for being recruited into sex services.

Entertaining Outsiders

The parents in the Lahu Na village were deeply concerned about the influx of male workers to their village, some of whom requested the local girls to serve whiskey in the evenings. Traditionally this can only be done under parental supervision, not in an unsupervised location in evenings as is currently the case.

Source: Hua Namkha interviews

Roads are currently being constructed to connect Thailand, Lao PDR, and the People's Republic of China, which will greatly increase the influx of travelers and put the unmarried girls at increasing risk of HIV/AIDS and exploitation⁶². The Lahu Na women interviewed in Bokeo Province had heard of a Lahu Na girl from a neighboring village visiting relatives in Chiang Rai and evidently becoming involved in sex services. Some of the research assistants and provincial government staff in the Northern provinces mentioned specific cases, often concerning relatives, in which ethnic youth traveled to Thailand or China, with no news of them since.

Crossroads of the North: Magnet for Ethnic Girls

The northern province of Oudomsay has become the primary crossroads between the northern provinces in recent years. Many ethnic village girls have been drawn into providing sex services first within the province, and later in networks between provinces and with neighboring countries. Of great concern is the lack of awareness concerning HIV/AIDS, coupled with the increased transportation links, and the rapid spread of HIV/AIDS among ethnic peoples in neighboring countries, many of whom speak the same ethnic languages, whether in Burma, Thailand or Yunnan Province of China.

Source: National Council for the Protection of AIDS, Oudomsay Province

4.3. Gender Issues Influencing Access to Reproductive Health Services

As gender is a new concept which is not always well understood by everybody, the Study had difficulty exploring gender issues. Highlights of the findings are as follows.

Decision Making

The most striking gender issue which emerged concerning pregnancy, delivery, and care of the newborn was the woman's lack of decision-making power concerning her own health situation.

- In most cases the woman was not involved in the decision-making concerning delivery at all.
- The decision-makers were usually the parents on both sides (i.e. of the woman and her husband), in consultation with the husband.
- Accessing preventative health care appeared to be quite different than going for treatment or assistance. Women did not need to ask their husband's permission or conduct spirit rituals in order to go to ante-natal clinics or get immunizations for themselves if the clinics were accessible by foot.
- Once a health problem arose, the woman usually was not involved in the decision-making concerning seeking help. A number of factors were involved in the decision, in addition to the deciding whether to perform spirit rituals, including: means and cost of transportation, availability of persons to accompany the patient as translator and caretaker, and very importantly, the sufficient finances to support both the patient and attendants.

Rights

⁶² See Chamberlain, James R. "HIV vulnerability and Population mobility in the northern provinces of the Lao People's Democratic Republic" UNDP South-East Asia HIV and Development Project. Vientiane. 2000.

- Rights of women varied widely, particularly with respect to kinship patterns (e.g., does the woman stay in her home village after marriage, or will she move to her husband's village)
- The rights of women often change depending on their marital status. For example, Hmong women became part of their in-laws' family, and did not have rights to their own children if their husband died and they wished to remarry out of the family or return to their parents' home.
- Unmarried Hmong mothers cannot deliver in their parents' house, but in a shack outside.
- Divorced Akha women could not keep their children if they remarried. They had to send them to a different village to be raised.
- Lahu Na girls can initiate a relationship with a boy, as she needs to find a husband in order to join her family and help with the farm work.

Access to Education

- Access to education was low for all girls, regardless of their gender roles. In most cases girls were kept at home to help with the household.
- The Hmong girls were much less likely to be able to communicate in Lao as compared to the Hmong boys. Their parents say they do not want to invest in their daughters' education as they will inevitably leave home to join her husband's family at marriage. In addition, the girls do not do as well in school as the boys (possibly due to the language of instruction). Thus it is not surprising that there is a huge gap in enrolment rates between Hmong boys and girls.

4.4. Cultural Factors Influencing Access to Health Services

Available data^{63[21]} shows that home deliveries are the norm for rural Lao as well as ethnic women; however, rural ethnic women are far more likely to have home deliveries by untrained attendants.

Empty Buildings, Empty Beds

The large new Ta 'Oy district hospital has had only 4 deliveries in the past year, and none of them ethnic women. Most of the beds were empty.

A nearby Ta'Oy/Katang village reported one of their members going to the district hospital for assistance during labor. However they brought her back to the village by push cart before the delivery, to avoid giving birth in the hospital.

The hospital staff explained about the empty beds: "People don't want to give birth in the district hospital because they cannot lie in the bed someone else who has been sick or even died in. Lying in a bed that someone else has died in is especially forbidden. We tell them that it is a new hospital, and thus no one has died here yet. All the beds are new."

The study team observed a man coming from a village 8 kilometers distant to request 'headache medicine' for his wife. She had delivered one week previously and had a fever, and thus could not walk to the center. He had already bought Chinese medicine at the market. The health staff instructed him to bring his wife in order to receive proper treatment, and sent ampicillin back with him.

^{63[21]} Source: Primary Health Care Expansion Survey (1999), as cited in "A Country Gender Analysis and Profile of the Lao PDR", Gender Research Information and Development (GRID), supported by the World Bank.

Source: District Hospital, Ta 'Oy District

Cultural Practices versus Health Services

- Villagers from all ethnic groups cited numerous cultural reasons which made them reluctant to give birth in a health center or hospital or to have a trained practitioner assist them if one was available. The responses included the following:
- Traditional medicine, administered by practitioners in the village, was often the first course of action for treatment.
- Very few reported delivery in the district or provincial hospitals. Those who did noted the following differences as compared with home deliveries:
 - The parents were not given the placenta to bury, and they were uncertain how the hospital disposed of it.
 - Family members were generally not allowed in the delivery rooms, and the women could not use the traditional birthing positions (such as crouching).
 - Breastfeeding in the district hospital was often delayed as compared to the traditional practices.
 - Newborns that had died could not always be taken back to the village for proper burial.
- The southern ethnic groups (Katang and Ta 'Oy) had a strong rule concerning a woman lying in or giving birth in a bed which had already been used. Hospital beds which had been used by a very sick person were thus forbidden, especially if the person had died.
- Spiritual rituals were usually required when a woman needed assistance during delivery, both for seeking someone to provide assistance at home, or moving her to a health center. Practices varied as to whether the rituals were required prior to seeking assistance, could be held concurrently, or were performed after the recovery. Sometimes the family conducted the spiritual ceremony first, and waited to see if it was effective in solving the medical problem, before considering referral to a health facility.
- The mothers and their newborns in some ethnic groups could not leave the village for the first month after delivery. This appeared to be the period when they experienced the most infant deaths. Neither the infant nor mother could go outside the immediate village for treatment, even to a health center within walking distance (e.g. Hmong).
- The ethnic villagers reported difficulty communicating with government health care providers. This was especially true for the women. Most health facilities had few, if any, ethnic staff.
- Most villagers preferred the services of private service providers to health center staff, e.g. for treatment of STIs, and assistance in difficult deliveries. These practitioners were generally males who were retired military medics. The villagers had confidence in their training, skill, and experience. In addition, the service was house-to-house, convenient, included patient follow-up, and allowed for privacy.

Health Centers: Activities and Utilization of Services

- Many health centers were effective sources of family planning supplies.
- Health center staff were usually from different ethnic groups to their clients, and unable to communicate effectively with them.

- Most health centers provided almost no outreach services to the community studied, except for immunization for infants once per year. Only one of the five health centers visited appeared to be actively serving the community members' reproductive health needs, apart from family planning.
- The vast majority of people did not go to the health centers for preventative care or treatment.
- There was a discrepancy in the number of village outreach visits reported by the health center staff, and the number reported by villagers. In many locations, the health center staff rarely made village or home visits, and village outreach visits were not as frequent as reported.
- In some locations where the health center was directly responsible for immunizations of women and children in the nearby villages, the coverage and frequency of outreach visits appeared lower than those directly served by the district mobile health team.

Gaps Between the Service Providers and Community Members

- The perspective of the health service providers and local authorities often differed greatly from the perspectives of the villagers.
- The team heard reports of 'waiting house for birth delivery' built by well-intended projects in southern Lao PDR which had instead been used as rice storage containers or at village meeting hall, due to cultural traditions which prevented women from delivering there.
- The system for selecting local trainees for various reproductive health programmes illustrates this gap, as local consultation with the community or person involved for TBA selection is often lacking, with selection depending on village authorities who lacked understanding of the necessary criteria. Thus the selection process did not always select the most appropriate person, as illustrated in the case of the 'Katang' TBA previously discussed.
- Health center reports concerning outreach visits differed from information provided by villagers. In some cases, the HC reports concerning frequency of outreach services to communities such as immunization and health education appeared quite exaggerated.

The following explanation was commonly heard from HCs concerning the reasons that ethnic women and their children do not come for immunizations:

'The women are not interested because they prefer their own traditional medicines, and are afraid of the injections'.

While there is truth in this statement, the Study also gathered the following information from the communities.

Differing Perceptions: Immunization Coverage

None of the ethnic men or women interviewed in any of the six villages visited knew what the tetanus injections were for. (286 persons were interviewed, including 164 females)

While the men often had the lead role in decision making, they did not necessarily have a clear understanding or information. Thus some ethnic groups tended to delay bringing their babies for immunization, since the men felt that it was dangerous for infants to be immunized before they were at least nine months or one year of age.

Misinformation commonly circulated in villages concerning the reasons for having immunizations (e.g. 'women should have tetanus injections in order to have easy deliveries, prevent leprosy, and have pretty skin').

Villagers were happy to use injections for other illnesses, usually with privately bought medicine administered by VHVs or private medical practitioners.

Lack of Ethnicity-Sensitive Data

While gender is a relatively new concept that was not well understood, there have been even fewer studies or information available concerning ethnicity. Many of the villages have not yet been classified by specific ethno-linguistic group, as detailed linguistic surveys and mapping have not yet been carried out in the country. The 1995 census was the first important step in gathering quantitative information concerning the ethnic peoples, followed by the 2005 census, the results of which had not yet been published at the time of this report.

- Most information gathering systems, including health and education, did not disaggregate data by ethnicity.
- Quantitative or qualitative information concerning ethnic groups is not readily available, even at local levels.
- Two of the three districts visited did not have basic information concerning their ethnic populations readily available, or information on the dialects or specific ethnic classifications for the villages. The notable exception was Meung district in Bokeo province, which had detailed and accurate information.
- Qualitative information gathering and discussions with villagers concerning traditions and ethnicity were new and sensitive.

4.5. Factors Influencing Access to Reproductive Health Information

Level of Reproductive Health Information and Knowledge

While difficulty in accessing information is the case for the rural population in general, the lack of information appears to be further compounded for ethnic peoples due to gender, cultural, and linguistic factors.

The level of reproductive health knowledge was fairly uniform in all six villages, namely, very little knowledge or understanding, and many instances of confused messages. This was due to the general lack of explanation to the village level from the health services. For example, frequently the village authorities and villagers alike confused the various health messages e.g. ‘immunizations for infants prevent fevers and malaria’).

Only a few of the 286 male and female respondents knew that a woman could get pregnant after having intercourse once⁶⁴. The exception was the Hmong males, who had a high level of understanding of the women’s cycle and fertility. Their source of information was Hmong language radio programming, which was in the form of radio drama to which the villagers listened daily. All age groups, all genders, had excellent understanding of HIV/AIDS due to this radio drama in the Hmong language.

The current standardized materials and uniform approach used with a wide range of ethnic groups, along with using the national Lao language which many of the villagers, especially women, did not understand well, appears to have resulted in villagers misunderstanding the

⁶⁴ Thus if an unmarried girl got pregnant after only having intercourse once or twice, it may be possible for the father may think she has had many partners, and not believe it is his child.

reproductive health messages and confusing the information. However, when reproductive health messages were conveyed in their own languages, the people clearly understood the messages and could repeat them correctly. Nearly all of the Hmong and many of the Khmu listened to the regular radio broadcasts transmitted from Luang Prabang in their own languages. The Hmong listened daily to the radio drama concerning HIV/AIDS.

Males and females who listened to the local language radio broadcasts had a clear understanding of the transmission, prevention, and result of HIV/AIDS. By comparison, villagers in the other four villages had quite a low understanding of HIV/AIDS, with the exception of students (usually secondary school males) who had learned about HIV/AIDS and reproductive health from school, and had in turn told their peers. Thus if a few youth of the village youth attended school and learned about HIV/AIDS or other reproductive health issues, often their family members or peers had gained some basic knowledge from them.

Very few of the 286 male and female respondents from any of the ethnic groups knew about STIs.

School System as a Source of Information^{65[23]}

There was a high correlation between school attendance and reproductive health knowledge:

- Most male teenagers ('never married' category) who had knowledge concerning HIV/AIDS cited the school as their main source of information, in particular, the teacher, special learning materials (e.g. illustrated pamphlets), and peers who attended school.
- Both boys and girls enrolled in school had a clearer understanding of reproductive health issues as compared to their out-of-school peers.
- Many of the girls enrolled in school planned to postpone courtship and marriage until they were older and had completed school, and some said their parents supported this plan.
- Villages which had schools tended to have only a portion of the children in the village enrolled, and usually many more boys than girls.
- A wide gap was evident between boys' and girls' enrolment in most locations. The gender gap was especially noticeable in the Hmong village, in which nearly all males were not only enrolled, but planned to continue through secondary school. Only a small minority of girls were enrolled, with less than a handful planning to continue to lower secondary school.
- All schooling, whether formal or non-formal education, is taught in the Lao language. This includes the reproductive health messages.

Communication

- A uniform approach for health service and communication was observed with all the ethnic groups. The approach used in ethnic villages did not appear to differ from that used with Lao villages.
- Males and females community members in all target villages had minimal or no oral Lao language skills. The general exception was the village authorities, and the few who had interacted with the government system or school.

⁶⁵ The study team could not get the accurate information on school enrolment at each location, however it is possible to observe the issue of school system as a source of information which is factors influence access to reproductive health information

- The commonly heard statement from the authorities that many of the villagers could speak Lao language did not match the situation in the villages. The study team found that it was not possible to carry on discussions with the villagers of any of the age groups of either gender without the ethnic research assistants acting as translators.

Literacy

- The vast majority of community members were illiterate.
- Several of the ethnic languages (Hmong, Khmu) have Lao-based scripts which have been used over the years, and many of the languages had scripts which had been developed either in the country or in neighboring countries.
- The Hmong research assistants could read and write White Hmong, a skill they had learned from each other rather than in formal schooling.
- None of the other ethnic villages studied aside from the Hmong had research assistants or community members who were literate in their own language.

Level of Interest

The villagers in each of the villages expressed a high level of interest in learning more about reproductive health. Thus impromptu discussions and explanations were held in local languages at the initiative of the villagers, and facilitated by the research assistants.

- The interviewees often initiated question-answer sessions, for example, the females expressed strong interest in learning more about the value of colostrum and exclusive breast feeding, and immunizations for mothers and the infants.
- Group question and answer sessions were initiated by the villagers after some of the village feedback sessions, with both males and females participating. Topics for which they expressed interest included: STIs, HIV/AIDS, breastfeeding, (colostrum and exclusive breast feeding), and immunizations.

4.6. Information, Education, and Communication (IEC)

A uniform approach for health education delivery and communication was practiced by the government health staff with all the ethnic groups. The materials, approaches, and policies for Lao-speaking and ethnic villages appeared to be the same. Males and females community members in all target villages studied had minimal oral Lao language skills. The commonly heard statement from the authorities that many of the villagers could speak Lao language did not match the situation in the villages. Overall, the level of information was very low for both males and females, however, the females had even less access to information than the males.

Channels of Communication

Many ethnic women never received the message concerning the schedule for immunizations for themselves or their infants. Those who received the message or even the immunizations did not understand the purpose of the immunizations. None of the women interviewed knew what the tetanus immunizations were for. In some villages, the teenage girls had never heard that they should be immunized.

Flow of Information

The villagers described the standard model for disseminating health messages such as immunization schedules, as follows:

- 1) The message is conveyed to the village from the health services, usually in the Lao language, and through the village headman
- 2) The village headman calls a meeting of the heads of families, either conveying the message himself, or translating for the health worker. The meeting is generally attended by the male heads of household. Not all families can attend these meetings, however, since their upland rice fields are often several hours by foot from the village, thus families staying at the field houses generally do not attend.
- 3) The men who attend the meeting are directed to pass the message on to the women in their families.

Health Education and Outreach

Villagers, health volunteers, HC staff, and TBAs provided the following information concerning health education and training programmes:

- Most of the government staff who conduct health education, training, and outreach from the health services and partnering organizations (e.g. Lao Women's Union) were ethnic Lao who could not communicate in the local languages.
- Training and health messages were generally relayed in the Lao language.
- Interpretation was often on an ad-hoc basis rather than an integral part of the methodology. The male village authorities often provided the translation.

Radio

- Radios were readily available for affordable prices in the markets in each of the districts visited. The radio was perceived as a reliable source of information, as noted by the village headman in a mixed Ta 'Oy/Katang village: "I prefer radio as a source of health information, because I can be confident that the content of the message is correct."
- The Study found that the radio broadcasts in the Hmong and Khmu languages were highly effective, especially the Hmong programming which followed the process developed by UNESCO Bangkok for local language radio drama⁶⁶.
- All of the Hmong, both male and female, could clearly describe HIV/AIDS (including the source of transmission, means of prevention, that no cure is available, and that HIV/AIDS is fatal). The Hmong radio drama broadcast daily from Luang Prabang was their source of information.
- Many Khmu could clearly describe HIV/AIDS, and they usually cited Khmu language radio as their information source. However, the programming was less frequent, the radio drama had not yet been launched, and listeners were mostly male.

Videos

The government health education staff in one of the Provincial Health services visited (Bokeo) mentioned that they had used videos to deliver health messages, and that they were extremely popular, although the numbers and languages of videos available are still very limited. One provincial health education team member described the popularity of health education videos in the ethnic languages, saying "The villagers want to stay and watch

⁶⁶ For description of the process, see the article "Radio Programming: an effective tool in preventative education", Cultural Unit, UNESCO BKK, in the publication: HIV/AIDS in the GMS, Issue 1, 2004. UNESCO Bangkok.

forever, they don't want to go home". At the time of the Survey, the newly produced Hmong and Khmu language videos supported by UNFPA concerning HIV/AIDS were in the process of being distributed to the provinces, however they had not yet been received or used at the remote sites visited, thus information was not yet available on their effectiveness.

Printed IEC Materials (Flipcharts)

The newly produced flipcharts for training ethnic village health volunteers (VHVs) appeared to present complicated content aimed at persons with a secondary education. This did not match the education level in the villages visited, and appeared to be more appropriate for training health center staff than village health volunteers and community members for which they were apparently designed.. Observations are as follows:

Illustrations

- Use of color illustrations (rather than black and white) appears positive.
- The field testing for illustrations and content had not been systematic or thorough, and had not included both males and females from each ethnic group.
- A standard set of illustrations is used in all locations.
- The illustrations present a large amount of sophisticated information. The developers appeared to assume a basic level of familiarity with pictures ('picture literacy') which the illiterate or semi-literate village women from the villages surveyed would find confusing.

Content

- The content, pacing, and presentation appeared to assume a higher education level than reality. The materials appeared appropriate for trainees who had completed lower secondary education, for example, HC staff, rather than illiterate villagers.
- Some local MCH and LWU staff were of the opinion that the materials were technically more appropriate for persons who had completed secondary education, and were being trained as HC workers than training VHV and villagers. The materials appeared to assume a much higher level of reproductive health understanding and educational background than was observed in the villages studied.
- Each lesson presented a large amount of information, which could increase the likelihood of messages being confused.

Networking, Coordination, and Monitoring

Networking to share materials and approaches designed for ethnic groups within the country and the region appeared weak. Coordination between various local partners involved with reproductive health programmes was weak, and the roles for multi-sectoral projects were not clearly defined. Monitoring systems did not appear to include spot checks or community consultation.

Health Monitoring Systems

The MCH team member from Oudomsay province noted that the health monitoring system does not include community consultations, but depends on meetings with local authorities and health center staff at the various levels for conveying and gathering information.

Prior to the Study, she had never had opportunity before for village consultations or spot checks in the field. Thus the views and experiences of the ethnic communities, especially women, were not available to her. She found the information and insight gathered from the communities to be valuable feedback, which strengthened her in her role of MCH and HC

training and monitoring.

Provincial stakeholders were often unaware of resources and successful HIV/AIDS community education programmes⁶⁷ in neighboring countries such as Thailand. They also appeared unaware of the HIV/AIDS radio dramas being produced in local languages in Luang Prabang. These and other creative initiatives are important resources for the ethnic peoples in Northern provinces of the Lao PDR.

The health staff interviewed in Oudomsay province had little information concerning the various radio programming concerning HIV/AIDS, whether from the local provincial radio station or Luang Prabang.

The village health worker training in Saravane province through the LWU appeared to lack sufficient coordination between the various sectors for effective implementation and follow-up. The district health staff could not clarify their role in providing technical assistance and follow-up, and the health center staff in one of the target villages was unaware of the training sessions which included members from the local village.

⁶⁷ For example, many effective HIV/AIDS community outreach materials have been developed in neighbouring Thailand, including materials in the local languages, through the Thai non-formal education system. They have produced and effectively used a mobile IEC campaign in the ethnic villages, developing videos concerning HIV/ AIDS and Trafficking (available in Lahu, Akha, and other ethnic languages). The videos result in the participation of all village members, males and females, young and old, as they are shown in an all-evening information event, similar to a village fair. Being held in the evening, the information event does not interfere with livelihood activities. The Chiengrai NFE Centre has hosted numerous study visits in the past and is willing to share their experience and resources concerning HIV/AIDS.

5. RECOMMENDATIONS

Many of the following recommendations arose from the review sessions in each of the respective districts: Ta‘Oy, Meung, and Beng, at which the relevant stakeholders analyzed findings and issues, in order to identify solutions to address the root causes effectively. Highlights of these are included below. The study team wishes to endorse these as well as include additional recommendations prepared after reviewing the information compiled from the six villages and the three district review sessions.

The recommendations which arose from the Study are in agreement with the direction of the Government of the Lao PDR, as stated in the 6th National Socio-Economic Development Plan (NSDP) for 2006-2010, which contains the following recommendation.

Ethnicity in Relation to Health & Education:

NSDP 2006-2010

Improve and expand the programme of education, health care, culture and information for ethnic groups. Increase people’s awareness on preservation and promotion of cultural values and traditions of all ethnic groups. Sustain and develop spoken languages and written characters/alphabets. Teach ethnic dialects in schools where ethnic characters/alphabets already exist.

(NSDP 2006-2010, Committee for Planning and Investment, Vientiane, October 2006)⁶⁸

Common Issues and Recommendations from Three District Workshops

Working groups together with relevant stakeholders and district leadership at each of the three district workshops spent one to two days reviewing findings, and analyzing reproductive health issues and possible solutions. The issues discussed were based upon the findings from the Study, which were presented by the central team and research assistants from their field work. This was followed by working group discussions to analyse causes and develop appropriate solutions and recommendations. These are presented in detail in Annexes 5, 6 and 7 :Ta ‘Oy district, Meung district, and Beng district. Many of these issues and recommendations have been expanded upon by the study team in workshops and discussions.

Issues

The following issues and solutions were raised in discussions and working groups by each of the three district workshops. Analysis of the three workshops shows that all three repeatedly raised the following needs which can be summarized into the following themes or issues:

- Community members need to access reproductive health information that is accurate, reliable, and relayed in a language and format they understand.

⁶⁸ Source: GoL, National Socio-Economic Development Plan (NSDP) 2006-2010, p. 100, Committee for Planning and Investment, Vientiane, October 2006

- Community members' need to access to reproductive health services of sufficient quality.
- The need to equip and training local community members and students to serve as volunteer outreach workers for reproductive health.
- The need to trial creative means of extending information services to the remote areas through the use of pilots, trials, field testing, rather than a uniform 'one size fits all' approach.
- The importance of improved coordination of existing efforts and programmes, and developing partnerships with various GOs, IOs, and NGOs to increase coverage and quality to effectively address reproductive health issues.

Lack of community access to reproductive health information that is understandable

Lack of access to reproductive health information emerged as a major issue during the community-level information gathering. The language of communication appeared to be a key issue to address, if health extension and primary health care are to be effective in ethnic communities. The Study found a generally low level of understanding of reproductive health issues and access to information in all locations. The notable exception was the knowledge of HIV/AIDS among the Khmu and Hmong in Oudomsay, which the villagers attributed to listening to radio broadcasts in their own languages which they could readily access in their own language and at any location, whether in their village houses or field huts. They were listening to local language radio dramas concerning HIV/AIDS, developed and broadcast from Louangprabang by ethnic staff at the Provincial Radio Station, with technical and financial support through UNESCO regional office⁶⁹.

Lack of access appeared to impact 2 key areas, as follows.

- *Women's access to reproductive health information that directly affects her well-being and that of her children*

Women's lack of information on even basic reproductive health services and issues was clearly evident in each of the villages. Examples of the realities in the village include the flow of information concerning immunizations, in which the key role of the village chief as conveyor of information to the villagers. In reality, the women community members often do not receive the message clearly.

Information Flow

“The Head of family who is called to village information meetings is usually male. This is how the information concerning immunizations for women and children is conveyed to the villagers from the health staff: the meeting is in the Lao language, (which the village chief helps translates), and the men are then supposed to convey the messages to their wives”.

Source: Finding from Hua Namkha village, discussed at Meung District Workshop

⁶⁹ For a description of the process, see the article “Radio Programming: an effective tool in preventative education”, Cultural Unit, UNESCO BKK, in the publication: HIV/AIDS in the GMS, Issue 1,2004. UNESCO Bangkok.

- *The lack of knowledge of the different age and social groups in the community concerning basic knowledge of HIV/AIDS, STIs, RTIs, immunizations, and trafficking*
The issue of reproductive health information flow, namely, “who is saying what to whom in what language” is fundamental. Ethnic youth in particular appear to be a vulnerable group. They lack knowledge of basic reproductive health information and issues, and are at risk of HIV/AIDS and trafficking. Many of the girls lacked knowledge of tetanus immunizations. At the same time, they are an important resource to the community for reproductive health extension; for example, boys pass on Reproductive health knowledge they have learnt in school to their peers.

Stakeholders at the district review meetings prioritized developing pilot IEC initiatives for training ethnic health extension workers (e.g. secondary students). Comprehensive lists for practical ‘next steps’ were proposed by the Study’s target villagers and district meetings selected from among the

Study sites. Many practical solutions were raised, including the following:

- Increase IEC in all Health Initiatives, with a Special Focus on Reproductive Health: community members interviewed had very little knowledge of reproductive health or health services in general. Including an IEC component in each community development or training initiative would help address this.
- Tailoring: Reproductive health extension and projects need to be tailored to the needs of the specific ethnic group. The perceptions and attitudes concerning reproductive health may vary greatly, even among villages of the same official ethnic classification. Therefore, the media must be tailored to address the local situation. The IEC and health extension would be designed specifically for the target audience, with creative and effective IEC methods, including popular education such as drama and, songs in the local languages. HIV/AIDS prevention, along with educating all age groups, and especially the vulnerable youth, concerning risky behavior has emerged as an important issue. The communities often confused the messages that they heard from the health staff, which was usually conveyed in the Lao language, which they did not understand.

IEC Extension Methods

- Local community members: Local communities can be trained to use local materials, and perform role plays using their own language. Local trainers speaking ethnic languages could include: different mobile volunteer teams (e.g. youth during school holidays) for each topic, with different team and mediums for the different topics. This has been done successfully elsewhere in the region by NGOs⁷⁰. Peer education may be an effective strategy in rural areas, for example, training youth in school to be extension workers with out-of-school youth in their communities.
- Videos: Videos using local languages can effectively present the realities of HIV/AIDS and human trafficking. The Thai government has already produced effective videos in local languages (including Akha, Lahu Na, Hmong, and other

⁷⁰The NGO, Health Unlimited, has been successfully piloted mobile health extension team in ethnic areas of Cambodia using EU funding to train ethnic minority mobile health teams on various topics: maternal nutrition, breast feeding and supplementary feeding, AIDS and STIs, Family Planning, etc.

languages) through their Non-Formal Education Center⁷¹, piloted in Chiang Rai Province.

- Training modules: These need to be produced and designed specifically to address the needs of the different ethnic groups. The Study findings underscore the importance of designing a flexible programme that allows for pilot approaches that are sensitive to the ethnic and linguistic situation, and can be tailored to the local realities. UNFPA should consider incorporating a special focus on ethnic groups into their approach for each of their six projects.

Monitoring and Feedback

Provide close monitoring of the health extension to ensure it is effective, and gather feedback to further adapt the extension approach for the specific ethnic group.

Community members' access to reproductive health service of sufficient quality

Raising the quality of the local health services and providing effective treatment will influence community members to use the health services available to them. Providing effective health service will influence people to go for treatment, whether the district hospital, TBAs, and VHV. Currently it appears that in the HC is a providing a duplicate service with the VHV in some of the locations. Recruiting and training both male and female ethnic staff at all levels will make the services more accessible to patients from ethnic groups. Training and strengthening the village-based TBAs and family members appears a more effective solution than trying to promote women to go to the district hospital or HC for deliveries, as illustrated in by the following Study findings:

Home Delivery Versus Hospital Deliveries

The district hospital is often not much better equipped than the HC for deliveries. Women interviewed never reported going to the HC for delivery. If they need help, they call the HC staff to help if there are problems with the delivery. If they have access to the district or provincial hospital, they skip the HC and go directly to the district or province.

Source: Field Study Interviews, all villages (both 'trial' villages and study villages)

A Katang woman went to Ta 'Oy district hospital when in labor, however, when she was close to delivery she went home by pushcart because she didn't want to deliver in the hospital (it is 'taboo' to deliver a baby in a bed that has been used.)

Source: Interviews in Ta 'Oy district

Disadvantages to hospital deliveries noted by village women include the following:

- Long delay before the baby begins to nurse
- Birthing Position not conducive to quick delivery
- Family members cannot be present
- Cannot observe traditional customs such as burying the placenta

Source: Interviews Akha women

⁷¹ funded by the US Center for Disease Control as a special project through Chiengrai Provincial NFE Centre.

Solutions suggested at the district meetings include:

Training: Train the community and family members who are actually providing the reproductive health care in the community.

Improved Management: Improve management of Health services, including Poverty Fund, logistics for immunizations, concerning immunizations, coordination and monitoring of the entire system.

Ethnic staff: Increase the ethnic staff in each district service, through flexible selection criteria for ethnic government staff (which doesn't require upper secondary completion). This would enable villagers to discuss reproductive health issues with health staff in a language they understand.

Improved TBA Selection: TBA selection processes need to be revised. In particular, gender restrictions need to be removed and greater attention paid to whether such a traditional position actually exists in each community. TBA selection currently requires the TBA to be female, but does not necessarily require the person to be experienced. The study team identified many cases of male medics trained through the military who were not eligible for TBA training and title, even though they are the primary person assisting with childbirth in the community. Instead, inexperienced females had been selected, as the District Health office specified that the TBA must be female. The following example illustrates the situation in a number of the villages studied.

Official TBA Selection Based on Gender, Not Experience

The male former medic has the official title of a VHV. Despite having assisted with 40 deliveries in that village, he was not appointed as a TBA. He is currently training another male to be his successor, but this person will also not be recognized through the government training programme because he is male.

Source: Ta Lum Lalao 'trial' study village

In addition to selection of TBAs, the language of training is also an issue. The majority of the ethnic women do not understand the Lao language. It is the opinion of the study team that the TBAs and family members are a valuable resource to the women during pregnancy and delivery, and should be targeted with special training initiatives.

Greater use should be made of indigenous knowledge specialists in selecting TBAs. If these persons could be trained as a TBA, then the traditional and official reproductive health practices could work together more effectively.

It is clear that the first action taken by most groups in the case of a difficult birth is to perform spirit ceremonies, often requiring a local specialist (a shaman, or 'Mo Phi'). If training efforts could recognize this, and encourage them to cooperate with the TBA and health services, for example by encouraging prompt referral, this may be effective step towards reducing maternal mortality⁷².

⁷² The NGO Health Unlimited working with related ethnic groups in neighbouring Ratanakiri, Cambodia, where it is also necessary for the patient to get permission from the shaman before seeking out other forms of treatment, devised an effective strategy. They conducted community outreach to encourage villagers to begin emergency referral and transport to health at

Public-Private Coordination: Currently the private service providers tend to be in competition, rather than cooperation, with the medical system. Private medicine providers, who are usually unlicensed, are in reality the first course of treatment for many ethnic people in remote areas. It is recommended that Quality Control, Training and Licensing be provided for Private Medicine Providers/shops in remote areas. Many of these people (e.g. the ex-army medics encountered by the Research teams) would be good candidates for TBAs, VHVs or other officially supported positions. The following example illustrates the issue:

Villagers Appreciate Mobile Services Provided by Private Doctor

The private doctor in Mang village is a former military medic. He rides his motorbike to make home visits in the village almost daily and returns to follow up on the people he has treated.

He currently has the skills to treat many practical ailments which the villagers face: treating STIs, helping with some cases of difficult childbirth, and removing retained placenta, miscarriage, pregnancy check, identifying cases which should be referred to the hospital (pregnancy and delivery), and provides vitamins for nursing mothers who have lactation problems. He can perform minor surgery (lance boils). He buys medicines at the Beng district medicine shops or at the Provincial CBF⁷³ outlet. He also sells condoms (PSI's Number 1 brand) but not birth control pills, as that is not allowed according to district health policy. He sells medicines at a reasonable price with low profit. He also provides treatment to villagers even if they have no money and must pay 6 months or 1 year later. He requests to be able to upgrade his skills by joining technical training sessions organized by the Health Sector. Topics he would like upgrading concerning women's health include: treating women's joint pains, headaches, dizziness, and painful nerves in neck.

Source: Private Mobile Doctor, Mang Village

Monitoring: Conduct regular monitoring of reproductive health efforts to the community level to ensure quality and impact (coordination between HC, VHV, LWU, DH, Youth, etc). Promote quality of reproductive health care at all levels (Province, DH, HC, and TBA) through improved coordination, technical training, monitoring and peer learning.

Strengthened Coordination: Currently, there is insufficient coordination of reproductive health services at the local level (HC and VHV-TBA). Strengthened coordination of reproductive health services at the local level would provide improved services at the local level. The need for coordination is illustrated by the following Study findings:

the first signs of obstructed labor, while other family members performed spirit rituals with the shaman concurrently. Many villages have now adopted this practice.

⁷³ National Pharmaceutical Factory

Village-level Coordination of reproductive health services

The local HC staff don't have sufficient capacity to do coordination for village-level health services; therefore the district health needs to coordinate the three service providers in Bong Nam village (VHV, TBA, and Pasom HC staff). They meet together when the EPI or other teams do their regular outreach visits.

District MCH Staff, Ta 'Oy district

The Huay Ngua HC staff person had neither information concerning the reproductive health training to be conducted for the VHV, nor information concerning whether she had a role in follow-up.

Staffing Hours for the Nearby HC

The HC near Mang village is often not open at the time the villagers needed, thus they requested that for their HC to be effective, the staff need to be there rather than in their fields.

Mang Village, Oudomsay Province

During the Study, the capacity of many of the local workers was undermined by lack of coordination. According to the management system, the HC staff should supervise the TBA and VHV. It may be better to have interactive learning with DH as facilitator, e.g. once or twice a year. This is the experience of Bong Nam, as the district staff coordinates the 3 service providers at the village for a meeting. No vehicle, so call all three to join, due to lack of vehicle, time, and logistical problems. As a part of this, interactive learning and cooperation should be promoted. The community-level HC staff, VHV, and TBAs could benefit from an atmosphere of interactive learning, rather than perceiving themselves to be part of a hierarchical system which prevents local cooperation and discussion.

Improve HC Staffing and Hours of Service: Community members and stakeholders recommended that in order for the HC system to be effective, the following conditions are needed:

- HCs need to be open and staffed by at least one person, with regular working hours, which fit the villagers' needs;
- HC staff must receive salaries on time so as not to be occupied with livelihood activities instead of fulfilling their responsibilities for the HC; and,
- Ideally the HCs should be staffed by one male and one female who speak ethnic languages.

In order to accomplish this, the HC could have several staff persons taking turns to ensure continuity of working hours. In addition, it is essential that staff receive their pay in a timely manner. Additional staff incentives would be useful, e.g. through separate small-scale income generation projects. HC staff who make home visits as well as follow up of patients are appreciated for all ailments, and especially important for deliveries and providing treatment related to reproductive health.

Review and Assessment of the HC System: It appears that when it is possible to train a VHV and TBA, the HC may be a duplicate service. The HC staff and VHV do the same tasks at the village level, such as dispensing essential drugs. When not in a remote area, the villagers prefer to go to the provincial hospital rather than the HC. Investigating the effectiveness of the HC is a highly relevant topic which should be studied further. It may be advisable to have fewer HCs, designated for remote areas, which provide better quality service. Raising the

level of the VHV and having well-trained TBAs may be more effective than having an HC which continues to provide low quality service.

Integrate Reproductive Health with Primary Health Care, IEC, and Education Initiatives:

Support pilot initiatives, staffed by ethnic people, which are community-based, and have a multi-sectoral approach. Communities will develop and coordinate activities appropriate for their situation. Various sectors will need to work together, e.g. health, education, Women's Union, Youth League, student volunteers, and village authorities.

Strengthen the Understanding of the Village Leaders Concerning Reproductive Health: In the current system, village chiefs play a key role as the communication link which enables their respective community members to access health services, and in particular, reproductive health services. In all locations visited, they are responsible for mobilizing villages for attending tetanus and children's immunizations, selecting the VHV, and selecting the TBAs. However many lack the necessary understanding of reproductive health issues to do this effectively.

Coordination of existing efforts and programmes in the different sectors to increase coverage and quality. :Effective coordination would enable districts to effectively address reproductive health issues through an integrated approach. Many partners are currently involved in reproductive health, including UNICEF, UNFPA, and various Lao government partners, sometimes through an inter-sectoral approach. A number of new projects, including those funded by UNFPA, have recently begun. However the coordination between sectors and partners, as well as the monitoring systems, are not yet strong.

Provincial health center:

Community Level Feedback Needed for Effective Monitoring

A provincial MCH director who joined the team in Oudomsay Province provided feedback to the study team concerning the value of gathering information directly from the community, rather than simply the HCs and government staff responsible for providing the health services.

Prior to the study, she had never before had time allotted to gather feedback from the community level concerning reproductive health issues. Thus she was very interested hearing in the community perspective. Usually her monitoring trips concerned collecting feedback and reports from the government staff. Throughout the Oudomsay field work, she repeated many times that the community-level feedback gathered through the Study process was of great value. This was the first time she had opportunity to gather information from the community level for the first time. This experience talking with community members themselves provided her with information necessary for improving the whole system, for assessing the impact of MCH initiatives on community-level beneficiaries, and for quality assurance. She herself speaks an ethnic language (Khmu), and thus can talk with many villagers without a translator.

Source: Study Field Notes

Recommendations:

Plans for strengthened coordination and monitoring are needed for both the sectoral and integrated reproductive health projects.

Careful planning, delineation of roles, and coordination are especially important for the integrated projects which include the various government sectors (for example, LWU, Health, Youth League, and Education). These integrated reproductive health projects need strong coordination with the Health sector, in order to ensure that they are technically strong and effective. It is also important that their implementation and impact at the community level be monitored through the existing Health monitoring system.

Strengthen Coordination, Monitoring, and follow-up for reproductive health initiatives, especially in the hard-to reach areas where ethnic groups live.

Special plans are needed to ensure coordination and monitoring of health extension and services in remote ethnic communities. Challenges include the increased budget for transportation, additional time to reach the remote communities, and services tailored to the needs of illiterate ethnic villagers who do not understand the Lao language well.

The monitoring system itself should include community feedback.

The quality of monitoring should be strengthened through community consultations, spot checks, and other means of gathering candid information from the community level beneficiaries. Currently monitoring is primarily through reports and visits to the HCs and government staff rather than discussions with villagers themselves. It is important that the monitor have an effective means of communicating with the villagers, for example, by being able to speak the local language, or to arrange an effective translator.

5.1. District Workshop Recommendations

The following key recommendations were raised during the District Workshops. Additional details of the district workshop results are included in Section 4.4, Section 5, and Annex 5, Annex 6, Annex 7.

Train ethnic staff in each of the District Services or Organizations⁷⁴ which are involved in reproductive health

The Reproductive health Study clearly showed that in order to be effective, health extension needs to be provided in a language the villagers understand well.

Currently there are very few ethnic staff in the majority of the HCs and district hospitals visited. Increasing the number of ethnic staff, especially females, would improve communication between the women from ethnic communities and health staff at the HCs and district hospitals. Ethnic patients would be more likely to use these health services if the facilities were staffed by could communicate in the language of the patients as well as understand their cultural background. This can be accomplished by:

- Identifying candidates and providing scholarships for ethnic students, especially females, interested in continuing their education in order to become health extension workers in their own communities, or district government staff (primary nurse, middle nurse, and doctor). These scholarships would include lower and upper secondary school, as well as training as medical staff for the government health system.

⁷⁴ LWU, Youth, Education, Health, etc

- Training representatives from ethnic minority groups to work with the various district departments for community development and extension.
- Provide on-the-job training/internships for ethnic minorities, especially for reproductive health issues.
- Lowering the staffing formal education requirement for district government staff in order to recruit ethnic minorities (i.e. require lower secondary level (level 3) rather than the current requirement of finishing secondary school (level 6).

Strengthen Reproductive Health Training in Primary and Secondary schools

The need to strengthen reproductive health in the school system
 “Currently people who have graduated from lower secondary school still can’t explain basic reproductive health concepts- this is an issue that must be addressed”

Source: Beng District Workshop

- Promote overall female enrolment.
- Extend existing training and materials to the remote ethnic districts. Materials and resources currently exist, however the ethnic villages are frequently remote and thus continue to use old materials.
- Ensure that the Ethnic Minority Schools all have up-to-date reproductive health curriculum, that teachers are trained in their use, and that the students themselves receive the necessary training to conduct awareness-raising sessions during school v holidays.
- Training in reproductive skills is needed in addition to formal education and skills training, with a regular schedule for monitoring of the training, e.g. at least two times per year.
- In the education sector, reproductive health training has not yet been conducted for teachers or monitors. Currently only a general national curriculum exists, which includes ethnic groups but no special modules for reproductive health specific to ethnic groups. The current curriculum is too general and should be more intensive and detailed.

Integrate Reproductive Health and Community Development

Integrated development is needed. The current tendency is for the individual sectors to be top down and highly sectoral.

All partners at the village level (Health post, village committee, teachers, LWU, Youth Union, and government staff living in the village) need to both understand, be interested in, and promote behaviors which protect reproductive health. They need to have access to and be trained in the use of illustrated materials, such as posters, pamphlets, CDs, and other materials appropriate for outreach designed specific to the needs of the respective ethnic group. Improved coordination of existing efforts and programmes, and development of new partnerships with various GOs, IOs, and NGOs are necessary to increase quality and ensure coverage to the local level.

See for further discussion: Improved coordination and integration of reproductive health efforts at provincial, district, and local levels.

Equip and Train Local Community Outreach Workers

Local community members and students should be trained to serve as volunteer outreach workers in their own and neighboring villages. They could effectively communicate information and raise awareness concerning reproductive health among their own ethnic groups: they are local residents, speak the local language, and understand the respective traditions and customs. Students at ethnic boarding schools and local secondary schools could be equipped to conduct outreach and community dramas when resident in their villages during school vacation. See Summary of Recommendation for further discussion and details.

Develop, Trial, and Field-test Creative and Appropriate IEC Methods and Materials

Trial creative means of extending information services to the remote areas through the use of pilots, trials, field testing, rather than a uniform ‘one size fits all’ approach. Much more effort needs to be devoted to this area of developing materials appropriate to the local ethnic groups rather than a ‘one size fits all’ approach. Local community members should be involved in the development, field testing, and trials.

See sections for further discussion (‘Media’), for further discussion .

5.2. Additional Reproductive Health Team Issues and Recommendations

Traditional and Official Reproductive Health Practices

Lack of information, mutual ignorance, and clashes between traditional and official reproductive health beliefs and practices were major themes emerging from research. The Study identified many examples of reproductive health projects which did not meet their original objective due to the contrast between the traditional animistic belief systems of the communities in relation to reproductive health, and the medical procedures or ‘scientific’ outlook of the service providers.

Examples

The following examples illustrate the profound relationship between childbirth and the spirit world.

Maternal Death Due to Childbirth: Malevolent Spirit

A woman who dies in child birth becomes a malevolent spirit which returns to haunt people. People believe that she will not be reincarnated. She must always be buried separately from her baby. Thus if the baby was still unborn, they must have someone remove it from her uterus, and then bury the baby separately from the mother. Otherwise the spirit of the mother will become the worst type of malevolent spirit and return to haunt the village. Her spirit cannot be reincarnated, and thus will continue to haunt the area. The shaman must conduct special ceremonies to placate the spirits when a woman dies in childbirth, in order to prevent the spirit from coming back to haunt the family and villages. This is true for the Khmu; it is also a common belief among the Lao, and maybe other ethnic groups too.

Source: Director of MCH, Oudomsay (female, Khmu ethnic group)

Blood Related to Childbirth Attracts Malevolent Spirits

The blood associated with childbirth must be cleaned up as soon as possible. This includes both the baby and the mother. This the reason that many times they wait to breastfeed until after the baby has been washed, the mother cleaned up, and often the placenta buried. The national MCH programme, “Baby friendly hospitals”, which has reached a number of provincial hospitals (but not yet all the districts) is promoting skin contact and breast feeding immediately after birth. This helps with delivering the placenta. However, the local tradition is usually to wait for both baby and mother to be cleaned, and often for the placenta to be disposed of, before breast feeding.

Many of the various ethnic groups as well as lowland Lao believe that a certain type of malevolent spirit which eats blood will come to devour the blood associated with childbirth. This vampire-type spirit is the worst of all the spirits, and really terrifies people. For many ethnic groups, this may be the reason behind the customs associated with cleaning the mother and child before breastfeeding.

MCH Specialist, Vientiane

Future of the Newborn Whose Mother Dies in Childbirth

The newborn of the woman who dies in childbirth will also die, because the mother’s spirit will come to take it away. The villagers don’t have a way to feed the newborn, as there are strict taboos preventing anyone from breastfeeding the baby except a very close relative. It is also commonly believed that the baby has no chance of living if the mother has died. They wait for the baby to die before burying it, as it is not necessary to bury the mother and baby together.

Katang Villagers, Ta’Oy District

This Study is the first of its kind to systematically gather and document community perceptions related to reproductive health for various ethnic groups from both the northern and southern parts of the country. Gender issues were found to impact access to and quality of reproductive services. Decision-making in the family was a key factor impacting the villagers’ access to reproductive health services and information. Among other issues, the traditions related to decision making in the family impacted :immunization rates for women and babies, their referral to health care services (or calling health care staff to make a home visit), and family planning (i.e. birth spacing). Numerous examples gathered from the various reproductive health study sites illustrate the influence of these issues on reproductive health, including traditional beliefs and practices, and decision making patterns, as in the following illustrations:

Potentially Dangerous Reproductive Health Practices

The Katang and Ta' Oy ethnic villagers surveyed believe that a woman cannot give birth in a bed which has already been used, thus the Ta'Oy district hospital had only four deliveries in the past year, and none of the deliveries was for ethnic women. Women do not want to be referred to the hospital, as using a previously-used bed goes against their traditional beliefs. This is in keeping with the reports that communal 'birthing rooms' built by IOs and NGOs in Katang villages are also unused for deliveries and used e storage).

Some of the Lahu Na community members surveyed believe that a newborn is too young to immunize, and therefore they wait until it is older (up to one year) before immunizing. In addition, the husband must make the decision for the child's immunizations, while the wife has little decision-making power. These challenges often result in the baby not receiving the full immunization series.

Women in many of the ethnic groups interviewed were not involved or consulted in the decision to call for outside assistance if complications arose during their time of delivery. Usually the women's family members (parents, in-laws, and husband) made this decision, including whether a TBA or HC staff should be called to their house, or whether to allow the woman to be referred to a district or provincial hospital. Often family members must consult the shaman, and perform spirit ceremonies before transporting. The women may have already died by the time everything is ready for her to get assistance.

Women in the Hmong Jua community surveyed could not leave their villages until after the traditional one or more month period of post-childbirth restrictions ('yu kam') is concluded. Women interviewed noted many cases of infants dying of unknown causes within the first 42 days of delivery. This was confirmed by the village chief who reported about six infants had died in the last year. They did not know the causes of death as this happened during the period of time that the women and infants must not travel outside their villages, even to a nearby health post.

Source: Reproductive Health Study Field Notes

Meanwhile, many traditional practices promote good health:

Healthy Traditional Practices

The Ta 'Oy and Katang always give birth in a bed and house specially built for this purpose, which would improve the hygiene.

Post-delivery restrictions against sexual intercourse (among some groups up to 4 months) which would provide a form of birth control as well as allow for recovery time for the woman both in relation to delivery as well as postponing the next pregnancy.

Some of the breast feeding practices of certain ethnic groups are closer to the MCH "friendly baby hospital" guidelines than those in the district hospitals which have not yet adopted these guidelines. For example, the Akha tradition requires that they must start breast feeding as soon as possible.

Some nutrition practices may promote health. For example, an Akha mother will eat an egg immediately after delivery, chicken soon after. In a number of ethnic groups, chickens are raised while the woman is still pregnant in preparation for her to eat chicken meat regularly during the one-month post-childbirth period. Dietary restrictions during pregnancy in many groups have spoiled food taboo.

Husbands and family members have an important role in supporting the woman during delivery in many of the ethnic groups, and the husband helps with the household chores for one month after delivery. The MCH instructions encourages the husband to be present during delivery, however, this is not yet practiced in the remote district hospitals visited, e.g. Meung district.

All of the ethnic groups interviewed used birthing positions which allowed for gravity to assist the birthing process, and often the husband has an important role. In contrast, the only position used in the district hospitals was a lying position, and the husband is not allowed in the delivery room. However, for home deliveries, the MCH staff train TBAs to allow the woman to use whatever birthing position was comfortable, and allow the husband to be present if he wishes.

The Katang and Ta'Oy teenage boys and girls are instructed by the elders that they must abstain from pre-marital sex, with strict parental supervision to enforce this. This may be a factor which could help protect the Katang and Ta'oy youth from the complications of romantic relationships together with premarital sex from a very early age. Ethnic communities where premarital sex is more freely permitted reported STIs, pregnancy out of wedlock, and in some instances, teenage suicides linked with broken romances.

Source: Study Field Notes

Recommendations

Conduct In-Depth Studies Concerning the Perceptions of reproductive health for the Various Ethnic Groups

Studying the perceptions and practices of ethnic groups would allow service providers to identify implications for planning reproductive health services and various health extension initiatives, including IEC. This Study is the first of its kind, and could be used as a foundation

for more in-depth studies and analysis. Little information is currently available as few studies have ever been conducted.

Include an Study Component in all Reproductive health Projects for Ethnic Groups

Reproductive health service providers at all levels should include a project component for action research and qualitative information gathering concerning Reproductive health. Few studies exist concerning reproductive health and the various ethnic groups. These would provide valuable information for programme planning, health extension and service delivery. For example, the reproductive health study in the Akha village identified a high rate of child death, possibly due to the following contributing factors: i) marriage and childbirth at a young age; ii) young and new mothers lack experience caring for infants; iii) infants may have caretakers other than the mother (other family members when the mother is working in the field). These could be specifically addressed by a Reproductive health programme tailored to their situation.

Conduct Awareness Raising at the Community Level to Find Alternatives to Potentially Reproductive health Dangerous Practices

Training sessions with TBAs, VHVs, and community members can raise awareness concerning potentially dangerous practices, e.g. pushing on the abdomen during delivery, cutting the cord with non-sterilized instruments, trying to pull out the placenta, not immunizing infants or pregnant women, delaying referral to the health facility for a woman experiencing complications in childbirth, discarding the colostrum, not allowing the sick newborn or mother to leave the village for treatment for over a month following delivery, and overly restrictive post-delivery dietary practices. The community can then hold their own discussions concerning how to mitigate the dangerous practices. For example, they may decide that it is possible to conduct the spirit ceremony at the same time the woman in delivery is being referred, as it is an emergency situation and otherwise she may die due to late referral.

Identify and Build on Positive Traditional Health Practices

Each of the ethnic groups has a wealth of traditional knowledge, for example, herbal medicinal practices, passed down from generation to generation, a number of which do promote health. The various health programmes including IEC would be more effective if they could identify and build on the positive practices, for example, by training traditional herbalists or spirit specialists as TBAs.

Tailor Health Service Delivery to the Needs Situation of the Specific Ethnic Group

The men and women from the various ethnic groups come from a wide range of traditions, needs, and situations which relate to reproductive health. These have implications for the community members' access to both information and services, and must be considered by those planning the health service delivery.

Conduct On-going and In-Depth Studies Concerning Impact of reproductive health and development projects

The Khmu and Akha communities in the Study have had long-term development projects. They both appear to have significantly decreased rates of infant and child death during the

lifetime of the projects. Studies to measure the impact of reproductive health initiatives in target villages, as well as comparison of the impact of reproductive health initiatives in project and control (non-project) villages may be a topic of further study.

Prioritize IEC in Local Languages Concerning the Value of Immunizations for all Community Members (Male and Female)

The vast majority of women did not know the reasons or understand the value of immunizations, whether for themselves (tetanus) or for their children. Males are usually the chief decision makers concerning the children's immunizations, despite having minimal understanding. The majority of males and female had never heard a clear explanation about the value of tetanus or children's immunizations in either local or Lao language. The village leaders were also unclear concerning the value of immunizations. As men are involved in the decision making, it is important that both men and women understand the value and reason for the immunizations. One possible means of promoting tetanus immunizations in remote areas may be to provide tetanus immunizations for men as well as women, as they are usually the chief decision makers.

Expand the Target Age for Immunizations (Tetanus for Females, Infants)

Ethnic girls often have pregnancies and marry before the target age for tetanus immunizations. Babies are often brought for immunizations when they are already one year old. Extending tetanus immunization for females of childbearing years to ages to 13 and up, and children's immunizations to five years and under, should significantly improve immunization coverage in ethnic areas.

Review the System for Scheduling Immunization Dates with Villagers

Villagers frequently said they were not able to access immunization services, even those who were wished to receive them. A chief reason was that they did not receive the schedule information in time. This is because although immunizations are given in the villages, however in many cases the villagers' primary residence was their distant necessitates they need more advance notice if the message is to be conveyed to them to return to the village in time for the immunizations.

In addition, the current system for announcing the immunization schedule and disseminating relevant information did not appear to be an effective means for information flow. The usual system is for the district health officials to inform the village chief using the Lao language, who in turn disseminates information through a village meeting attended by male heads of households (in Lao or the local language), who in turn were instructed to tell their wives

5.3. Key Recommendations

These recommendations and others have been summarized into nine recommendation areas and several areas for further research by the study team. These were drawn from study findings, (both field information and district workshops) as well as discussions between team members. They are presented in detail with practical solutions that the study team feels are realistic and appropriate.

1) Tailor reproductive health programming to the specific needs of ethnic groups and local realities, and pilot new approaches.

It is important to ensure that the activities address the social/cultural context, are gender sensitive, and take into account emerging issues (outside influences). All approaches should be flexible and adapted to the local situation, rather than a uniform approach.

These should include:

- Male and female members of various ages from the ethnic groups representing the target villages on the teams developing the activities and projects;
- Using local language and field-tested materials;
- Conducting community feedback sessions of pilot materials and approaches for each ethnic group;
- Conducting information gathering specific to the gender, ethnic, and linguistic situation prior to developing materials and approaches;
- Involving community groups including ethnic village health volunteers and self-help groups in project planning, implementation, and monitoring;
- Increasing ethnic and gender sensitive materials including issues related to young people, the involvement of students, and the family-level decision makers;
- Piloting and expanding innovative approaches to community outreach, such as radio drama and VCDs in local languages; and,
- Exploring innovative and participatory approaches to include the local population in design and implementation of programmes.

2) Trained ethnic people, both male and female, should be used to provide services

Increase the number of trained male/female ethnic staff at local health facilities and government institutions (e.g. Health, Education, Lao Women's Union, and Lao Youth League, Radio), through:

- Adopting flexible hiring policies concerning the education requirement, along with innovative training programmes;
- Providing scholarships for the ethnic youth completing their basic education to attend the existing government training programmes;
- Establishing special training programmes and workshops as appropriate, especially at the community and school levels, for example, for developing peer trainers and mobile extension teams from among members of ethnic villages and schools. Special emphasis should be placed on training youth and students as volunteer outreach workers.

3) Strengthen health service delivery

This includes:

- Integrated outreach services, including regular ante-natal clinics at village level conducted by skilled midwives;
- Home delivery with skilled medical attendance, coupled with strengthened links to skilled services;
- Delivery practices which take into account traditional positive practices, and allows involvement of family as appropriate (whether at home, or at health center or hospital);
- Monitoring which includes regular community consultation as well as frequent ‘spot checks’; and
- Reviewing the current health center system.

4) Conduct community-level awareness raising and training of assistants for home delivery

In the locations where the family plays a major role in the delivery, conduct village-wide training for awareness raising of both men and women. Training should include basic principles concerning safe delivery and referral (for example, the importance of ante-natal care, eliminating dangerous practices, recognizing danger signs, prompt referral).

In locations where Traditional Birth Attendants (TBAs) play an important role, they should be prioritized for training, along with awareness raising for family members to promote safe deliveries. Training methods should be practical, hands on, and held in the local language. Follow-up should include case-conferencing if possible, led by a skilled midwife. TBA training should include the following knowledge and skills:

- Nutritional counseling;
- Recognition of danger signs and refer to skilled midwife before the delivery;
- Filling the role of an interface between the community and the HC/health care system; and,
- Eliminating dangerous practices, following safe practices, and prompt referral.

5) Introduce flexible age limits for immunization policies and improve information flow

Current policies need to be adapted in order to address local realities. The immunization age limit for tetanus for child-bearing females should be extended to include females below the age of 15. Immunization for babies should be extended to include children over one year of age. Improved IEC, logistics, and communication are also essential if coverage in remote and ethnic and remote areas is to be realized.

6) Extend and strengthen sexual and reproductive health information

Information should be disseminated through multiple channels. This includes:

- **Formal and non-formal education systems**
Strengthen and expand coverage of existing reproductive health materials both in the formal and non-formal education programmes. This would extend the new materials and training methods to the remote ethnic areas.
- **Media: radio, illustrated IEC materials and videos in local languages**
Pilot a number of creative approaches using local languages for health education, including: radio broadcasting (in particular, health-related radio dramas⁷⁵), videos, posters, and flipcharts. Community theatre, through trained community members and

⁷⁵ Such as the UNESCO-supported project through the national radio station in Louang Prabang

students, both male and female, can be conducted by mobile teams in both their own and neighboring villages using the local language. Care should be taken to select and prioritize topics to avoid the community being confused by a proliferation of health messages.

7) Equip the community members to provide health education in local languages

- Train a group of volunteer male/female community health educators from the community who are representative of the various age groups. Youth and students in particular should be trained in creative outreach methods.
- Approaches should be creative and interactive.
- Methods for outreach must be appropriate for non-literates and those with limited Lao language skills, e.g. a mobile community drama team comprised of current and former students, illustrated posters and flip charts in local languages.

8) Promote girls' education, both enrolment and progression

Approaches should include:

- Pilot initiatives and scholarships specific to the needs of the ethnic communities, to increase girls' enrolment;
- Strengthening the relevance of the education programmes to address local realities and provide life skills;
- Designing and piloting special reproductive health modules for teenage ethnic girls enrolled in school. These should be available to teenage ethnic girls regardless of their grade level, including teenagers in primary school.

9) Improve coordination and integration of reproductive health efforts at provincial, district, and local levels

- Stronger and more effective local coordination is needed between the various partners involved in reproductive health, including Lao Women's Union, Youth League, and the Health and Education Services.
- Additional partners such as NGOs and local organizations should be recruited and mobilized. Decentralization of decision-making of special projects to the local level would facilitate adaptation of the programme to the local realities, as well as local coordination.
- Effective coordination is a necessary pre-requisite for effective integrated activities.

5.4. Future research study recommendations

This section contains proposals for follow up research and implementation which builds upon this study.

- It is highly recommended that any further studies or pilots use a similar model to Study, which was successful in gaining a wealth of information from isolated ethnic villagers where few of the community members Lao.
- The approach was key to gathering information disaggregated by gender and age group, despite the fact that very few of the respondents could communicate in Lao.
- Further studies should build on and include the following components:

Participatory, Bottom-up Process which is Locally Managed

The Study piloted an effective model which can be effectively adapted to the local situations. The model provided a means for participatory, qualitative information gathering. The local district and Study villages took a key role in managing the process and reviewing the field information gathered. The information gathered was reviewed by a two-step process, first by the Study village, and lastly by a district workshop involving all counterparts and decision makers relevant to reproductive health. The participatory presentation meetings enabled the findings of the Study to be immediately useful to the local counterparts from village to Provincial levels. In addition, they provided an opportunity for validation of the information gathered by the Study village themselves, and disseminate the findings to the district officials together with work shopping to find appropriate solutions. Future studies, action research, or pilots should follow a participatory model which is: decentralized, managed by the local districts, and has a strong on-the-job capacity building component for local ethnic technicians, especially youth.

Key Role of Local Researchers

Key to the information gathering process were the research assistants, who were selected from similar ethnic communities, and trained locally through on the job training. When possible, the Research Assistant was a villager, came from a different community, and was unknown to the target community. district and village authorities were not used for information gathering unless necessary, as they represent a different social strata. This care to select ethnic, local, and neutral research assistants facilitated candid responses and avoided mixing persons from different social strata. Many of the research assistants were youth who were either enrolled in school or had recently left the school system.

The importance of the local capacity building for local ethnic research assistants through such opportunities cannot be overstressed. Practical hands-on training sessions, with guided practice and on-the-job training, are required. Thus it is recommended that any further Study or pilot have a stated objective of building capacity for local ethnic men and women at the district level. As they speak the language and know the culture of the local ethnic villages, they are the best communicators with the ethnic villagers.

Further research around the following areas should use these methods:

Improving qualitative and quantitative systems for gathering reproductive health data, including disaggregation by sex and ethnicity

Qualitative and quantitative information concerning reproductive health that is disaggregated by sex and ethnicity, and available at all levels, is essential for effective programme planning.

Ethnographic studies and participatory social research, which includes the involvement of ethnic groups in design and implementation.

Ethnographic studies that include gender analysis should be used as the basis for designing effective reproductive health programmes. Only a handful of ethnic surveys or studies have been conducted in the country to date, and few, if any, concerning reproductive health. Such studies should be a pre-requisite for programme development among the various ethnic groups, since the belief system in each of the ethnic villages plays an integral part in decision-making and health-seeking behaviour concerning reproductive health.

In-Depth Studies Concerning the Perceptions of Reproductive health for the Various Ethnic Groups

Studies of the perceptions and practices of ethnic groups would allow service providers to identify implications for planning Reproductive health services and various health extension initiatives, including IEC. The Reproductive health Study could be used as a foundation for more in-depth studies and analysis. Little information is currently available as few studies have ever been conducted.

Following is a draft project proposal for such a study:

Recommendations for Future Study Proposal

It would be useful to have a very small team from central level work together with local partners in a similar model to the training undertaken. Rather than having broad coverage of 6 ethnic groups, the study would focus on a limited number, for example, 2 or less. The study would be more intensive and thorough than the Study's Assessment. A larger number of villages representing a more limited number of ethnic groups would be undertaken. Technical backstopping would need to be provided throughout. team preparation and training should include a literature review. Advance preparation is needed through field visits to determine the exact ethnicity of each of the villages in the study, select Research Assistants, and ensure they are the same ethnicity as the target villages. Initial training should be followed by a final selection of the top Research Assistants to participate in the research.

Ethnicity and Gender concerning specific topics (e.g. delivery, infant feeding, tetanus, communication) similar to the practical topics in this Study, should focus on a limited number of ethnic groups. Within the same ethnic group, it would be useful to have villages representing a number of variables. However, these add to the complexity of the Study, which should not be too ambitious and exceed the experience level of the researchers and their time availability. Possible variables include:

- Project village and non-project village
- Different geographical locations for same ethnic group
- Near main road and distant from main road,
- Large and smaller village
- Same ethnic group in different locations
- Original or relocated villages

- Remote, not remote

It is essential that in addition to scheduling their time for field visits, the study team members must schedule sufficient time for data collation, verification of any missing facts, analysis, translation, and report writing.

Include a Study Component in All Reproductive Health Projects for Ethnic Groups

Reproductive health service providers at all levels should include a project component for action research and qualitative information gathering concerning reproductive health. Less than a handful of studies exist concerning reproductive health and the various ethnic groups. The findings would be valuable for informing programme planning, health extension and service delivery.

Each project, no matter how small, should include an information gathering and feedback component. For example, the wealth of practical and relevant information gathered from the Study can be used to advise local programmes. An illustration is the Akha village studied. The Study identified a high rate of child death, possibly due to the following contributing factors:

- i) marriage and childbirth at a young age;
- ii) young and new mothers lack experience caring for infants;
- iii) infants having caretakers other than the mother when she is working in the fields, in particular, other family members. Such issues could be specifically addressed by a reproductive health programme tailored to their situation.

Conduct On-going and In-Depth Studies Concerning Impact of Reproductive health and Development Projects

The Khmu and Akha communities in the Study have had long-term development projects. They both appear to have significantly decreased rates of infant and child death during the lifetime of the projects. Studies to measure the impact of reproductive health initiatives in target villages, as well as comparison of the impact of reproductive health initiatives in project and control (non-project) villages would provide useful information concerning impact.

Implementation

All studies and action research should include an implementation component, to ensure that information from the study is disseminated, and action is taken whenever possible.

Build on the Study: pilot initiatives and implement recommendations in the three target districts.

The study team recommends that small-scale reproductive health pilot projects which are linguistically and ethnically appropriate be developed within the existing framework of the six UNFPA projects. These could include: IEC using specially trained mobile teams from among the community youth, scholarships for ethnic girls to continue their education, as well as get specialized training, and community theatre and songs using local languages. Successful dramas and songs could be produced into VCDs to show within the local communities.

It would be advantageous for the pilot initiatives to be trialed in target sites correlating with the Study, to enable them to build on the foundation of capacity building and awareness raising already accomplished through the study process.

The district review meeting results demonstrate that such pilots would be welcomed by the local authorities and District and Provincial services. Government staff from the various sectors are aware of the need to pilot flexible approaches and to implement new tailor-made approaches. Some districts already had plans for implementing different approaches if they had funding and technical support. For example Meung district would like to strengthen reproductive health awareness raising through various sectors. Education modules produced in recent years through the Education sector (produced with support from UNFPA) are currently used elsewhere in the province. However, Bokeo Provincial Education Service lacked the necessary funding and technical expertise to expand to the remote ethnic areas of the province. Thus Meung district had not been included in provincial level teacher training workshops due to the increased travel costs associated with inviting participants from remote districts. They note that remote areas are often precluded from participation due to the additional expense involved for travel, which often prevents Meung district from participating in new initiatives.

It would be very useful to conduct small-scale pilot initiatives in the three districts to implement selected recommendations from the Study, working together with the pool of the trained ethnic research assistants, community leaders, and relevant stakeholders who participated in the Study. To accomplish this, it is necessary to prioritize recommendations for each locality, develop strategies, and train a team of local volunteers. The approach should include on-the-job training and frequent monitoring.

To implement pilot initiatives, it is suggested that UNFPA and local governments build partnerships with organizations specializing in small-scale, 'hands-on' approaches, including non-government organizations and specialized action research teams, to provide the technical assistance and monitoring for these pilots.

Using Feedback from Action Research to Inform Policy and Pilots

Lessons learned from pilots can feed into government policy, and indicate successful approaches suitable for replication. Feedback gathered should be provided to organizations piloting new initiatives that may not have a mechanism for gathering feedback. This includes Government Organizations, International Organizations, and Non-government Organizations.

For example, the findings of this Study concerning the outstanding level of awareness of all sectors of the Hmong community studied concerning HIV/AIDS, which was attributed to the radio drama, should be disseminated. These findings would be of great interest and use to those responsible for the initiative⁷⁶, especially if they are basing expansion of their coverage on the success of the pilots.

Suggestions for Action Areas

The following recommendations relate specifically to the 6 ethnic villages in the Study. Further study and action research is needed to determine appropriate recommendations by ethnic group and locality. However the Study results form an important basis of information for further investigation on the following topics.

⁷⁶In the case of the Hmong radio drama concerning HIV/AIDS, the findings should be shared with the UNESCO Cultural Unit (Bangkok Regional Office), together with the implementing government organizations (Ministry of Information and Culture, and Louangprabang Radio Station), as well as other stations in the region.

District Level:

The following are recommendations for strengthening the capacity of action research and extension in ethnic villages at the local level:

Practical Action Research: IEC and Reproductive health Extension Materials Development and Trial

The need for effective communication of basic health messages to female ethnic villagers clearly emerged as a significant issue. Materials need to be tailored to the specific needs of the specific groups, rather than the current trend of producing general IEC health materials for use with the general rural population including ethnic groups.

In order to accomplish this, action research and specific study would need to be conducted to determine the most effective media and form of the IEC effort and reproductive health materials. The IEC initiative would need to be based upon the reproductive health needs identified during the Action Research, with extension materials tailored to the needs of each specific ethnic group. The IEC materials need to be produced using the local language, as the villagers in general and the females especially often do not understand Lao. Repeating the reproductive health extension messages in the Lao language results in the messages being confused in their minds.

Action Research should be conducted with the specific aim of identifying gender and cultural implications for designing extension materials. Below is a suggested research program and trial pilot project.

Potential Research Program

- Conduct a specific, localized study and pilot project entitled “Reproductive health issues and IEC Materials Development for Ethnic Villages”, to examine perceptions and health seeking behavior in a limited number of ethnic villages for the specific purpose of designing effective IEC materials. Care must be taken not to generalize findings to pertain to villages of the same ethnicity throughout the country; rather, further studies should be conducted specific to the various areas and the respective ethnic groups.
- Develop trial IEC/health education materials tailored for the specific ethnic group using creative media (drama, songs, VCDs, locally produced modules for schools, posters, cassettes for use over the district or village loud speaker, all in local languages).
- Pilot, field test, and revise the materials and extension methods being developed. Technical expertise will be needed to guide the process.

Ethnic Extension Workers for Pilot IEC

Extension workers can be trained to work in their own communities. Only volunteers motivated to strengthen their own level of reproductive health understanding as well as that of their communities would participate. Community members, both male and female, as well as the ethnic students at the day schools and boarding schools can be trained as peer educators. Boarding school students could impact villages throughout the district when they return to

their villages during the school break. The training for such peer educators could be conducted at the village level whenever possible.

The main concept of a pilot extension project using community members (students, community youth and adults) was drafted in the Beng district workshop. The discussion focused on finding a practical means of training the ethnic students and other local villagers to be informal reproductive health extension workers, as follows:

Proposed Pilot Project Concept:

Government staff need to study/research the needs of the ethnic groups, as well as increase the number of ethnic staff (or interns) working in health services and the hospital

Both students and community members could play a key role in providing local community-based extension. The district could help motivate them by helping set up a contest to see whose team did the most effective extension:

Train a group of ethnic students as extension workers. They could form a mobile team, and be active in community theatre, composing songs and stories, disseminating information. Lower secondary students as well as former students could compose the team.

Recruit and train ethnic community volunteers to conduct extension in their own and neighboring communities. A core group, representative of the population (male and female, married and unmarried), could be trained in basic concepts and methodology and conduct extension for their own and neighboring villages. Training would include the health concepts as well as extension methods, including community theatre.

Source: Beng District Workshop

The study team is confident that local villagers and students would be motivated to participate as volunteers in reproductive health outreach teams. This is based on the high level of enthusiasm demonstrated by the Research Assistants in each of the three districts during the Study, as well as discussions with ethnic students at the Ta'Oy boarding school during the initial visit to the district to prepare for the Study.

In Beng District, a number of the research assistants took action to continue their studies to pursue opportunities as teachers and health workers, as follows:

Research Assistants Motivated through the study

The ethnic Research Assistant youth participating in the Study appeared highly motivated to pursue further education and career options that would help their communities.

In Beng district, the following Research Assistants took steps to continue their education. Some of them already had tentative plans prior to their involvement with the study team, however, they all stated that their participation motivated them to follow through with their plans for further study:

- 1 male Hmong research assistant applied for an HC training programme
- 2 Hmong female research assistants were motivated to try to continue their studies in upper secondary school
- 1 Khmu male research assistant entered the provincial teacher training programme

Source: Beng District Field Notes

The study team is also convinced that a number of the impoverished, remote districts would be interested in partnering in pilot projects for reproductive health. All three of the participating districts have strong potential pilot projects. For example, Meung district has a number of ethnic groups, and highly motivated district leadership, of whom the majority attended the district workshop. The Beng district Governor's closing speech specifically stated the value of the local training provided by the study team local study process, especially towards developing the capacity of local ethnic persons. Any further action research could build upon the foundation provided through the Study training and guided practice process.

Expansion of Reproductive Health Awareness through General Education⁷⁷ with Action Research to Adapt Reproductive health Modules

Dissemination of existing reproductive health materials is needed, along with further adaptation and revision to ensure they are appropriate for each ethnic group:

- Train local teachers (ethnic teachers whenever possible) in new reproductive health curriculum (Primary, Secondary, NFE) which is available in some provincial towns, but not yet extended to many ethnic districts, or the ethnic schools;
- Make reproductive health texts/curriculum available in local schools; and,
- Conduct local workshops with ethnic participants to field test, adapt, and revise reproductive health modules to address local reproductive health needs.

Ethnic Students as Reproductive health Extension Resource

- Train ethnic students as reproductive health outreach/extension workers, and to assist in activities such as reproductive health action research, information collection; and,
- Find creative ways to increase ethnic staff in district departments which partner with reproductive health projects, possibly through internships of ethnic youth.

⁷⁷ Source for recommendations (6.3.3.2): Meung District Education Director

Investigate reproductive health practices as compared with MCH Guidelines/Instructions

An overarching theme to the IEC and action research could be to investigate the reality of reproductive health Practices in the village in relation to MCH Guidelines/Instructions. This would include the impact of local realities of reproductive health service provision and ethnic community reproductive health practices as compared with MCH Guidelines/Instructions. Such research could build directly upon the findings of the Study.

Specific Topics and Locations

The following specific topics are recommended for further exploration in specific locations, with the districts identifying target villages and ethnic groups:

Table 6 Action Research Proposals

Location	Specific Pilot	Specific Action Research Topic
Saravane-		
Ta'Oy District		
General	IEC reproductive health training at District Ethnic School	Local human resources Investigate reproductive health practices in relation to MCH Guidelines/Instructions Find creative ways to increase Katang ethnic staff in district departments which partner with reproductive health projects.

<p>Ta'Oy and Katang Villages</p>	<p>IEC concerning reproductive health in villages</p>	<p>IEC Conduct action research to identify topics and methods for effective IEC , especially for VHV, females and mothers</p> <p>Infant and child health Investigate customs and means to feed infants whose mother has died. Special attention should be given to newborns whose mother died in childbirth.⁷⁸</p> <p>Local human resources Investigate means to strengthen skills/knowledge of birth attendants and local service providers VHV, husband, parents, TBA</p> <p>Conduct survey to identify potential former medics ⁷⁹, and formulate programme to upgrade their reproductive health skills; conduct research on the effectiveness of current TBA training</p> <p>General Investigate the relationship of hygiene to health in general (e.g. related to water supply, skin disease, cholera, etc.)</p>
<p>Bokeo</p>		
<p>Meung District</p> <p>General</p>		<p>Local human resources Meung Education Service and LWU are especially interested in Reproductive</p> <p>Health issues: Education Service requests teacher training in reproductive health curriculum plus supply of new NFE curriculum with Reproductive health topics</p> <p>Find creative ways to increase ethnic staff in district departments which partner with reproductive health projects</p> <p>Action Research Investigate reproductive health Practices in relation to MCH Guidelines/Instructions</p>
<p>Akha Villages</p>	<p>IEC concerning reproductive health in the Akha language</p>	<p>Risk groups Action research concerning potentially risky practices among youth (e.g. sexual initiation, hospitality)</p> <p>Infant and child health Survey concerning causes of high child death rate</p>

⁷⁸ Related to the finding that “the child always dies if the mother dies in childbirth as they do not expect the child to live, and can find no means of feeding it”. The belief in some locations is that: ‘her spirit will come back to get the baby so it will die anyway’.

⁷⁹ e.g former military medics

Lahu Villages	Na IEC concerning reproductive health in the Lahu Na language, especially VCDs, songs (resource is UNESCO Cultural Unit, Bangkok)	IEC Action research to identify topics and methods for effective IEC , especially for VHC, females, and mothers, e.g. tetanus immunizations for girls and women, breast feeding (colostrum), safe sex, girls at risk
Oudomsay		
Beng District General	IEC reproductive health training at District Ethnic School (Na Hom in Beng District; Provincial Ethnic which has students from all northern provinces	Local human resources Survey and identify potential former medics ⁸⁰ in ethnic villages, and formulate programme to upgrade their reproductive health skills Provide scholarships for ethnic youth to study reproductive health related workshops Action Research Investigate reproductive health Practices in relation to MCH Guidelines/Instructions
Khmu Villages	IEC concerning reproductive health in Khmu language	Specific reproductive health issues Conduct survey concerning specific reproductive health issues: maternal mortality, lactation (breast feeding)

⁸⁰ e.g former military medics

Hmong Villages	IEC concerning reproductive health outreach in the Hmong language, especially community drama and songs	<p>Infant mortality Survey reason for high infant mortality within first month of birth (Kiusangvanh village)</p> <p>IEC methods and topics Action research to identify topics and methods for effective IEC , especially for females and mothers (tetanus immunization for girls and women, family planning, infant health, infant immunizations, breast feeding (colostrum)</p> <p>Local resources Identify ethnic youth are in need of scholarships for the lower and secondary school, especially females; provide scholarships for ethnic youth to study reproductive health related workshops</p>
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Issues to Explore Concerning Adapting National Policies & Guidelines and Reproductive health Projects to Local Realities

It is recommended that policies and guidelines be adapted and flexible in order to effectively address local realities. Pilots for specific ethnic locations could trial flexible policies, in order to promote access to reproductive health services and the strengthening of potential reproductive health human resources at the local level.

Criteria for Government Staff

Pilot project for flexible criteria in minority areas, with lower secondary requirement rather than upper secondary.

Immunization Age for Females 15-45

Pilot project to extend tetanus immunization for child-bearing females to ages 12-45 in minority areas, consider possibility of tetanus immunization for males.

Immunization Age for Children up to 1 year

Pilot project to extend age from infancy to up to 5 years of age in minority areas.

Education

The reproductive health modules are designed for lower and upper secondary school. However, ethnic girls often attend primary school only, and are already age 13 (and thereby involved in male/female relationships) in grade 4. Options for effective strategies to consider include the following:

- Design special reproductive health modules to train primary level ethnic girls as peer trainers, as they will likely not have opportunity to attend secondary school; and,
- Investigate the policy requiring girls to leave school due to pregnancy, to see if this could be flexible in minority areas.

Review Implementation of the Poverty Fund

Re: National Decree #52, which says that impoverished people have the right to get free medical treatment, if they have a letter of certification from the village chief. The following example illustrates the issue:

'No Referral, Too Expensive'

Villagers in Hua Namkha village reported that they did not go for treatment to the district hospital, even when by referred by the HC. This was because they could not pay the hospital fee, buy medicines, or provide for their own living expenses. Even with a referral letter from HC and a letter from the village chief guaranteeing that they were impoverished, they could not be sure of getting free treatment.

Source: Discussion after observing case in Hua Namkha Village

6. CONCLUSION

The Study succeeded in training a pool of local ethnic researchers, gathering information, facilitating analysis, and developing recommendations together with the relevant partners. Organizations wishing to support reproductive health initiatives among the six ethnic groups studied, or in the three target districts, would find the detailed reports of the findings useful and of interest. The reports documenting the results of each of the three district review sessions are also valuable as a foundation for further work in this area, as all key stakeholders from the various sectors were active participants in the workshops. In addition, they could tap into the local human resources developed through the study, by working with the pool of local research assistants and local staff who received on-the-job training in qualitative methods through the Study.

The Study provided opportunities for the District authorities and heads of the different district services to be presented with the Study findings, and form working groups to discuss issues and seek solutions. In the words of the Beng district governor:

“I am proud that we have had this opportunity to develop the ethnic persons here, especially concerning reproductive health issues. You have used this opportunity here to really invest your time and efforts for nearly two weeks in our district. The capacity building processes well as the information that you have gathered are very valuable and useful for us.”

It is the hope of the study team that the model of the localized study process will be followed by other organizations for further local information gathering, in order to inform development initiatives, and in particular, those related to reproductive health. If taken forward with further action, the findings and recommendations resulting from the Study should prove useful towards the goal of strengthening ethnic and gender-sensitive approaches to reproductive health project and policy development. This in turn would increase the level of understanding and access to services by all sexes and age groups in the ethnic communities, and in particular, the vulnerable groups within each community. The recommendations from the Study provide concrete suggestions for tailoring health services to the special needs of the ethnic communities, in keeping with the GoL’s goal for improving and expanding basic services to ethnic communities as stated in the National Socio-Economic Development Plan (NSDP) 2006-2010, namely, to:

“... improve and expand the programme of education, health care, culture and information for ethnic group. Increase people’s awareness on preservation and promotion of cultural values and traditions of all ethnic groups s,. Sustain and develop spoken languages and written characters/alphabets. Teach ethnic dialects in schools where ethnic characters/alphabets already exist.”

It is hoped that creative pilots and initiatives will be undertaken at the local level, based upon the recommendations of this study.

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Annex 1 Persons Involved: Study Team Members and Research Assistants

Table 7: Central Level Study Team Members

CPI	PSC (NUOL)	Consultants
Ms.Singkha Khongsavan* Mr. Lienthong Suphanny Mr. Kalouna Nanthavongduangsy (*planning sessions only)	1. Mr. BouaphanThammavong* 2. Ms. Phouvone Phimmavong 3. Ms. Tek Kham Inthasay 4. Mr. Patisith Mithaphapone (*preparation trips only)	1. Ms. Ny Luangkhot 2. Ms. Anne Thomas

Table 8: Provincial Level Study Team Members

Saravane Province	Bokeo Province	Oudomsay Province
1. Mr. Wisian Winthakun (CPI) 2. Ms. Phouthone Keoubouanthong (CPI)	1 Mr. Jom Saysongkham (CPI)* 2. Mr. Jompheng Wilaisone (CPI) 3. Ms. Chansamone (CPI) 4. Ms. Phouvone Siliya (LWU) * Oversaw planning and logistical arrangements, but did not join the team for field work	1. Mr. Siamphone Keobuta (CPI) 2. Ms. Wanthong** (Head of MCH) 3. Mr. Sichan Kosayheu** (Provincial High School) ** Provided technical backstopping for Research Assistants, conducted interviews in local languages
Ta 'Oy District	Meung District	Beng District
Mr. Saykham (Deputy CPI) Mr. Sisuwan* (Deputy District Office)	Mr. Sengphet Keosingthong *(Deputy District Chief)	1. Mr. Sengkeo* (District Chief)

<p>Ms. Phetsamone (MCH, District Health) Mr. Lakeuy (National Front)** Ms. Inthavong (Deputy LWU)**</p> <p>**Conducted interviews in local languages, and provided technical backstopping for Katang and Ta ‘Oy Research Assistants.</p>	<p>Mr. Khamman Chanthalit* (Deputy District Chief) Mr. Khamsuk Keopingsay (CPI) Ms. Khamchang** (District Health) Mr. Phosi Bolameung** (National Front) Mr. Khamsy Yoboseut** (Director, National Front) Mr. Sonesai Leuangmany* (Director, District Education) Ms. Simone*(Director, LWU) Ms. Bun (Deputy, LWU)</p> <p>** Provided technical backstopping for Research Assistants, conducted interviews using related dialects</p>	<p>Director*, CPI Mr. Bounpone Chanthaket* (CPI) Ms. Wongphone* (District Health) Mr. Engna Impathan* (Director, District Education) Mr. Kin Wilaysay *(District Education) Mr. Mayla Sitthilat* (Director, National Front) Mr. Bounhome*(district Youth) Ms. Wansi Inthasone* (Director, LWU) Ms. Khamnang** (Youth) 11. Mr. Chayeu ** (District Health)</p> <p>** Provided technical backstopping for Research Assistants, conducted interviews in local languages</p>
<p>*Note: Participated in planning and district review sessions, but not in field information gathering.</p>		

Table 9: Local Ethnic Research Assistants

Ta ‘Oy	Katang	Akha	Lahu	Hmong	Khmu
<p>Ms. Sisawat Ms. Kommany Mr. Khamneun Mr. Phonesai</p>	<p>Ms. Phoy Mr. Honeret Ms. La*</p>	<p>Ms. Soumontha Ms. Mitti Mr. Maw Mr. Saychong</p>	<p>Ms. Napheu Ms. Yaw* Mr. Jakhony*</p>	<p>Ms. Bouasy Ms. Onekeowsy Mr. Khamsy</p>	<p>Ms. Lyphone* Mr. Nitoudom</p>

*These persons participated in training but did not have sufficient education background to successfully complete the task. The Katang and Khmu did join in the field work, the Lahu did not.

**Ethnic district and provincial team members who conducted interviews together with the Research Assistants.

Annex 2 Reproductive health Study Field Schedule

Schedule for Reproductive health Study in Three Provinces

Part 1: Preparation Trips to 3 Provinces

1) Preparation Trip: Saravane Province (29 April – 1 May 2005)

Visit to Ta 'Oy District

Meet District Governor, Ta 'Oy District

Present objectives of the Study, Present the criteria of local Research Assistants who will conduct village- -level information gathering

Preparation Team from Vientiane:

- Center for Population Studies, NUOL: Mr. Bouaphan, Dr. Khammany, Ms. Phouvone
- Committee for Investment and Planning: Mr. Lienthong, Mr. Kalouna
- Consultants: Ms. Ny Luangkhot, Ms. Anne Thomas
- Saravane Provincial participants traveling to Ta 'Oy with the team:
- Mr. Saynadet (CPI); Mr. Bounyong (MCH)

2) Preparation Trip to Beng District, Oudomsay Province (5 –8 May 2005)

Visit to Beng District

Meet with Office of Planning, Beng District

Present objectives of the Study,

Present the criteria of local Research Assistants who will conduct village- -level information gathering

Visit 4 villages and 3 HCs from which to select the target villages (both study villages and trial village)

Preparation Team from Vientiane

- Center for Population Studies, NUOL: Mr. Bouaphan, Mr. Pathisith
- Committee for Investment and Planning: Mr. Kalouna
- Consultant: Ms. Anne Thomas
- Oudomsay Provincial participants traveling to Beng District with the team:
- Mr. Siamphone, CPI; Ms. Wanthong, MCH Director, Oudomsay Provincial
- Health Service

3) Preparation Trip to Meung District, Bokeo Province: (8-12 May 2005)

Visit to Meung District

Meet with District Chief, Deputy District Governor, and Office of Planning, Beng district:

Present objectives of the Study, present the criteria of local research assistants who will conduct village- -level information gathering

Visit village from which to select the target villages (both study villages and trial study village)

Preparation Team from Vientiane:

Committee for Investment and Planning: Mr. Lienthong
Bokeo Provincial participants traveling to Beng District with the preparation team: Mr. Wanasone, Ms. Chansamone, CPI; Ms. Phuwan, Provincial LWU
Consultant: Ms. Ny Louangkhot

Part 2: Training And Information Gathering in 3 Provinces

1) Province 1: Saravane Province 17 May - 1 June 2005

Note: Saravane was the first province surveyed, and thus the master training for the Central Team from Vientiane was incorporated into the training workshop held at Ta 'Oy District

17 May 2005	Travel from Vientiane, by car and by plane Part of the Study Team translated the community information gathering tools into the Lao language in Pakse, while others went to do advance preparation in Saravane Province, in order to do the necessary coordination with the Provincial planning office and Health Service in order to prepare for the trip to Ta 'Oy District.
18 May 2005	Travel to Ta 'Oy District, meeting with the Deputy District Chief and the District Planning Committee
19-20 May 2005	Hold training at District Hospital Meeting Room
21 May 2005	Trial and field testing of information gathering tools at the trial village of Talung Lalao, within the district town which are within the zone zero of the District Hospital
22-23 May 2005	Training at District Hospital Meeting Room
24-25 May 2005	Divide into 2 teams to gather information in Bong Nam Village, (Ta 'Oy ethnic group) which has an HC located in the village; and Hua Namkha (Katang ethnic group) which has an HC located in the village.
26-27 May 2005	Review workshop with district partners at district meeting room
28 May 2005	Return travel to Saravane Provincial Center
29 May 2005	Information gathering: Provincial Planning, LWU, and Statistics Committee, and World Concern.
30 May 05	Return travel to Vientiane
3 June 2005	Team meeting at Population Studies Center (NUOL), to revise the information gathering form

2) Province 2: Bokeo Province 4-21 June 2005

- 4 June 2005 Travel from Vientiane to Houey Sai, by car and air.
- 5 June 2005 Meet with the head of the Committee for Planning and Statistics, Bokeo Province, present the work plan for Meung District information gathering, prepare the cars and food
- 6-7 June 2005 Prepare car and food for travel from Houey Sai to Meung District
- 8 June 2005 Meeting with the leaders of Meung District, introduce the Study Team, present the objectives of the Study and the works schedule; District coordinated with the villagers in order to prepare the Research Assistants who would participate in the training; and contact each village involved in the information gathering; the district leaders and Study Team traveled to one of the trial villages in order to recruit male and female ethnic Research Assistants for information gathering
- 9-11 June 2005 Training at the District Meeting Room
- 12 June 2005 Divide into 2 teams for the trial information gathering and field testing the information gathering tools in two villages: Phangam Village (Akha ethnic group) which is 7 kilometers from the District Center, (of which the District Hospital provides immunization service at the village level); and Hua Namkha village (Lahu Na Ethnic Group), of which the Ja Law hamlet at the top of the village was the 'trial' site. The Hua Namkha HC is located within the village.
- 13 June 2005 Continued Training at the District Meeting Room
- 14 -15 June 2005 Divide into 2 teams for the field information gathering: Phonesavanh Village (Akha ethnic group), with is Zone Zero of the District Hospital; and Hua Namkha Village (Lahu Na ethnic group), of which 2 hamlets were studied (Ja Feu and Law Sy), one located in the center of the village and the other at the lower end of the hill. All are 'zone zero' (within three kilometers) of the Hua Namkha HC.
- 16 June 2005 Each of the Field Teams presented their findings to the community members for validation, followed by analysis and discussion
- 17 June 2005 Workshop at Meung District with relevant partners to analyse and discuss issues identified by the Study Team from the field information gathering
- 18 June 2005 Travel from Meung District to Houey Sai
- 19 June 2005 Rest day (Sunday)
- 20 June 2005 Report to Provincial Planning Committee, additional information gathering at the Provincial Health, Education

Services and LWU
21 June 2005 Travel from Houey Sai to Oudomsay Province

3) Province 3: Oudomsay Province, 22 June-2 July 2005

22 June 2005 Meeting with Provincial Planning Committee; travel to Beng District, Meeting with District Planning Committee, Health Service, National Front, Education, Youth, and LWU in order to introduce the Study Team, Study objectives, and work schedule; trip to the trial village by the Study Team and District representatives in order to recruit ethnic Research Assistants

23-24 June 2005 Training at the Meeting room of the District Planning Office
25 June 2005 Divide into 2 teams to trial the information gathering tools: Phakeo Village (Hmong ethnicity); and Na Hom Village, located about 1 km from Na Hom HC

26 June 2005 Continued training at the District Meeting Room
27-28 June 2005 Divide into 2 field teams for information gathering: Mang Village (Khmu ethnic group) which is 2 km from and HC; and Kiusangvanh Village, (Hmong ethnic group) which is about 3 km from the Na Pa HC.

29 June 2005 The two field teams present findings to each other followed analysis and discussion

30 June 2005 District level workshop with relevant partners to present findings and discuss issues identified by the Study Team from the field work findings

1 July 2005: Return travel from Beng District to Oudomsay town, additional information gathering at Provincial Level: Education Service, Provincial Committee for the Prevention of AIDS, LWU.

2 July 2005 Return to Vientiane, part of the team traveling by car, and part traveling by plane -

Annex 3 Persons and Institutions Interviewed

Table 10: Number of Villagers Interviewed by Categories

Village	Ethnic Group	Individual Interviews							Group Interviews					
		Never Married	Married Over 35		Married Under 35		Infants (Mothers Interviewed)	Never Married		Married Over 35		Married Under 35		
		M	F	M	F	M	F		M	F	M	F	M	F
BN	Ta 'Oy	2	2	2	2	2	5	5	5	5	5	6	6	4
HNG	Katang	2	2	1	2	2	3	2	5	4	6	4	4	3
HNK	Lahu	4	4	4	4	4	4	5	4	4	4	4	4	4
PS	Akha	4	4	4	4	4	4	5	4	4	4	4	4	4
M	Khmu	4	4	4	4	4	4	5	4	4	4	4	4	4
KSV	Hmong	4	4	4	4	4	4	5	4	4	4	4	4	4
TOTAL		24	24	19	20	20	24	27	26	24	27	26	26	23

Village Authorities and Service Providers

(number of persons in parenthesis, male unless indicated)

Bong Nam (Ta 'Oy)

- Village Chief (1)
- VHV (Clean Water) (1)
- HC Staff (1)
- TBA (1-Female)

Huay Nqua (Katang)

- Village authorities (3)
- HC Staff (1- female)
- TBAs (2-female)

Hua Namkha (Lahu Na)

- Village Chief (1)
- VHV (1)
- HC Staff (1)

- TBA (2-female)
- Teachers (2)
- Private Medicine shop (1)

Phonesavanh (Akha)

- Village Chief (1)
- VHV (1)
- TBA (1-female)
- Head of Village Youth (1)
- LWU (1-female)

Mang (Khmu)

- Village Chief (1)
- VHV for reproductive health (3, of whom 1 was female)
- HC Staff (1)
- TBA (2-female)
- Teachers (2)
- Traditional Healer (1)
- Village Youth Leader (1)
- Private Mobile Medic (1)

Kiusavang (Hmong Jua)

- Village Chief (1)
- VHV (1)
- HC Staff (1)
- Teachers (1)
- Traditional Healers (2)
- Deputy Village Youth Leader (1)
- LWU (1- female)

Provincial and District Levels: Institutions Interviewed

(Lists of names included in Annex 1)

Saravane Province

- DPI
- LWU
- World Concern (NGO working in Bong Nam)

- Ta 'Oy District
- DPI Office
- District Hospital Staff

Bokeo Province

- DPI
- LWU
- Provincial Health
- Provincial Education

- Meung District
- DPI
- LWU
- District Health Office
- District Hospital
- District Education

Oudomsay Province

- DPI
- LWU
- Provincial Health,
- National Commission for the Prevention of AIDS
- Provincial Education

- Beng District
- DPI office
- LWU
- District Health Office
- District Hospital
- District Education
- Private Medicine Shop

Annex 4 Community Interview Tools

The Lao versions should be of special interest to those interested in conducting information gathering, as they have been fine-tuned and adapted for the specific ethnic groups⁸¹.

The Community Questionnaires were adapted from:

“Women’s Interviews in Ta Veng and O’chum villages, Ratanakiri, Cambodia”. Evaluation ICC Health Project, June 2004.

“Guidelines for Focus Groups of Women in Ta Veng and O’chum villages, Ratanakiri, Cambodia”. Evaluation ICC Health Project June 2004.

Which were in turn based up the tools developed and field tested by?
Educating For Good Health, COORD Project Prey Veng Province, Cambodia.

Attached: Introduction/Training Guidelines

ENGLISH FORMS:

Form 1: QUESTIONNAIRE- UNMARRIED (‘NEVER MARRIED’) WOMENS' INTERVIEWS

Form 2: QUESTIONNAIRE= UNMARRIED (‘NEVER MARRIED’) MEN'S' INTERVIEWS

Form 3: QUESTIONNAIRE- MARRIED WOMEN'S INTERVIEWS (UP TO 35, AND OVER 35).

Form 4: QUESTIONNAIRE - MARRIED MEN'S' INTERVIEWS (UP TO 35, AND OVER 35).

Form 5: SURVEY FORM FOR MOTHER OF EACH INFANT UNDER 1 ½ MONTHS (or youngest babies in village)

Introduction

Questionnaires/Training for research assistants included the following guidelines:

Explain this in general terms to the individuals or group:

During this interview/discussion we are trying to find out something about:

Courtship and marriage,

Common health problems and treatment

Marriage, Pregnancy, and Delivery

Information and practice concerning Birth spacing,

HIV/AIDS, (Information, who is at risk, prevention)

Sexually transmitted infections (STIs) and Reproductive Tract Infections (RTIs)

(Information, who is at risk, prevention)

Risk of youth being victims of trafficking or sex services

For each of these, we want to know about what information they have received, and from whom, and in what language, and if they have used the information they have received.

We want to know what kinds of health problems they have, or are at risk of getting, how frequent the problems are, and how they or their friends prevent or treat them.

⁸¹ Numbering systems vary between forms

(On the form we give some possible answers to help you record answers clearly, but do not suggest answers to the persons you are talking to.)

We also want to know the role of the family members, local birth attendants, village health volunteer, HC, and district or provincial hospital in prevention, assistance, treatment, or information and counseling.

Form 1:QUESTIONNAIRE FOR UNMARRIED WOMENS' INTERVIEWS

(never married)

Reproductive health Information Gathering

May 2005

Target group: 4 'never married' women per village,
4 unmarried women
Trial village/Research Village(Circle One)

GENERAL INFORMATION

1. Name of village Ethnic group
.....
Name of Nearby Health Center.....
Education Level..... Currently in school?
Can girl speak and understand Lao well? (Y/N)
2. Number of people in the family
3. Live at home? In boarding school?

QUESTIONS

Health and Pregnancy

- 6 a What kind of health problems do young women your age tend to have?
- 6 b Who do they go to for help if they have health problems? (record which person they go to for what problem. Skip any persons they don't go to)
 - Woman relative or older friend.....
 - Friend of own age.....
 - HC.....
 - Village health volunteer.....
 - Village midwife (Maw Tam Ya).....
 - Private doctors/medicine shops.....
 - Teacher.....
 - Other.....
- 6.c How old are most girls when they get married? Who chooses her husband? (the girl and boy? The parents? The boy?)
- 6.c where do young people learn about sex and pregnancy? From friends? From boyfriends? Parents talk to them? Relatives talk to them? Others?
- 6.e Do any young girls ever get pregnant before marriage? If yes, what are the customs in the village? Who does she go to for health care?

- 6.f What kind of reproductive health problems do young women your age tend to have Unwanted pregnancy? “long khao?” (If so, describe when it comes and what it is like)? itchiness? Irregular or painful periods? Don’t know?
- 6 g Who do they go to for help if they have these health problems? (HC? Private doctor? Village Midwife? District Health Center? Friends?)
- 6 h How does a girl know if she is pregnant?
- 6 i How does she get pregnant?
- 6 j What should she do to take care of herself when she is pregnant?
- 6.k Do girls or women in your village ever have abortions? If yes, please describe why, and where they would go/what they would do to have an abortion.
- 6 l Have you ever had anti-tetanus vaccine? Y / N How many times? 1 2 3
4 5
- Can you tell me what the anti-tetanus vaccine is for?
Did you finish the series? Why or why not?
Do you have a Tetanus card? Y / N (Look at Tetanus card to verify)

Delivery

7. a. What are customs in your village related to childbirth, cutting the cord, etc?

Health Center and Village Health Volunteer

- 8.a. Have you been to the Health Center (HC) in the last year? Y / N
- 8.b How did you communicate with them? (Speak Lao? , take a Lao speaker with you? They speak your language?)
- 8.c Why did you go to the HC?
.....
- 8.d How were they able to help you at the HC?
- 8.e Have the HC staff been to your village in the last year? Y / N
- 8.f How many times has the HC been to your village?
- 8.g What does the HC do in your village?
.....
- 8.h What does the village Health volunteer do in your village?

Breastfeeding and Nutrition

- 10.a Do you know when it is best to start to breast-feed babies after birth?
- | | |
|-----------------------------------|-------------------------|
| 1. first half hour after delivery | 5. 2-3 days after birth |
| 2. 1-2 hours after birth | 6. Other..... |
| 3. 3-8 hours after birth | |
| 4. one day after birth | |
- 10.b What do you think about the first breast milk (colostrum)? Is this good for the baby? (If don’t know, skip this question).
If knows, ask-Why? or why not?
- 10.c What food is usually given to the baby besides breast milk (for newborns until age 1 ½ months old)?
- Only breast milk
 - Water
 - Honey or sugar water
 - Rice

- Other....

Birth spacing

- 11.a What do you know about preventing pregnancy or birth-spacing?(If knows nothing, skip to #12)
- 11.b Where did you learn this information? (HC? Midwife? Volunteer Health Worker? Poster? Friends? Private doctor? Other?)
- 11.c What kinds of birth spacing can you name?
What kinds do young people use, and why?
- 11.d Are you using (or have you ever used) birth spacing? (Y/N) (If no, skip to #12)
- 11.e Who decides about using birth spacing? (boy? girl? Both together? Other ?)
- 11.f Did you every have any problems when using birth spacing? If yes, where did you go for help? If yes, what problems?
Where did you go for help?

.....
.....

HIV/AIDS

- 12.a Do you know about HIV AIDS? (if no, skip to #13)
- 12.b Where did you learn this information? (HC? Midwife? Volunteer Health Worker? Poster? Friends? Private doctor? Other?)
- 12.c How is HIV/AIDS transmitted?
- 12.d How can HIV/AIDS be prevented?
- 12.e Who is at risk for getting HIV/AIDS?
- 12.f Do you know anyone who might have HIV/AIDS?

STIs/RTIs

- 13.a Do you know of anyone with STIs or RTIs? What are common ones in your village?
If don't know, skip to #14)
- 13.b Where do people go for treatment of STIs or RTIs?
- 13.c How are STIs transmitted?
- 13.d How can STIs be prevented?
- 13.e Who is at risk for getting STIs?

Changing Society/Risks associated with travel

- 14.a Do you know of people coming to your village looking for unmarried girls or boys to go work outside the village? If yes, describe.

- 14.b Do you think there are any health risks associated with people going outside the village for work?
If yes, what kind of risks? Who is at risk? How can risk be prevented?

Interviewer.....
Recorder.....
Observer.....
Date.....

Names of woman
(If they don't want to give their names, that is OK)

Form 2:QUESTIONNAIRE FOR UNMARRIED MENS' INTERVIEWS

(never married)

Reproductive health Information Gathering

May 2005

Trial village/Research Village(Circle One)

Target group: 4 unmarried men per village

GENERAL INFORMATION

1. Name of village Ethnic group
.....
Name of Nearby Health Center.....
Education Level.....Currently in school?
Can boy speak and understand Lao well? (Y/N)
2. Number of people in the family
3. Live at home? In boarding school?

QUESTIONS

Health and Pregnancy

- 4.a What kind of health problems do young men your age tend to have?
- 4.b Who do they go to for help if they have health problems? (record the person they go to for what problem. Skip any persons they don't go to)
Woman relative or older friend.....
Friend of own age.....
HC.....
Village health volunteer.....
Village midwife (Maw Tam Ya).....
Private doctors/medicine shops.....
Teacher.....
Other.....
- 4.c How old are most boys when they get married? Who chooses who you will marry? (the girl and boy? The parents? The boy?)
- 4.d Where do young people learn about sex and pregnancy?
From friends? From experimenting with girlfriends? Parents talk to them? Relatives talk to them? Others?
- 4.e Do any young girls ever get pregnant before marriage? If yes, what are the customs in the village? What happens to the boy? Where does she go to for health care?
- 4.f How does a girl know if she is pregnant?
- 4.g How does she get pregnant?
- 4.h What kind of reproductive health problems do men your age tend to have? Itchiness? Discharge? Infections? Other? Don't know?

Health Center and Village Health Volunteer

- 5.a Have you been to the Health Center (HC) in the last year? Y / N
- 5.b How did you communicate with them? (Speak Lao? , take a Lao speaker with you? They speak your language?))
- 5.c Why did you go to the HC?
- 5.d How were they able to help you at the HC?
- 5.e Have the HC staff been to your village in the last year? Y / N
- 5.f How many times has the HC been to your village?
- 5.g What does the HC do in your village?
- 5.h What does the village Health volunteer do in your village?

Birth spacing

- 6.a What do you know about preventing pregnancy or birth-spacing? (If knows nothing, skip to #7)
- 6.b where did you learn this information? (HC? Midwife? Volunteer Health Worker? Poster? Friends? Private doctor? Other?)
- 6.c What kinds of birth spacing can you name?
What kinds do young people use, and why?
- 6.d Are you using (or have you ever used) birth spacing? (Y/N) (If no, skip to #12)
- 6.e Who decides about using birth spacing? (boy? girl? Both together? Other ?)
- 6.f Did you every have any problems when using birth spacing? If yes, where did you go for help? If yes, what problems?
Where did you go for help?

HIV/AIDS

- 7.a Do you know about HIV AIDS? (if no, skip to #13)
- 7.b Where did you learn this information? (HC? Midwife? Volunteer Health Worker? Poster? Friends? Private doctor? Other?)
- 7.c How is HIV/AIDS transmitted?
- 7.d How can HIV/AIDS be prevented?
- 7.e Who is at risk for getting HIV/AIDS?
- 7.f Do you know anyone who might have HIV/AIDS?

STIs/RTIs

- 8.a Do you know of anyone with STIs or RTIs? What are common ones in your village?
If don't know, skip to #14)
- 8.b Where do people go for treatment of STIs or RTIs?
- 8.c How are STIs transmitted?
- 8.d How can STIs be prevented?
- 8.e Who is at risk for getting STIs?

Changing Society/Risks associated with travel

- 9.a Do you know of people coming to your village looking for unmarried girls or boys to go work outside the village? If yes, describe.
- 9.b Do you think there are any health risks associated with people going outside the village for work?

If yes, what kind of risks? Who is at risk? How can risk be prevented?
9.c. Which age group of boys or men is most likely to go outside the village looking for work?

Are there any health risks they or their families could face? Please describe.

Interviewer.....

Recorder.....

Observer.....

Date.....

Names of young man

(If they don't want to give their name, that is OK)

Form 3:QUESTIONNAIRE FOR MARRIED WOMEN'S' INTERVIEWS

Reproductive health Information Gathering May 2005

Trial village/Research Village

(Circle One)

Target group: 4 married women (who have had children) per village,
Women preferably have not participated in focus group discussion,
preferably with a child under 1 year old if possible (0-12 months)

4 women under age 35

4 women over age 35

(Circle one of the above)

GENERAL INFORMATION

1. Name of village Ethnic group

.....

Name of Nearby Health Center.....

Education Level

Can the woman speak and understand Lao well? (Y/N)

2.a Age of woman

2.b Age of youngest child.... /months

3. Number of people in the family

4. Total number of children (living and dead) living ... dead ... miscarriages
/abortions

5.a Age of oldest child now

5b. Age of youngest child now

.....

QUESTIONS

Health and Pregnancy

6 a What kind of health problems do women your age tend to have?

6 b What kind of reproductive health problems do women your age tend to have? Unwanted pregnancy? "long khao?" (If so, describe when it comes and what it is like)? itchininess? Irregular or painful periods? Don't know?

Where do they go for treatment or counseling?

(record which person they go to for what health problems. Skip any persons they don't go to)

- Woman relative or older friend.....
- Friend of own age.....
- HC.....
- Village health volunteer.....
- Village midwife (Maw Tam Ya).....
- Private doctors/medicine shops.....
- Teacher.....
- Other.....

- 6.c When you were pregnant last time did you go to anyone for an examination or counseling? If so, what did they counseling or assistance did they provide? (HC? Village Midwife? Village Health volunteer? Private Doctor? District Health Center? Friends?)
Have you ever been to a midwife or HC for an exam when you were pregnant?
- 6.d Have you ever had anti-tetanus vaccine? Y / N How many times? 1 2 3
4 5
Can you tell me what the anti-tetanus vaccine is for?
Did you finish the series? Why or why not?
- 6.e Do you have a Tetanus card? Y / N (Look at Tetanus card to verify)
- 6.f Where do women go if they have trouble during pregnancy? What kind of problems are common during pregnancy?
How/where are they treated?
- 6.g What customs/food taboos do you have when pregnant?

Delivery

- 7 a Who helps women deliver your babies?
Husband? Relatives? Village Midwife? HC? District or Provincial Hospital?
- 7.b What kind of problems might a woman face during childbirth?
- 7.c If there are any problems with delivery, where does the woman go?
Where does she go first? Where does she go if that is not successful?
- 7.d Who makes the decision to go for help? (woman? Husband? Relatives?)
- 7.e What problems during delivery can be successfully solved? by whom?
- 7.f What are customs in your village related to childbirth, cutting the cord, etc?
- 7.g If you have had deliveries both at the HC and in the village, how are they different?
- 7.h Do women in your village ever have abortions? If yes, please describe why, and where they would go/what they would do to have an abortion.

Health Center and Village Health Volunteer

- 8 a Have you been to the Health Center (HC) in the last year? Y / N
- 8.b How did you communicate with them? (Speak Lao? , take a Lao speaker with you? They speak your language?))
- 8.c Why did you go to the HC?
.....
- 8.d How were they able to help you at the HC?
.....
- 8.e Have the HC staff been to your village in the last year? Y / N
- 8.f How many times has the HC been to your village?
- 8.g What does the HC do in your village?
- 8.h What does the village Health volunteer do in your village?

Child's Vaccinations

- 9a Has your youngest child ever been vaccinated during its first 6 months? Y / N (If no, skip to #10)

9b How old for the first vaccination?

9c Do you have a vaccination record (yellow card?) for the child? Y / N (Look at card to verify the vaccinations)

Breastfeeding and Nutrition

10 a When did you start to breast-feed your youngest child after birth?

- | | |
|-----------------------------------|-------------------------|
| 1. first half hour after delivery | 5. 2-3 days after birth |
| 2. 1-2 hours after birth | 6. Other..... |
| 3. 3-8 hours after birth | |
| 4. one day after birth | |

10 b What do you think about the first breast milk (colostrum)? Do you give this to the baby? Why or why not?

10 c What food do you give to the baby besides breast milk (for newborns until age 1 ½ months old)?

1. Only breast milk
2. Water
3. Honey or sugar water
4. Rice
5. Other....

Birth spacing

11.a What do you know about birth-spacing? (If knows nothing, skip to #12)

11.b Where did you learn this information? (HC? Midwife? Volunteer Health Worker? Poster? Friends? Private doctor? Other?)

11.c What kinds of birth spacing can you name?

What kinds are popular in your village, and why?

Do the men ever use condoms?

Who goes to get the birth spacing supplies, the husband or the wife?

11.d Are you using (or have you ever used) birth spacing? (Y/N) (If no, skip to #12)

11.e Who decides about using birth spacing? (husband? Wife? Both together? Other relatives? Other ?)

11.f Did you every have any problems when using birth spacing? If yes, where did you go for help? If yes, what problems?

Where did you go for help?

HIV/AIDS

12.a Do you know about HIV AIDS? (if no, skip to #13)

12.b Where did you learn this information? (HC? Midwife? Volunteer Health Worker? Poster? Friends? Private doctor? Other?)

12.c How is HIV/AIDS transmitted?

12.d How can HIV/AIDS be prevented?

12.e Who is at risk for getting HIV/AIDS?

12.f Do you know anyone who might have HIV/AIDS?

STIs/RTIs

- 13.a Do you know of anyone with STIs or RTIs? What are common ones in your village?
If don't know, skip to #14)
- 13.b Where do people go for treatment of STIs or RTIs?
- 13.c How are STIs transmitted?
- 13.d How can STIs be prevented?
- 13.e Who is at risk for getting STIs?

Changing Society/Risks associated with travel

- 14.a Do you know of people coming to your village looking for unmarried girls or boys to go work outside the village? If yes, describe.
- 14 b Do you think there are any health risks associated with people going outside the village for work?
If yes, what kind of risks? Who is at risk? How can risk be prevented?
- 14. c Do you see any health risks in the village in recent years, which were not problems when you were younger? If yes, describe.

Form 4:QUESTIONNAIRE FOR MARRIED MEN'S' INTERVIEWS

(UP TO 35, AND OVER 35).

Reproductive health Information Gathering

May 2005

Trial village/Research Village

(Circle One)

Target group:

8 married men (who have had children) per village,

Men preferably have not participated in focus group discussion,

preferably with a child under 1 year old if possible (0-12 months)

Interviewees:

married men under age 35 who have children (4 persons)

married men over age 35 who have children (4 persons)

(Circle correct age group above)

GENERAL INFORMATION

- 1. Name of village Ethnic group
-
- Name of Nearby Health Center.....
- Education Level
- Can he speak and understand Lao well? (Y/N)
- 2.a Age 2b. Age of children.....
- 3. Number of people in the family Number of times married
- Number of wives now.....
- 4. Total number of children (living and dead)/living/dead
- 5.a Age of oldest child now 5b. Age of youngest child now
-

QUESTIONS

Health

- 6.a What kind of reproductive health problems do men your age tend to have? Where do they go for treatment?
(record answers below, skip any person they don't go to)
- Male relative or older friend.....
- Friend of own age.....
- HC.....
- Village health volunteer.....
- Village midwife (Maw Tam Ya).....
- Private doctors/medicine shops.....
- Teacher.....
- Other.....

- 6 b When your wife was pregnant last time, did she go to anyone for an examination or counseling? (If don't know, skip to next question)
If he knows, where- HC? Village Midwife? District Health Center? Friends?)
- 6.c Where do women go if they have trouble during pregnancy? How/where are the problems best treated?
Who decides where they go and what treatment? What is the husband's role?
- 6d What kind of reproductive health problems do men your age tend to have? Itchiness? Discharge? Infections? Other?

Pregnancy and Delivery

- 7.a What is the husband's role during the pregnancy? During delivery After delivery?
- 7.b Who helps women deliver their babies?
Husband? Relatives? Village Midwife? HC? District or Provincial Hospital?
- 7.c What kind of problems might a woman face during childbirth?
- 7.d If there are any problems with delivery, where does the woman go?
Where does she go first? Where does she go if that is not successful?
- 7.e Who makes the decision to go for help? (woman? Husband? Relatives?)
- 7.f What problems during delivery can be successfully solved? by whom?

Health Center and Village Health Volunteer

- 8 a Have you been to the Health Center (HC) in the last year? Y / N
- 8.b How did you communicate with them? (Speak Lao? , take a Lao speaker with you?
They speak your language?)
- 8.c Why did you go to the HC?
.....
- 8.d How were they able to help you at the HC?
.....
- 8.e Have the HC staff been to your village in the last year? Y / N
- 8.f How many times has the HC been to your village?
- 8.g What does the HC do in your village?
- 8 h What does the village Health volunteer do in your village?
- 8 i How often do private doctors come to your village?

Birth spacing

- 9.a What do you know about birth-spacing? (If knows nothing, skip to #12)
- 9.b Where did you learn this information? (HC? Midwife? Volunteer Health Worker?
Poster? Friends? Private doctor? Other?)
- 9.c What kinds of birth spacing can you name?
What kinds are popular in your village, and why?
Do the men ever use condoms?
- 9 d Are you using (or have you ever used) birth spacing? (Y/N) (If no, skip to #12)
- 9 e Who decides about using birth spacing? (husband? Wife? Both together?
Other relatives? Other?)
- 9 f What are popular methods? Why?
What are unpopular methods? Why?

9 g Did you or your wife or friends every have any problems when using birth spacing? If yes, where did they go for help? If yes, what problems?

HIV/AIDS

- 10.a What do you know about HIV AIDS? (if no, skip to #13)
- 10.b Where did you learn this information? (HC? Midwife? Volunteer Health Worker? Poster? Friends? Private doctor? Other?)
- 10.c. How is HIV/AIDS transmitted?
- 10.d How can HIV/AIDS be prevented?
- 10.e Who is at risk for getting HIV/AIDS?
- 10.f Do you know anyone who might have HIV/AIDS?

STIs/RTIs

- 11.a Do you know of anyone with STIs or RTIs? What are common ones in your village? If don't know, skip to #14)
- 11.b Where do people go for treatment of STIs or RTIs?11.c. How are STIs transmitted?
- 11.d How can STIs be prevented?
- 11.e Who is at risk for getting STIs?

Changing Society/Risks associated with travel

- 12.a Do you know of people coming to your village looking for unmarried girls or boys to go work outside the village? If yes, describe. (If no, skip to question 12 e)
- 12 b Do you think there are any health risks associated with people going outside the village for work? If no, skip to question 12c.
If yes, Do you think people going know about the risks?
If yes, what kind of risks? Who is at risk? How can risk be prevented?
- 12 c Which age group of men travels out of the village more for jobs? (young unmarried, young married, older married?)
- 12 d Do you know of any health risks for them? If yes, explain.
Do you know of any health risks for their families when they return to the village? If yes, explain.
- 12.e Do you see any health risks in the village in recent years, which were not problems when you were younger? If yes, describe.

Interviewer.....

Recorder.....

Date.....

Name of Interviewee (only if they want to give their name).....

Form 5: SURVEY FORM FOR MOTHER OF EACH INFANT UNDER 1 ½ MONTHS

General Information

1. Name of Mother.....
2. Name of Father.....
3. Name of child.....
4. Age in Months.....
5. Sex: M/F

5. Where was the child born?
 1. At home
 2. At health center
 3. At District hospital
 4. At Provincial Hospital
 5. Other.....

6. Who helped deliver the child? (Name.....)
 1. Trained midwife
 2. Untrained midwife
 3. Health Center staff
 4. District Midwife
 5. Relative (what relation?.....)

7. Is this child still alive?
 1. Yes- go to #10
 3. No

8. How old was the baby when it died?days.....weeks.....months

9. What was the cause of death (May be more than one answer)
 - Fever
 - Don't know
 - Too small
 - Diarrhea
 - Tetanus/stiff body
 - Cried too much
 - Vomiting
 - Other.....

10. How soon did you start to breast feed this child after delivery?
 - In the first half hour after birth.....
 - 1-2 hours after birth.....
 - 3-8 hours after birth.....
 - one day after birth.....
 - 2-3 days after birth.....
 - Other.....

11. Are you giving the child food other than breast milk? If so, what?

12. Has the child had any vaccinations? Y/N
13. Do you have a vaccination card?
 - No, never received one
 - Lost it
 - Child has never been vaccinated
 - Child is too young to be vaccinated
 - Health center staff keep the vaccination card
 - Parents don't want child vaccinated
 - Health Center staff have not yet come to do vaccinations
14. Who is the main care giver for the baby?
15. What relationship does the respondent have with the child?
 Mother? Father? Grandmother? Grandfather? Aunt? Uncle? Foster mother?
 Other?.....)

THANK YOU VERY MUCH FOR ANSWERING THESE QUESTIONS

Interviewer.....
 Recorder.....
 Observer.....
 Date.....

Names of person interviewed

 (if they don't want to give their name, that is OK)



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