

# Reproductive Health at the Margins

## Results from PEER Studies in Southern Laos



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## Foreword

The report of the Participatory Ethnographic Evaluation and Research (PEER) was conducted in collaboration with the Centre for Information and Education for Health (CIEH), Ministry of Health, provincial health department of Saravan, Sekong and Attapeu, Lao Women's Union and Lao Youth Union. This study was supported by United Nations Population Fund (UNFPA), Lao PDR, and Option Consultancy Services, UK provided technical assistance.

The PEER study took place from November 2007 – January 2008 and was undertaken in Saravan, Sekong and Attapeu to gain a better understanding of the social context of ethnic and rural women's perceptions of marriage, family relations, gender norm and health-related behaviour, their livelihood strategies, and information sharing channels. PEER is qualitative method that produces actionable results in around 10 weeks. In PEER, members of the community are full participants in setting research agenda, conducting discussions, and analyzing information. The method does not rely on written tools, hence can be used with any community whether literate or non-literate.

PEER taps into the already established trust to generate rich data of narratives and stories to give insight into how people view their world, conceptualize behavior and experiences and make decisions on key issues. But this research does not attempt to represent all ethnic groups in Saravan, Sekong and Attapeu provinces. The variety of ethnic groups and contexts in which they live are too great for this relatively small study to capture. This study covered fifteen villages in two districts in Sekong province (Lamam and Kaluem), three districts in Saravan province (Saravan, Ta Oy and Toumelane) and three districts in Attapeu (Phouvong, Sanexay and Sanamxay).

Nevertheless, the study collected rich information on (1) insider views of social and cultural beliefs and practices relating to pregnancy, childbirth, family planning, and STIs; (2) decision-making and health seeking behaviours; (3) barriers to using reproductive health services. The findings of this research informed the development of the UNFPA-supported demand creation programme for reproductive health services which will complement the work of the reproductive health service provision programme in order to increase use of contraceptives, attendance of skilled personnel at deliveries, and reduce early marriage and unwanted pregnancy. The overall aim is to reduce maternal and infant mortality.

We thank all the women participating in the research, taking parts as PEER researchers as well as those women that shared their views and opinions. We also thank all of those dedicated individuals who assisted in conducting the PEER study, analyzing, writing and advising the PEER report. They provided us with this important information for improving reproductive health services for three southern provinces of Lao PDR.

Mieko Yabuta  
UNFPA Representative  
Vientiane Lao PDR

## Research Teams

### **Sekong Province**

Ms Sally Sakulku	Consultant for UNFPA
Dr Joanne Hemmings	PEER advisor, Options Consultancy Services
Dr Sengsay Siphakanlaya	Programme Officer, UNFPA
Mr Phonesavanh Keomanyone	Programme Assistant, UNFPA
Dr Bounsong Douangpraseuth	Chief of Research & Training Division, Centre of Information & Education for Health, Ministry of Health
Ms Thong Nheme Champavilay	Technical staff, Lao Women's Union
Ms Choumaly Chanethavong	Statistician, Provincial Health Department, Sekong
Ms Linxay Phasaveng	Technical staff, MCH Division, Provincial Health Department, Sekong
Ms Kongkeo Ounninhom	MCH Officer, District Health Office, Lamam
Ms Chantala Heuangpaseuth	MCH Officer, District Health Office, Kaleum

### **Saravan Province**

Ms Sally Sakulku	Consultant for UNFPA
Ms Sonenaly Phetsavong	Reproductive Health Programme Assistant, UNFPA
Dr Bounsong Douangpraseuth	Chief of Research & Training Division, Centre of Information & Education for Health, Ministry of Health
Ms Maniphet Chounlamany	Technical staff, Lao Youth Union
Dr Somkit Boualavong	Chief of MCH division, Provincial Health Department, Saravan
Dr Phonphet Phoxay	MCH Officer, Provincial Health Department, Saravan
Ms Tiksavanh Boutlavanh	MCH Officer, District Health Office, Saravan
Ms Saysamone	Technical staff, Provincial LWU, Saravan
Ms Thongdouang	MCH officer, District Health Office, Toumlane
Ms Douangchan Phouangchampa	MCH Officer, Provincial Health Department, Saravan
Ms Khamphong	MCH Officer, District Health Office, Ta Oy

## **Attapeu Province**

Dr Sengsay Siphakanlaya	Programme Officer, UNFPA
Mr Phonesavanh Keomanyone	Programme Assistant, UNFPA
Ms Thong Nheme Champavilay	Technical staff, Lao Women's Union
Dr Saysana Kethsisouphanh	Statistician, Provincial Health Department, Attapeu
Mr Keo-Oudone Soulileuth	Health Educator, Provincial Health Department, Attapeu
Ms Banthalay Koemanivong	Chief of Cabinet, Provincial LWU, Attapeu
Mr Khampheuang Saysongkham	Chief of District Health Office, Phouvong
Ms Phouangsith Saysongkham	Vice Chair of District LWU, Phouvong
Ms Keosamone Koeyasack	Chair of District LWU, Sanexay
Ms Phanakhone	MCH Officer District Health Office, Sanexay
Ms Vongphet	MCH Officer District Health Office, Sanamxay
Ms Nouphat Chanthaphay	Head of Cabinet District LWU, Sanamxay

# CONTENTS

1	Research Summary .....	10
2	Person Profiles .....	15
3	Implications for Demand Creation Programme .....	19
3.1	Prioritising key issues .....	19
3.2	Priority One.....	19
3.3	Priority Two.....	22
	Box 1. Women’s groups and birth outcomes in Nepal.....	23
3.4	Priority Three .....	24
3.5	What is demand creation in this context? .....	26
	Box 2. Components of Demand Creation.....	27
3.6	Recommended approach to tackling marginalisation at district level.....	28
	Box 3. Illustrating the importance of empowerment .....	28
	Table 1. Information, education and communication compared with empowerment approaches .....	28
	Box 4. What can participation do? .....	30
	Box 5. Key Informant Monitoring in the Supporting Safe Motherhood Programme, Nepal .....	31
3.7	Tailored Implementation.....	32
	Box 6. Stages of Change.....	33
3.8	Messages, materials and tools.....	34
3.8.1	Characteristics of a good message .....	36
3.9	Channels for delivering demand creation .....	37
3.9.1	Interpersonal communications.....	37
3.9.2	BCC and IEC materials .....	38
3.9.3	Mass media communications .....	39
3.9.4	Other innovative approaches.....	39
3.10	Reducing financial barriers to access.....	40
	Box 7. Current initiatives to reduce financial barriers to health care in Laos.....	41
3.11	Implications for supply side activities .....	42
4	Detailed PEER Report .....	43
4.1	Programme objectives .....	43
4.2	Research objectives.....	44
4.3	Research method: Overview of PEER .....	44
4.3.1	Selection of Peer Researchers.....	46
4.3.2	Peer Researcher Training Workshop .....	47

4.3.3	Data Collection.....	47
4.3.4	Data Analysis .....	48
5	Background: Reproductive Health and Ethnic Groups in Laos.....	49
6	Findings.....	52
6.1	Study context.....	52
6.1.1	Sekong Province .....	52
6.1.2	Health Services .....	53
	Box 8. Summary of health services in Kaleum and Lamam districts .....	54
6.1.3	Ethnicity and language.....	54
6.1.4	Livelihoods .....	55
6.2	Social life .....	59
6.2.1	Schooling .....	60
6.2.2	Marriage.....	61
6.2.3	Gender dynamics.....	63
6.3	Reproductive health.....	66
6.3.1	Pregnancy.....	66
6.3.2	Childbirth.....	70
6.3.3	Post-partum period.....	73
6.3.4	Demand for family planning.....	76
6.3.5	Perceptions and experiences of family planning.....	78
6.3.6	Sexually Transmitted Infections.....	83
6.3.7	Immunisation.....	83
6.4	Perceptions of illness, health and treatment seeking.....	84
6.4.1	Treatment seeking .....	84
6.4.2	Financial barriers to access and provider attitudes.....	85
6.5	Communications .....	88
7	Bibliography.....	91
8	Appendices.....	93
	Appendix 1. PEER results, Saravan and Attapeu Provinces.....	93
	Appendix 2. Peer researcher prompts .....	103
	Appendix 3. What is a rights-based approach?.....	105

## Acronyms

ANC	Antenatal care
BCC	Behaviour change communication
CBD	Community Based Distributor (of contraceptives)
CIEH	Centre for Information and Education for Health
CPR	Contraceptive prevalence rate
IEC	Information, education and communication
LWU	Lao Women's Union
LYU	Lao Youth Union
MCH	Mother and child health
MMR	Maternal mortality rate
MWH	Maternity waiting home
NGO	Non-governmental organisation
PEER	Participatory Ethnographic Evaluation and Research
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
VHV	Village Health Volunteer
WHO	World Health Organisation

## **Report Structure**

This report is structured as follows:

### **Research summary:**

- Main findings
- Implications for demand creation programme
- 'Person profiles' – characters created by peer researchers to represent a typical person like them

### **Main report:**

- Background: introduction, literature review, methods
- Main findings for Sekong Province in detail with illustrative quotations
- Bibliography
- Appendices, including summary of findings from Attapeu and Saravan Provinces, with illustrative quotations

# 1 Research Summary

**Background:** This study took place from November 2007 – January 2008, with the aim of understanding perceptions and behaviour related to reproductive health among vulnerable ethnic communities in Sekong, Attapeu and Saravan Provinces, southern Laos. Findings will inform the design of a UNFPA-led demand creation programme for reproductive health services. In particular, this report explores possible barriers to effective use of reproductive health services. Using the PEER method<sup>1</sup>, local women developed their own research questions, interviewed their friends, and fed back findings to the research team. They collected detailed qualitative data on determinants of risk and barriers to accessing services. The PEER method is particularly suitable for gathering data in hard to reach, non literate groups. This report suggests ways in which the community participation initiated by the research could continue into the next phase of the demand creation programme. This report focuses on findings from Sekong Province. Data from Attapeu and Saravan are summarised in Appendix 1.

**Study context:** Sekong, Attapeu and Saravan provinces are populated by numerous different ethnic groups, each with their own languages and customs, but sharing many similarities: they are largely rice farmers, who practice animist religion, and who supplement their livelihoods by hunting and gathering wild foods. Social, economic and health indicators for ethnic groups in rural areas tend to lag behind those for peoples in urban areas. In particular, disparities exist in reproductive health indicators such as maternal mortality rate (MMR), and contraceptive prevalence rate (CPR). These ethnic groups are often seen as very 'different' from the Lao Loum majority ethnic group in Laos, and as both geographically and culturally isolated. However, great social and economic change is occurring among these ethnic groups as the government increases efforts to draw them closer to towns and away from remote forest highlands. Widened participation in the market economy, increasing contact with government services (formal schooling, modern health services), and the relocation of many communities are all impacting on norms and behaviours related to reproductive health.

**Findings:** Rather than looking at 'barriers to access' (which implies that people want to access services but are prevented from doing so), this report asks *'Why are ethnic*

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<sup>1</sup> Participatory Ethnographic Evaluation and Research

*groups not making full use of available reproductive and maternal health services, and what might prevent them from doing so in future?’* From this perspective, numerous factors emerge from the data:

### **Negative perceptions and experiences of services**

- **Expectations dashed:** communities report being promised free services which actually cost money, and safe contraceptives which are then perceived to have side effects. This results in lack of trust and unwillingness to use services again.
- **Fear of side effects from contraceptives:** women and men feared that contraceptives could damage women’s health. Women sought information and reassurances about contraceptives, but little information is available. Rumours and stories about ill-effects have spread quickly in communities. Women want to find a method that ‘agrees’ with them but have limited choice.
- **Perception of providers:** there were fears of unpredictable costs at health facilities; many providers do not speak ethnic languages; some providers are said to scold or ignore poor and ethnic patients.

### **Lack of perceived need for services**

- Although there is demand for family planning in many villages, **large family sizes are often seen as desirable** for household and agricultural productivity.
- **Unwillingness to engage in new behaviours** for which there is little perceived need (e.g. attending antenatal care, using IUDs, attending hospital to deliver).
- **Low levels of risk perception** around potentially risky behaviours (lack of skilled birth attendants, early childbearing).
- **Women take pride in their resilience** (e.g. not resting after childbirth), and question why they should change from the ways of their parents.
- **Competing priorities:** food production, other illnesses, and domestic duties compete for time and attention with self-care activities and accessing health care and services.

### **Historical, political and social factors**

- **Introduction of reproductive health services linked to eroding of traditional ways of life:** the identity and perceived wellbeing of some ethnic communities, according to their responses in the research, is threatened by developments such as relocation programmes and dam building. Behaviour change initiatives, such as promoting family planning or attending health facilities for childbirth, may be

perceived as unnecessary attempts at changing their way of life, and may be resisted by some community members.

- **Communities have not been empowered** to participate in managing the introduction of reproductive health services, to articulate their own demands, or to hold providers to account. Apart from a few selected (and inevitably male) leaders, individuals participate in health programmes as passive recipients of information and services, which is likely to limit the effectiveness of programmes.
- **Services new and barely known:** for many communities, technologies such as contraceptives are still very new.
- **Ethnic practices and traditions** such as birthing alone in the forest or making an animal sacrifice before attending hospital may increase risk of adverse health outcomes. However, these practices are not static; there is evidence of behaviour change across the region.
- **Gender norms and dynamics:** men retain decision making power, but many are unwilling to attend village events on reproductive health or gender equality, or do not support their wives in using contraception.

#### **Affordability of services**

- **Users cannot afford services and associated costs** such as hospital fees, medication, blood tests, and transport. They fear costs mounting uncontrollably.
- **User fees appear unpredictable and uneven** across service providers.
- **Not wanting to spend money or assets:** fear of debt, not wanting to impoverish household by liquidising assets.
- **Subsistence farmers are cash poor:** it is difficult for some people to find enough cash for even small registration fees (5,000-10,000 kip<sup>2</sup>).

#### **Accessibility of services**

- **Health facilities difficult to reach** due to nature of geography and terrain. Some villages are up to five days walk from district health facilities, along steep, uneven, narrow paths. Risks include wild animals and having to cross rivers.
- **Transport and associated costs:** including opportunity costs such as missing out on domestic duties while visiting services.



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<sup>2</sup> Between US \$0.57 - \$1.14: at the time of writing, one US \$ was worth 8756 kip.

- **Coverage of mobile services inadequate and irregular:** Very few villages are covered by Community Based Distributors of contraceptives (CBDs). Mobile immunisation teams (who recently began to distribute contraceptives) only visit 3-4 times a year. Maternal and child health teams visit less frequently and do not visit all villages.

### **Implications for demand creation programme**

The evidence base generated by these studies will be important for designing an appropriate, rather than generic, demand creation strategy. In designing such a strategy, efforts must be focussed on priority behaviour change areas with known potential to reduce maternal mortality, and which are amenable to change within the scope of the programme. PEER results suggest three priority behaviour change areas<sup>3</sup> for the strategy:

- **Increase knowledge and awareness** around family planning for men and women, including addressing perceived risks associated with contraception
- **Develop community capacity** to stay healthy, make healthy decisions when planning for childbirth, and respond appropriately to obstetric emergencies
- **Build linkages** between and within communities and health services, by promoting attendance at health facilities for ANC services and skilled delivery

In order to succeed in changing behaviour in these areas, and in line with WHO recommendations, it is strongly recommended that UNFPA and its partners develop **participatory, gender-sensitive, rights-based ways of working** with these communities, with the aim of empowering communities members to improve their control over maternal health and increase their access and utilisation of quality health services (WHO 2006). Empowerment is a process of gaining internal skills and overcoming external structural barriers in accessing resources (WHO 2006). This is particularly important given the marginalisation of some ethnic groups, and of groups within these communities such as women. Empowerment strategies help to produce sustainable groups, help to build self efficacy and collective efficacy, encourage the adoption of healthier behaviours, and increase the effective use of health services (WHO 2006). Practical suggestions for how UNFPA and its partners can work towards empowering communities are discussed in section 3.

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<sup>3</sup> Building capacity, increasing awareness and developing linkages are three of the four priority areas for working with individuals, families and communities recommended by the WHO Making Pregnancy Safer initiative. The fourth recommended area is improving the quality of services, which is being addressed by a separate supply-side programme.

**Finally, it is essential that the demand creation programme work in tandem with supply side activities** to ensure that demand created and promises made are fulfilled. If expectations of reproductive health services are generated in the community, the supply side must be able to meet this demand with quality services. It is recommended that the supply side particularly focus on increasing the transparency of health care costs and improving client/provider relationships by improving both technical and communication competencies of providers.

## 2 Person Profiles

At the end of the study, local researchers were asked to describe a 'typical woman like them'. In Lamam district, this character was named 'Noi'. Reading about her life helps bring findings to life, and encourages providers and programmers to think about issues from the point of view of those they are trying to serve. Similar profiles were developed for Kaleum, Xanexay and Sanamxay districts.

### **Person profile from Lamam District: 'Noi'**

Noi is 25 years old, and married with three children (a girl and two boys). She farms paddy fields and also grows vegetables and beans. She sells her vegetables and chickens to earn money. The family supplement their diet by finding frogs, and picking wild vegetables and bamboo shoots. Their village was relocated from a remote area seven years ago. Noi's husband goes out drinking, but on the days he isn't drinking, he helps out a little bit around the house. Noi works very hard, every day, pounding rice, and feeding the ducks. When she is working her husband or mother-in-law looks after the children. She earns a bit of money for use within the family by selling birds, but it is always insufficient: she just has enough to get by. She enjoys gardening. She also goes looking for casual paid work on farms, such as plantations owned by the Vietnamese nearby. Noi enjoys listening to the news on the radio, and also watches some TV programmes at a neighbour's house.

Noi's best friend is called Pang. Together, they sit under a tree and talk about everything, such as how to improve their lives, and about their husbands. They compare their husbands, talking about what makes a good husband and what makes a bad husband. They agree that a bad husband is one who goes out drinking in the evening to small beer shops.

They also discuss contraception, and what would be the best method for her. She has asked Pang whether she could help her by going with her to see the doctor. She hasn't asked her husband about contraception yet, but if she decided she wanted to use it she would ask Pang to go and talk to her husband for her, to explain why it was a good idea.

## Person profile from Kaleum District: 'Kai'

Kai is 32 years old, married, and has five children, one of whom died in infancy. All of the children were born either at home in the kitchen, or in a hut near the rice fields if it was harvest time, as they live out by their fields at that time of year. She does upland rice farming, which involves clearing woodland before planting crops. Wild foods from the forest are an important part of the family's diet: her husband goes hunting and fishing, and she seeks out wild plants, shrimps and small fish. They have a tiny cash income: her husband sells scrap iron when he finds it in the forest. They only sell their animals in emergencies. The labour of her family is crucial to the household – the extended family relies on each other, including the children, to help with the work.



Kai does not use birth spacing methods, and only heard about them for the first time last year when a mobile immunisation team visited her village. She does not feel comfortable about going on the nine hour walk to hospital for ANC or birth spacing methods as she does not know any women who have been there before. Although she does not want any more children, several people in the village have said that contraceptives can make women very weak and ill, which would be no good for her as she has to work hard all the time.

In the evenings, if she has time, she will sit with her women friends, smoking a pipe and chatting. But they have to get up early to pound rice. Sometimes they go to the chief's house and watch a DVD drama about avian flu, or sit together sharing meat from a successful hunt.

## Person profile from Xanexay District: 'Mrs Keo'

Ms. Keo 36 years old, and is married with five children: one girl and four boys. She is from the Alak ethnic group. She farms paddy fields, and does upland rice farming. She works hard every day: her daily work includes cooking, cleaning the house, feeding her pig, ducks and chickens, growing vegetables, pounding rice, and collecting water. After finishing the housework she goes out to collect firewood or collects long grass



for the roof of the house, or finds frogs, and picks wild vegetables and bamboo shoots. She earns money by selling her pigs and chickens, but it is not sufficient for the family's needs.

Her husband is 40 years old and his daily work is paddy rice farming, slashing and burning for upland rice planting, fishing, and sawing wood for constructing houses. Sometimes her husband assists her in cooking, feeding the animals and looking after the children, but he does not do this very frequently. Her husband likes to drink with his friends in her house, and he is always drunk. When he gets drunk he sometimes loses his temper and argues with her.

During pregnancy, Mrs Keo has never attended prenatal care in hospital or at the dispensary. She works hard as normal during pregnancy. She has always given birth at home with the assistance of a traditional birth attendant (TBA) or traditional (faith) healer. Her husband and relatives help to boil water. Her husband is very happy when he has a new child. She stays by the fire (hot bed) for only three days after giving birth. During this time she takes a rest but after three days she will return to work as normal.

Mrs Keo has a best friend, Mrs Deng, who is 30 years old, and is married with three children: a girl and two boys. They both like to sit together and listen to the radio. The programmes that they like are country songs, folk songs, traditional songs and health programmes on birth spacing. She talks to Deng about daily life, the family economy, and she also talks to her friend about her husband's behaviour (such as his drinking, having another girl, and not assisting the family). They also talk about children and birth spacing.

Mrs Keo does not use family planning and her husband does not allow her to do so. Her husband wants to have more children to help him, but she would like to use family planning. Mrs Deng uses family planning and her husband supports her in doing so. Mrs Keo consults Mrs Deng about this matter and Mrs Deng talks to her husband, but her husband refuses to let her to do family planning. Mrs Keo's family is very poor, because they have so many children.

### **Person profile from Sanamxay District: 'Mrs Pheng'**

Ms Pheng is 28 years old, and is married with three children: a girl and two boys. She is from the Oy ethnic group. She farms paddy fields and also grows all kind of vegetables. Her daily work includes cooking, cleaning the house, feeding her pig and chicken, growing vegetables, pounding rice, and collecting water. After finishing the housework she goes out to collect firewood or find frogs, and to pick wild vegetables and bamboo shoots. She earns money by selling her vegetables, pigs and chickens. Her husband is 40 years old and his daily work is rice farming, fishing, and sawing wood for constructing houses. In her village men never do house work. Her husband likes to drink, and is always drunk. When he comes home he always loses his temper and argues with her.

During pregnancy, Ms Pheng has never been to hospital or to the dispensary. She visits the traditional birth attendant and she gives birth at home with the assistance of the TBA. Her husband helps to boil the water, and he is very happy when he has a new child. She stays by the fire on the hot bed for around 20 days after giving birth. During this time she has to do light housework, and after 20 days she will return to work as normal.

She has a best friend, Ms Keo, whose house is next to hers. She talks to Keo about everything. They discuss daily life and poverty, and she also talks to her friend about her husband: that he is not actively helping with the family's works. She talks about how she does not want to have so many children, and family planning. They both like to listen to the radio.

Mrs Pheng does not use family planning: her husband does not allow her, although she would like to do so. She always talks to Ms. Keo about this matter. Ms Keo suggests that she has to talk to her husband about this, but Mrs Pheng does not feel brave enough to talk to her husband. Another reason for not using family planning is that her family does not have money to pay for contraception. Ms. Keo does not feel brave enough to talk to Mrs Peng's husband either, and also does not want to interfere in her family. Ms. Keo uses family planning and her husband allows her to do so.

Although these profiles only cover a small fraction of the findings of the study, they have several uses in the demand creation programme. They are based on the data, have been created by members of the target group, and can be expanded upon to present research findings to programme staff unused to reading research reports. They may be used to brief the creative team designing information, education and communication materials. They can be used to think about appropriate messages for women in these target groups. Person profiles also help keep the everyday realities of women's lives at the centre of designing the demand creation programme.

## 3 Implications for Demand Creation Programme

### 3.1 *Prioritising key issues*

The demand creation programme potentially covers a wide range of topics: birth spacing, safe motherhood, community mobilisation, immunisations, and sexually transmitted infections (STIs). An effective programme will focus on a small number of key areas, as too much information can be confusing for the target audiences and implementers. The PEER study has highlighted three main areas with potential for maternal mortality reduction through a demand creation programme implemented in tandem with quality supply side services.

**The three priority areas for demand creation are:**

- **Priority One: Increase knowledge and awareness** around family planning for men and women, including addressing perceived risks associated with contraception
- **Priority Two: Develop community capacity** to stay healthy, and make healthy decisions when planning for childbirth
- **Priority Three: Build linkages** between and within communities and health services, by promoting attendance at health facilities for ANC services and skilled delivery

These areas are informed by the most recent evidence for what works in reducing maternal mortality (Campbell and Graham 2006, Costello 2004). Several areas of reproductive health importance have not been addressed under these priorities including STIs and maternal pre-natal health (e.g. smoking and diet during pregnancy). These risk factors are discussed further in the results section of the report, but recommendations for programmatic activity in these areas have not been made.

### 3.2 *Priority One*

**Increase knowledge and awareness around family planning for men and women, including addressing perceived risks associated with contraception.**

**Rationale:** If existing demand for family planning was met, this might reduce maternal mortality by 20% or more in developing countries (Costello et al 2004).



Increasing birth intervals is likely to lead to decline in fertility rate and thus to the exposure women have to maternal mortality across their life. PEER data suggest that demand for family planning is suppressed by concerns about side effects and incomplete understanding of how methods

work. The aim of this priority is to reduce the perceived risks that both men and women associate with using contraceptives.

Messages such as 'family planning improves the health of the mother and child and gives women more time to work' are well known in almost all communities, and continued repetition of these messages is unlikely to have great impact on demand. Although women know it is meant to be healthier to practice birth spacing, there was little evidence that they actually understood why. Building knowledge about childbearing and contraceptive methods to increase understanding of the mechanisms by which birth spacing might improve health would be more powerful than repeatedly telling people to practice a behaviour without them understanding why.

In reality, the benefits of having a small family are ambiguous in many communities, and such messages do little to tackle important barriers in demand such as fear of side effects, lack of husbands' support for contraceptive use and poor management of perceived side effects. Moving beyond often time-worn messages to developing couples' capacity for deeper understanding and confidence in contraceptive methods would be a more productive next step for the demand creation programme.

It is particularly important to reduce the fear of sickness associated with contraceptives, and the fear that husbands will not be willing to look after their wives if they become sick after using contraceptives, presumably whether or not this is actually caused by the contraception. By taking contraceptives, women risk a lack of support from their husbands if they do become sick, and this risk must be reduced.

**Empowerment strategies:** Suggestions for facilitating this process include:

- Setting up confidential one to one sessions where women and men can discuss their experiences and concerns with a health professional (this will require boosting the skills of, and materials available to, health professionals to deal with expected queries and problems)

- **Build capacity of men and women to talk to each other** about their concerns. This should start with a period of single-sex discussion and sensitisation. A successful example of this approach has been the participatory HIV prevention package 'Stepping Stones', in which facilitated single-sex group activities take place over several weeks, culminating in a mixed sex



session where participants share their findings and experiences<sup>4</sup>. This approach has received very positive evaluations and has been adapted to numerous countries, and could inform the development of a similar tool to work through information and issues around family planning including:

- Basic reproductive biology
- How contraceptives work
- Tackling fear of side effects of contraception
- Countering common misconceptions
- Supporting correct use of contraceptives
- Accessing a steady supply of contraceptives

An additional recommended step for the demand creation programme is to address the lack of positive information about family planning and contraceptives in the PEER data<sup>5</sup>, which limits understanding of positive experiences for the demand creation programme to draw inspiration from. One powerful way of working against the general negative atmosphere in the community around contraceptives would be to

<sup>4</sup> See [www.stratshope.org/t-training.htm](http://www.stratshope.org/t-training.htm) for more information on Stepping Stones

<sup>5</sup> This has two likely explanations: firstly, when recounting stories or explaining issues, there is a tendency for peer researchers, their informants, and members of the research team collecting the data to focus on negative stories (e.g. people tend not to recall the woman in the village who used the pill and was perfectly happy, but rather recall the woman got sick and was rejected by her husband). Secondly, it may reflect a widespread lack of satisfaction with current services and choices available.

**collect testimonials from satisfied users, or to encourage such women and men to advocate directly to their communities.**

### **3.3 Priority Two**

**Develop community capacity to stay healthy, and make healthy decisions when planning for childbirth**

**Rationale:** Health centre care at delivery and immediately postpartum has been recommended as the most effective strategy for preventing maternal deaths (Campbell and Graham 2006). Others have argued that 'primary care strategies (e.g. community based interventions) can reduce maternal and neonatal mortality substantially in areas with high rates, even if institutional approaches are necessary to reduce them further' (p 1167. Costello 2004). Although it may sound obvious, strategies around the process of childbirth itself are of fundamental importance to reducing maternal mortality, and should be a central priority for behaviour change and for raising of community capacity to make healthier decisions. PEER data highlight health seeking behaviours, avoidable risk factors, and barriers to care that could be addressed through a demand creation strategy.

**Recommended empowerment approaches:**

- **Establish facilitated women's discussion groups** (following example from Nepal, box 1). This process of shared discussion and learning will empower women and build their capacity to network with other groups or institutions (e.g. village leaders, health providers).



- **Establish village level maternal health action group.** Use a tool such as Participatory Learning and Action. Recruit a wide range of people from the community (including representatives from the aforementioned women's group, local lay experts, village leaders etc) and support the group in identifying local solutions to community-identified problems in childbirth. This could include:

- o Supporting women to go for antenatal care
- o Advice on nutrition, breast feeding, family planning and vaccination

- Birth and emergency preparedness: diagnosing labour, assistance during labour (companion and skilled attendant if possible), detect maternal complications early, refer maternal complications early
- Sustainable transport plans: co-operation with other villages, ambulance tractors, saving money communally to deal with issue.
- Community financing: Pooling funds for transport and hospital cots
- Men's role in childbirth: Build on positive male role models as identified by the community.

This group will not only identify feasible and sustainable local solutions, using local expertise, but will also encourage the community to support women to access and use health care when they need it, and will strengthen the community's linkages with health services, for example, by feeding back proposals to health providers.

### **Box 1. Women's groups and birth outcomes in Nepal**

This intervention was designed to reduce neonatal mortality, and to be low cost, potentially sustainable, and scalable. The intervention consisted of:

- Women's group meetings convened every month with a female facilitator
- Groups took part in an action-learning cycle to identify local perinatal problems and developed strategies to address them

Results:

- In the intervention group, neonatal mortality rate was 26 per 1000, compared with 37 in the control group, and maternal mortality ratio was 69 per 100,000 compared with 341 in the control group
- Women in the intervention group were more likely to have ANC, institutional delivery, trained birth attendance and hygienic care than the control group.

Why did it work? Hypotheses are that the programme:

- Harnessed creativity, self interest and self organising activities of poor women (Costello 2004)
- Improved awareness of warning signs
- Decreased reliance on traditional remedies
- Stimulated the development of stretcher schemes and funds to allow transport of sick mothers to health facilities

*Source: Manandhar et al, 2004*

There is no 'one size fits all' model for what healthy decision making in planning for childbirth should look like in these communities. Decisions will reflect local availability of services and current behaviours and beliefs. For instance, in some communities,

routine delivery in health facilities may be unfeasible, and the community may wish to focus on gaining skills to identify and manage obstetric emergencies. In other communities, transport to health facilities may be the main barrier to access, in which case they may wish to prioritise establishing a funding mechanism for transportation during labour. This is why it is essential that communities are equipped with the information, capacity, and resources to decide their own healthiest course of action.

Communities are unlikely to embrace radical change overnight (e.g. changing from the practice of unattended deliveries to utilising maternity waiting homes (MWH) or health facilities to deliver) and it is more feasible to start wherever communities are at present, and encourage gradual change towards the ultimate goal. Communities should be supported in taking the most appropriate steps to healthier childbirth planning, by giving them information and supporting them in sharing and analysing it.

#### **Other strategies:**

**Mass media** may be appropriate for:

- Informing or persuading the public about improvements in quality or access to delivery services
- Delivering information requirements e.g. recognising danger signs in labour and what to do in the event of such signs

**Birth preparedness cards** adapted for non-literate audience. These cards illustrate the different stages in preparing for birth to encourage advance preparation and contingency planning (e.g. planning transport to hospital, discussing who will attend the birth). They also show danger signs for obstetric complications.

**Supporting village finances:** At present, some villages have 'village fund' loan schemes with low monthly interest rates, and some have 'rice banks'. Community based health insurance schemes are being set up to help address financial barriers to health care. Opportunities for collaborating could be investigated to ensure these resources are available for supporting women in safe delivery.

### **3.4 Priority Three**

**Build linkages between and within communities and health services, by promoting attendance at health facilities for ANC services and skilled delivery**

**Rationale:** There is little evidence that ANC alone reduces maternal mortality (Campbell and Graham 2006). However, ANC can be a useful vehicle for health promotion and emphasising health-seeking behaviour, including birth preparedness. If women attend facilities and experience quality services, this is a powerful way of building trust and positive regard. Building stronger linkages and more equal partnerships with health services will be essential to tackle the issue of ‘shyness’ around attendance at health facilities. These are the building blocks upon which the ultimate goal of reducing maternal mortality through improved use of services will be built. ANC can also be used to distribute other packages such as anti-malarial drugs or bed nets, nutrition and infant care.

**Empowering strategies:**

- **Discuss ANC and skilled delivery at health facilities in women’s groups and feed back to providers:** For example, what are ‘women-friendly services’? What preferences do women have from services and providers? Who do they trust to promote access?
- **Involving women in monitoring the quality of ANC and skilled delivery at health facilities:** For example, in defining quality, completing exit cards.
- **ANC and health facility open days.** Arrange for women to attend ANC in groups, promoted as a social and learning event. Recruit volunteer ethnic women in district towns to accompany women who speak their language. (Note: the quality of service must meet the level of expectation generated, otherwise mistrust may be perpetuated). Encourage feedback between service providers and visitors at the end of the day.



**Other strategies:**

- Increase and publicise the benefits associated with ANC and skilled delivery at health facilities: Malaria treatment, nutritional information and supplementation etc could be offered to boost the benefits associated with these services.

- Provide incentives (travel money, seeds, expenses for a chaperone to travel with the woman etc.). These should not be excessive, as there is a danger that incentives can be coercive, especially among poorest populations. However, it is culturally appropriate for women to travel with a chaperone through remote areas, so supporting this behaviour would be reasonable.

One suggestion for encouraging ANC attendance and skilled delivery at health facilities is to recognise that small behaviour change steps are easier to achieve than more fundamental changes. Rather than expecting women to attend ANC and have a full physical examination the first time they attend, it might be possible to design a staged approach so that women are more gently introduced to the idea of physical examination. For instance, women could attend the first session with a friend. The health worker could explain the function of ANC, check blood pressure, offer advice on malaria, provide iron supplementation, and carry out counselling on diet. Physical examination could remain voluntary, but women might feel more inclined to accept this once they are familiar with the environment and providers.

### **3.5 *What is demand creation in this context?***

Findings from these studies pose numerous challenges for the demand creation programme. Firstly, it is beyond the scope of the programme to tackle many of the barriers to accessing reproductive health services, such as building new roads or removing all financial barriers to services. Secondly, delivering a comprehensive demand creation programme to such a dispersed and varied population will be resource intensive. Transportation in the area is often difficult, and there is relatively low capacity in existing networks to implement activities (both in terms of skill levels and overall number of personnel). However, there are many activities that can be implemented to build upon the positive behaviour change and demand creation that has started to grow in some villages, and to extend the reach of these activities.

For demand creation to be effective, it must adopt a behaviour change approach, supporting the empowerment of communities to act for their improved health, together with supply side interventions. It will have to focus on much more than providing information alone, as information alone is rarely enough to change behaviour (see Box 2).

The demand creation programme will operate at two levels. Central level will be responsible for producing appropriate messages and materials, guidance, organising

training and advocacy etc. Provincial and district levels will be responsible for implementing the majority of the programme on the ground. The remainder of the implications section is therefore divided into two sections: one primarily concerned with district level activities, followed by one primarily concerned with central message and materials development.

## **Box 2. Components of Demand Creation**

### **Empowering communities**

- Building local decision making and problem solving capacity
- Facilitating participation of appropriate individuals and communities (especially typically excluded groups) in all parts of the programme, including strategic planning, implementation, and monitoring and evaluation
- Supporting groups and networks to work for improved health and to build linkages with health services

### **Increasing knowledge**

- Provide information about services: what services are available, how they work (referrals, registration etc), opening hours
- Raise awareness of rights to services
- Provide information about costs and management of costs and fees
- Highlight health needs or risks
- Highlight the benefits services can offer  
= 'informed demand'

### **Improving access**

- Ensuring information is provided in clients' language or that interpreter is available
- Reducing real and perceived barriers e.g. reducing perceived risk of changing a behaviour
- Respectful treatment and non discrimination; ensuring privacy and social and cultural acceptability of services
- Provider training, e.g. communication skills
- Logistical support for access e.g. subsidised transport costs
- Increasing trust in services
- Improving perception of services, e.g. transparent financing (no unauthorised additional payments, no inappropriate fees for medicines or contraceptives)

### **3.6 Recommended approach to tackling marginalisation at district level**

This section describes why empowering communities should be central to efforts to tackle the three behaviour change priority areas. Demand creation must not take the form of outsiders coming in and telling communities ‘what is good for them’. The PEER findings show why traditional information and education approaches are unlikely to succeed in meeting the objectives of the maternal and infant mortality programme. The changes required are complex, including challenging fundamental beliefs and practices in communities, tackling the marginalisation of communities (including their lack of confidence in dealing with health providers and their lack of ability to hold providers to account), and community level inequalities (e.g. women’s lack of decision making power) (see box 3).

#### **Box 3. Illustrating the importance of empowerment**

When mobile health teams visit villages in southern Laos, they are generally warmly welcomed and accommodated. Mobile services were found to be preferred over static services in the PEER studies. One reason for this may be because mobile teams serve the community while relying on the community for their co-operation, and often for food and shelter in remote areas. Because of this, the community itself is relatively empowered in the client/provider relationship. This is a fundamentally different power relationship than in health centres or hospitals where users rely on the service provider entirely and, according to PEER findings, often feel disempowered. In many villages, state service provision relies on the co-operation of villagers. For instance, for school teachers and mobile health teams, villagers donate food and accommodation. In this sense, villagers take an active role in supporting the services they receive. In return for this investment and co-operation, they should participate in identifying priorities and making plans.

Empowering approaches are summarised in the following table which compares them to traditional information, education and communication (IEC) approaches:

**Table 1. Information, education and communication compared with empowerment approaches**

<b>Traditional IEC approach to demand creation</b>	<b>Empowering approach</b>
Health problems and solutions are determined at central level	Those affected by issue are involved in defining the problem and suggesting ways of

	tackling it
Inform community of decisions determined at central level	Build community capacity to make decisions (e.g. selecting local leaders, allocating resources)
Aim for increased attendance at events or education sessions	Aim for increased participation in all aspects of programme, with equitable participation by previously excluded groups (e.g. women)
Delivery of information to passive recipients	Facilitating access to information and creation of knowledge through critical reflection and analysis
Delivery of services to passive recipients	Delivery of services to critical recipients with ability to hold providers to account (e.g. through monitoring of quality of care)
Consultation with local male leaders or local representatives of government institutions	Focus on consultation with, and empowerment of, marginalized groups
Information and ideas delivered by external agents to assembled audience	Information and ideas delivered by community members, e.g. through group dialogue, peer-to-peer discussion
Deliver materials and messages in dominant language (e.g. Lao)	Deliver information in local language, allowing for discussion, analysis and questions by all community members
Inform community of available services	Provide information about services AND build capacity of community to make demands from services and hold providers to account

Empowering communities is not about leaving communities do things entirely for themselves. To challenge long standing behaviours and power structures, skilled facilitation is needed. For example, facilitators may need to ensure the inclusion of vulnerable or excluded community groups. Numerous tools exist to aid programmes begin this process of empowerment of communities. One good example of a tool to aid participation is the 'Participation Guide: Involving Those Directly Affected in Health and Development Communication Programs' (Tapia et. al. 2007). Effective strategies tend to involve small group efforts, and are sensitive to health needs as defined by the community themselves (WHO 2006). Participatory Learning and Action tools may be appropriate for conducting this sort of exercise. While these are broad recommendations for strategies and tools to empower communities, specific examples are given under each of the priority behaviour change areas.

**Empowerment should be firmly based in a rights based framework** (see summary table in appendix 3). A rights framework will be useful in underpinning all future activities, and has the potential to tackle many barriers simultaneously. Participation and gender equity and equality are two important components of a rights based approach which are now discussed further.

**Participation** is an important component of empowerment. It fosters a sense of ownership of activities, and also aims to facilitate people's power to make decisions and to promote higher levels of self-reliance (Tapia et. al. 2007). Participation is increasingly recognised as an effective strategy for health programmes (see box 4).

#### **Box 4. What can participation do?**

A recent synthesis of evidence by the Department of International Development (UK) found that increased participation in planning and managing services led to a variety of improvements:

- Dialogue between the community and health providers on limitations of the health system can help to focus public expectations and encourage the community itself to fill the gaps in the health system
- Participation by community members in planning and monitoring services can stimulate positive health provider behaviour (e.g. improved attendance)

SOURCE: DFID Policy division

Due to limited experience for both implementers and communities in participatory approaches, initial levels of participation should be appropriate and feasible, and may be increased gradually over time. The first step of increasing participation is involving affected people by seeing issues from their viewpoint. PEER has demonstrated that it is both possible and productive to work with ordinary community members, including non-literate women from vulnerable ethnic communities, in this task. Higher levels of participation include community members being involved in selecting leaders, participating in monitoring and evaluation, setting programme objectives, and even being able to advocate for policy change.

Considering the current context, it is recommended that community members and their representatives be involved in the following stages of the demand creation process<sup>6</sup>:

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<sup>6</sup> Model of participatory process taken from Tapia et al 2007

- **Strategic decision making:** Ensuring that strategies and approaches selected are adequate, appropriate, and responsive to needs
- **Development and testing:** Ensuring the cultural appropriateness and comprehension of messages, materials and tools
- **Implementation and monitoring:** Community decision making in incorporating programme activities into local social contexts (e.g. how and when activities are carried out), involvement in monitoring quality (e.g. key informant monitoring (see box 5 below), inputs into the definition and design of service quality monitoring tools)
- **Evaluation:** Involvement in analysing the effectiveness of activities, and planning for the future

**Box 5. Key Informant Monitoring in the Supporting Safe Motherhood Programme, Nepal**

An adapted version of PEER, KIM (Key Informant Monitoring) has been established to support the wider activities of this maternal mortality reduction programme. In ten districts of Nepal, a yearly round of Key Informant Monitoring is carried out. Groups of local women undergo training similar to that in PEER. Their narrative data on issues such as gender, health and decision making are analysed and used by the programme for different monitoring and advocacy purposes at village, district and national level. KIM helps to capture subtle social changes over time, and allows ordinary community members an opportunity to voice issues and demands.

*For more details see Price and Pokharel 2005*

**Gender:** some community members are more empowered than others, and in this context it will be important to consider gender when facilitating community groups and working with leaders. Although the status and behaviour of women has been the focus of reproductive health programmes in the past, work was generally done through male channels and messengers. Without sensitive intervention, it may be that women are excluded from equal participation due to power dynamics.

**Challenges:** Community participation has been set in motion with PEER, and has demonstrated to UNFPA and its partners that participation is possible, productive, and potentially transformative. However, there are many challenges in working with communities to help them play a more active role in determining their needs and working out solutions. These communities are more used to being told what to do than being asked for their opinions. In addition, participatory and empowering

approaches have not been widely used in reproductive health in Lao PDR, and national staff and partners would benefit from increased capacity for implementing participatory approaches. Health providers and community workers themselves will need to be empowered to carry out this type of work, for example by upgrading their skills to include participatory facilitation. Mechanisms by which they can feed back regularly to central level to make their concerns and ideas known are also essential.

### **3.7 Tailored Implementation**

Each village has a different set of circumstances, beliefs and practices related to reproductive health, and it is not feasible to compile an accurate, up-to-date profile of practices and beliefs in each village. However, it is not necessary to do this, as cultural practices are not the main factor in discouraging or preventing women from accessing services.

Villages have different level of familiarity with services and will require different levels of intervention to stimulate demand for services. Communities vary in their attitudes to and experiences of services. For some, family planning has become a widely recognised part of life, even if some barriers to access remain. For others, such services are still extremely new. To manage this variation, behaviour change communication (BCC) materials and approaches should cover a range of stages of behaviour change (see box 6 below).

### **Box 6. Stages of Change**

This model of behaviour change states that changes in health behaviour rarely occur overnight. Individuals may progress through stages of change, and may move backwards and forwards through the stages. Stages of change are:

- Pre-contemplation: the behaviour has not even been considered
- Contemplation: the behaviour is being considered, and perhaps evaluated for costs and benefits
- Preparation: the individual has decided to try to change the behaviour and is preparing to change
- Action: the behaviour is carried out
- Maintenance: the behaviour is routinely maintained

Individuals or groups at different stages of change require different approaches by demand creation programmes. For example, if individuals in a community have never considered using birth spacing methods, communications/activities should target a wide audience with simple information and messages. However, if women have tried using contraceptives but have discontinued their usage, they may require more intensive support to resume appropriate contraceptive use, such as through interpersonal counselling from a health professional.

The following groups are likely to be at the highest risk of maternal and neonatal mortality, and efforts should be made to focus on them in particular. These are referred to as the primary target groups for the demand creation programme (the groups for whom activities are intended to benefit).

#### **Primary target groups: women themselves and men as their partners in reproductive health**

- Women under 20 and over 35 years of age
- The poorest households
- Recently relocated villages, where people are less likely to be familiar with available services, and may not have received regular health information
- Women and men who have the greatest challenges in accessing services (geographically and/or financially)

**Secondary target groups:** these are individuals and groups who influence behaviour and whose support is needed for success of activities. Those with the greatest ability to influence change should be targeted. They are likely to be:

- Older women
- Existing leaders of the community – village chiefs, representatives of Lao Women’s Union (LWU), Lao Youth Union (LYU), Lao National Front
- Village health volunteers (VHV)
- Health personnel: outreach district health team and maternal and child health (MCH) staff

### **3.8 Messages, materials and tools<sup>7</sup>**

While community empowerment and behaviour change activities will be taking place at district and village level, implementers will require resources such as messages, materials and tools from central level. These can then be used across different communications channels and by different implementing partners. It is important that messages are in harmony with each other across these different channels and among different partners. For instance, posters and radio spots about family planning should have the same key messages, and community based distributors (CBDs) and outreach health care teams and health staff should also work with the same key messages. This means that messages are more credible and likely to be reinforced and remembered.

#### **A ‘positive appeal’ should be used rather than trying to spread fear.**

A positive appeal concentrates on the benefits of behaviour change, whereas a fear message tries to increase people’s sense of danger to spur them to change. In communities with low levels of perceived vulnerability (as there are with many reproductive health issues in these communities), fear messages are unlikely to be effective, and may lead to denial of risk. In addition, it is inappropriate for programmes to give out fear messages unless they are confident that it is possible for people to reduce danger. At present, services are not universally accessible and thus the programme can not be confident about this.

Positive messages should be written in positive language, avoiding phrases such as ‘don’t’. Messages can focus on direct benefits such as health, strength, or financial advantages. However, social or emotional benefits may be more effective: persuading people that the benefit is being ‘modern’, gaining control, feeling safe, feeling trusting, or gaining respect from peers. In most cases promising a direct

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<sup>7</sup> Section 3.6 was informed by an unpublished Options Communications Strategy authored by Ben Rolfe for the ‘Reducing Maternal Mortality Programme’ in Cambodia, funded by the UK’s DFID.

benefit of 'health' is ineffective. For instance, among ethnic women, it is not ill health they fear as much as not having enough time to attend crops and other duties, or not having the support of their husband if they become ill. The benefits of birth spacing, for example, might be to have more time to work to increase productivity and income, and to have time to participate in social activities.

Traditionally, reproductive health and family planning messages have stressed the benefits of a smaller family, and the dangers of overpopulation. Neither of these messages is likely to be effective in this context. Messages telling communities that they should have fewer children when the benefits of a large family still feel tangible to many people may be alienating rather than contributing to behaviour change. This is particularly true when some community members suspect family planning efforts threaten the survival of ethnic groups. UNFPA does not aim to reduce fertility *per se*, but rather to ensure that every pregnancy is wanted and that every birth is safe. **There is no obligation to stress fertility reduction in this demand creation programme.** PEER findings support the argument that messages should focus on the healthy timing and spacing of pregnancy, rather than fertility reduction<sup>8</sup>.

For each priority demand creation area, the following approach to message creation is suggested. The 'person profiles' at the start of this report should be kept in mind, and each of these questions should be answered from the target group's perspective:

- What are existing beliefs in the community to reinforce?
- What are beliefs in the community that need to change?
- What are the benefits to individuals or communities of this service or behaviour?
- What are the barriers in each community to change?

Looking at these key issues will stimulate ideas for message creation.

For example, if we were to focus on 'increasing uptake of contraception':

**Beliefs to reinforce:** women believe they can discuss decisions with fellow women and seek advice from people who know about contraception

**Beliefs to change:** that contraceptives are dangerous to health

**Perceived benefits of changes:** be smart like other women and have more time for work, supporting the family, making more income and participating in social activities

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<sup>8</sup> Although it is recommended that the programme does not concentrate on fertility reduction messages, it should be noted that in almost all parts of the world, growing provision of safe and accessible reproductive health and family planning services is accompanied by a decline in total fertility rate (TFR).

**Perceived barriers to change:** side effects, husband's opinion, lack of choice of contraceptive methods, provider attitudes.

'Beliefs to change' are most difficult when they relate to a traditional belief, such as sacrificing an animal before attending hospital. The programme does not want to appear judgemental or threaten people's traditional ways of life. There were not a large number of traditional beliefs that need to be challenged to achieve positive behaviour change; the most obvious are unattended childbirth and delaying emergency hospital treatment while carrying out traditional procedures such as animal sacrifice first. In these situations, it may be more effective to initiate change with community leaders rather than trying to persuade individuals to go against the system.

### **3.8.1 Characteristics of a good message**

Messages should be short, simple and free from jargon. This is particularly important in this context where messages will ultimately be delivered in numerous different ethnic languages and will not necessarily be written down in these local languages. They need to be amenable to quick and accurate translation.

Messages should offer concrete realistic solutions or alternative behaviours rather than just telling people to 'take care' or other vague advice. This is often called including a 'call to action'. For example, rather than just saying 'Stop maternal deaths!' or 'don't delay going to hospital if there is a problem', give specific instructions about what to do (e.g. 'If x, y or z happens, go to hospital for help'). Good messages will also encourage people to think about their choices rather than telling them what to do.

Ideally, messages should be developed in partnership with the community. At the very least they should be tested for comprehension and acceptability by ordinary community members. Messages should be attractive and engaging, and incorporate local interests and influences if possible, such as references to social life or subsistence activities.

Communications should be open about what they are trying to achieve. No one should suspect or fear that the programme has damaging goals, or is trying to get people to behave in a secretive manner. As mentioned several times in this report, it

is extremely important that messages are credible and do not make promises that cannot be kept.

### **3.9 Channels for delivering demand creation**

This section describes additional recommendations to support the priority behaviour change areas and empowerment activities.

Just as there are numerous objectives within demand creation, there are numerous ways of delivering demand creation activities. The approach for remote villages will be different from that in towns and villages near roads, which have easier transport links and greater access to education, mass media etc. But although it is more expensive and arduous to implement demand creation in remote areas, these areas have the greatest need the greatest potential for maternal mortality reduction (and often directly related infant mortality reduction). The programme will need to decide how best to balance resources between these two approaches.

The following recommendations apply to all channels of delivery:

- Materials, messages and tools should be designed and tested in collaboration with the community (e.g. with the peer researchers)
- Positive stories and testimonials from trusted individuals are persuasive
- Ideally, communications should be delivered in the local language(s) whenever possible. Interpreters should be used if this is not possible.
- There may be a mixture of languages spoken in any one village.

#### **3.9.1 Interpersonal communications**

These approaches consist of:

- Individual and couple counselling
- Peer to peer schemes (often described as peer education e.g. mothers' group)
- Presentations and discussions with target groups (small group discussions may be more effective than inviting the whole village) involving dramas, songs, BCC materials etc.

Recommendations for interpersonal communications:

- These communications should include not only information, but also skills building (e.g. role play, communications skills), discussion and debate.

- Dramas and stories should show 'pathways' to seeking help or advice. For instance, how to access emergency funds, how to request services at a health facility, if confronted with a particular problem.
- Sessions should be interactive, getting people to think about their behaviour.
- Make use of existing advocates for reproductive and maternal health in villages (Village health volunteers, CBDs, Village chiefs, LWU, LYU if they are sympathetic to messages). Boost their skills, and resources and materials available to them. Their activities will need to be monitored as capacity to deliver behaviour change communications may be limited in some villages.
- The amount of training required to establish peer education schemes, given generally low levels of education, might be impractical.
- Think about alternative sites to deliver interpersonal communications. Would rubber plantations, army garrisons or factories be suitable for health education activities?
- Demand creation activities need to be planned seasonally and in accordance to the routines of each village. They should be short and to the point, as people are busy and have other demands on their time.

### 3.9.2 BCC and IEC materials

For all materials, it should be remembered that there are relatively low levels of literacy (especially among the most at risk groups) and therefore written materials are not appropriate for many target groups. If in doubt, do not use written materials. Visual materials must also be extremely simple as visual literacy may not be high either. Some peer researchers had never held a pen or drawn a picture before, and were not familiar with simple pictures representing aspects of daily life.

Materials should clearly depict people from ethnic groups so that people can relate to them. A range of different but authentically dressed images of people (i.e. as people look and dress currently) should be included such that all groups see them as relevant. These must be field tested to ensure communities relate to them.

Suggested IEC materials include:

- **Posters** are very popular in the area but are likely to remain in health workers' and chiefs' houses to decorate the walls.
- **Printed materials for health workers:** Although health workers are literate, this does not mean they want to read long and complicated leaflets (as some current

leaflets observed in the area are). Rather than overloading health workers with information, these should be brief and simple, filling specific knowledge gaps.

- **'Frequently Asked Questions'** concerning aspects of reproductive health, with simple model answers and pictures to help explain the answers. For example, questions might include 'why am I having irregular menstruation since having a contraceptive injection?', 'what will happen to me when I go to ANC?', followed by a simple description of the answer, with pictures if necessary, avoiding technical terms.
- **Educational tools:** flip charts, games, cards etc. on priority topics in reproductive health. These should be designed with specific priority areas in mind, e.g. countering misconceptions around contraceptives.
- **Appropriate packaging of drugs/contraceptives:** contraceptive pills and medicine packets were noted to have English labels which no one locally could read. Developing packaging in Lao, which at least someone in the village could read, could be useful.

T-shirts, caps and other give-away items are not recommended for this programme. They may help raise the profile of an issue, but have little value in actually changing behaviour.

### **3.9.3 Mass media communications**

People are selective in their radio habits and are not always interested in listening to programmes, messages or jingles that are explicitly about health. Story lines could be worked into soap operas and dramas. Case studies and stories can be adapted from the PEER data to form the basis of storylines for dramas or debates. This would help to ensure that scenarios are meaningful to the target audience. Mass media campaigns must run over substantial periods, and be intensive enough to stick in people's minds. However, if they last for too long and are too regular, campaigns will turn people off from listening, or even turn them against their message.

### **3.9.4 Other innovative approaches**

Using a variety of channels over time helps to avoid people becoming tired of messages. The following section describes several possible ideas, demonstrating the range of activities that could stimulate demand:

**Maternity Waiting Homes:** These need to gain people's confidence, while showing the benefits and reducing the costs of attending (skills-building and vegetable

growing are strategies suggested in Eckerman's Needs Assessment (2006)). Invite influential men and women to visit. Build capacity in communities to recognise high risk cases that will benefit most from using this service.

**Opportunities in the education system:** Support plans to introduce a reproductive health component to the curriculum. Support efforts to keep children, especially girls, in school.

**Fairs/markets/festivals:** These draw visitors from remote communities to central locations. Demand creation activities could be located at such events, e.g. a stall providing advice, answering questions, giving out information, posters, etc.

**DVD showings** in villages with hydroelectric power (this would require good technical back up and the production of an appropriate short film).

**Plantations/factories/saw mills:** These may be useful places to partner with industry to deliver health education and demand creation to large numbers of employees.

**Social marketing techniques:** Producing materials that are 'branded' rather than seen as 'from the government' can be a more effective way of delivering products and services. Giving the programme a particular character or personality could make it more attractive.

**Adapted toolkit** of maternal survival resources – there are many such resources online which can be refined and tested in the communities – e.g. [www.changeproject.org/technical/maternalhealthnutrition/maternaltoolkit.htm](http://www.changeproject.org/technical/maternalhealthnutrition/maternaltoolkit.htm)

### **3.10 Reducing financial barriers to access**

The PEER studies produced clear evidence of multiple financial barriers to accessing health care. The particular concerns raised in PEER suggest several actions that could reduce barriers:

- Flat or capped fees, which would reduce uncertainty in the system
- Improving transparency of finance: clarity about the amount that should be paid for a particular service. Services that are meant to be free should be free. Subsidies or informal payments should not be charged
- Supporting the system of waivers for the poorest of poor

- Supporting community based health-insurance schemes.

Some of these initiatives are already underway in Laos (see box 7 below). Even if participating in these initiatives is beyond the scope of the demand creation project, they may be of broader interest to the Ministry of Health and development partners.

Community involvement in monitoring financial transparency is possible through schemes such as exit cards (where users are asked to evaluate their experience on a simple data collection card, which can be designed in collaboration with community members who help to define the 'quality' of services from their perspective) or even 'mystery client' visits to health services.

If financial transparency can be assured and maintained, efforts must be made to communicate this to the public, as at present there are low levels of trust around financial transparency. Community based monitoring would add credibility to such claims.

#### **Box 7. Current initiatives to reduce financial barriers to health care in Laos**

Community based health insurance is currently being piloted in 11 districts in 6 provinces, with around 27,000 members. Twenty-one further districts will be added over the next three years. Eventually this scheme aims to merge with existing social security schemes that cover the formally employed to achieve universal coverage. The poor will be covered by health equity funds (schemes whereby a third party pays providers for services rendered to pre-identified eligible poor).

The Ministry of Health and development partners could contribute to overcoming financial barriers to services, especially for deliveries, in the following ways:

- **Conditional cash transfers:** remunerating women for services they have paid for if they comply with antenatal and postnatal care, and deliver at a hospital; coupled to an **incentive for providers.**
- **Vouchers** that allow women free delivery or access to other services
- Supporting the **health equity fund:** a fund which identifies the poor and pays for their treatment
- **Purchasing premiums** from community based health insurance<sup>9</sup>

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<sup>9</sup> Information provided by WHO office, Vientiane.

### ***3.11 Implications for supply side activities***

Demand creation cannot be separated clearly from supply side issues. Demand creation activities will not work if there is not a concomitant increase in the quality of services. Demand and service provision need to be strengthened simultaneously at a local level for demand creation activities to be credible and effective. The demand creation programme will need to ensure that they only create demand and raise expectations when services are available that are accessible and of acceptable quality. For example, the supply side needs to ensure that villages are visited frequently enough to ensure adequate supplies of contraceptives.

This report does not provide explicit recommendations for the supply side programme. However, important supply side issues have been highlighted through PEER; issues that might not be immediately obvious to the supply side of any programme. For instance, perceptions of quality of care are extremely important. While a supply side programme might focus on providing hardware to health facilities, and upgrading the technical skills of staff, other skills are necessary to ensure that people are happy with the service they receive. If they are not happy, they will not come back, and their community will hear about their negative experiences. Improvements in facilities, outreach services and overall health systems are also required, but the importance of quality of care (including explaining treatment, respectful communication, privacy, a clean environment, transparency of payment) should not be overlooked.

The supply side team visited Kaleum district two weeks before the PEER study. They visited remote villages and held discussions with local CBDs, village chiefs and VHVs. Their trip shed additional light on issues around demand creation. All the CBDs the team met were men, as were most of the VHVs. The model of family planning promotion that CBDs were using was 'men influencing men'. This risks reinforcing or increasing male dominance and control, and goes against UNFPA's commitment towards gender equality. Careful thought needs to be given as to how women, who often do not speak Lao or are not as readily available for training as men, can be integrated into the CBD system, and how women can be encouraged and enabled to participate equally in decision making around family planning.

## 4 Detailed PEER Report



Sekong, Attapeu and Saravan are three neighbouring provinces in the south east of Lao People's Democratic Republic (PDR). They are amongst the poorest provinces in the country, with some of the worst health outcomes in areas such as maternal and infant mortality. An estimated 80% of the population

in these provinces come from ethnic groups other than the Lao Loum. Access to reproductive health services is restricted by numerous factors, including distance, poverty, transport costs, alternative practices for childbirth and treating illnesses, and inadequate services. Likelihood of accessing services is determined by a combination of political, historical, geographical, social, individual and epidemiological factors. This study explores such factors from the perspectives of ethnic women, whose findings will shape the design of a strategy to increase awareness of, and demand for, reproductive health services in the region. This section of the report presents findings from Sekong province, where the first qualitative study from the three provinces was carried out. Results from the remaining two provinces are presented in Appendix 1.

### 4.1 Programme objectives

The demand creation programme has goals of increasing use of contraceptives, increasing attendance of skilled personnel at deliveries, and reducing early marriage and unwanted pregnancy. The overall aim is to reduce maternal mortality. The objectives of programme are:

- 1) Improved understanding of barriers to access in rural populations
- 2) Increased political and community support
- 3) Improved knowledge and awareness to encourage health seeking behaviour
- 4) Improved access to quality health care
- 5) Improved planning and capacity of government partners

UNFPA is working with the following Lao PDR government partners to implement the programme: Lao Women's Union (LWU), Lao Youth Union (LYU), Ministry of Education, Ministry of Culture and Information, Ministry of Health (MOH), Mother and

Child Health (MCH) Sector (at District and Provincial level), and the Centre for Information and Education for Health.

A supply side programme, which aims to improve the overall package of reproductive health services in the region, is being implemented simultaneously. The programme in the three provinces is focussing on:

- Upgrading the skills and quality of reproductive health services at service delivery points
- Integrating family planning services to the package of services provided to villages when child immunisation outreach teams are mobilised
- Integrating family planning into village drug revolving funds
- Piloting community based contraceptive distribution in extremely remote areas
- Establishing maternity waiting homes in all 17 districts

The demand creation project will seek to inform the local population about these services and encourage their usage.

## **4.2 Research objectives**

The PEER study was undertaken to gain a better understanding of the social context of health-related behaviour, including livelihoods, marriage, gender norms, and information channels. In particular, the study aimed to collect information on:

- Insider views of social and cultural beliefs and practices (including those relating to pregnancy, childbirth, family planning, and STIs)
- Decision-making and health seeking behaviours
- Barriers to accessing reproductive health services (geographical, financial, social, perceptions and expectations of services, and availability of services)

A qualitative approach was taken to gain insight into the target populations' perspectives. Findings will inform the development of the demand creation strategy as well as supporting the work of the supply side programme.

## **4.3 Research method: Overview of PEER**



The PEER method was used to conduct this research. PEER is a participatory qualitative research method involving ordinary members of the community. In each of the three provinces, fifteen

women from rural areas, known as peer researchers, were recruited from different villages. They attended four day residential workshops where they developed interviewing skills and designed an interview schedule. After training, peer researchers returned to their villages to carry out in-depth interviews with two friends, on three different topics (resulting in six interviews each in total). Peer researchers ask about what *other people* say or do in relation to particular issues, rather than asking for personal information. Supervisors from the research team visited peer researchers to collect their findings in a series of de-briefing sessions, making detailed notes of the narrative data that peer researchers had collected. Some groups reassembled after data collection, giving feedback on their experiences, and helping to analyse the data (including developing the profiles of typical women). De-briefing notes and results from these workshops form the final data set, which has been translated into English and analysed by a social scientist.



The PEER method was chosen for the following reasons:

- It generates in-depth, contextual data on a range of issues related to the research topic.
- Existing relationships of trust between peer researchers and their informants mean that findings are more detailed and insightful than if they had been gathered by an outside researcher.
- PEER involves the participation of the target group from the early stages of the programme, building ownership and involvement in programme activities.
- The method is particularly suitable for carrying out research with hard-to-reach populations, and is suitable for non-literate groups (pictures rather than written interview prompts can be used).
- PEER builds capacity of local partners to carry out research in future.
- By participating in PEER, peer researchers become 'lay experts' in important issues in their community, and form a pool of expertise who can be involved in future stages of programmes (e.g. materials and message testing, participation in interpersonal communications activities).

The first PEER study took place in Sekong province with the guidance of an advisor from the PEER unit at Options Consultancy Services. PEER studies in Saravan and Attapeu were then carried out by UNFPA staff and their local partners. Ongoing technical support for data analysis was provided remotely by the PEER advisor.

The Ministry of Health National Ethics Committee for Health Research (NECHR) approved PEER studies in Saravan, Sekong and Attapeu provinces in October 2007. The PEER method received ethical approval from the University of Wales Swansea Ethics Committee in July 2007.

#### **4.3.1 Selection of Peer Researchers**

Provincial health offices were asked to select 15 peer researchers from their respective provinces according to the following criteria:

- That they were women of reproductive age (15-35 years old)
- That they speak Lao (in order to communicate with supervisors and each other) and their own ethnic language
- That they represent typical local women as far as possible (e.g. not hold an official position in the village)
- That their villages were no more than two hours travelling time apart (to enable the research team to debrief peer researchers regularly)

Villages were selected such that some were far from health centres, whereas others were close to health facilities, to examine the influence of distance to services.

This study does not attempt to represent all ethnic groups in the three provinces. The variety of ethnic groups and contexts in which they live are too great for this relatively small study to capture. The aim of the exercise is to understand the main structural factors (such as poverty, geography, relationships between providers and service users etc.) which shape demand for reproductive health services. By comparing and contrasting data from many, but not necessarily all ethnic groups, it is possible to generalise about the most important issues.

Due to resource and time constraints, it was not possible to conduct PEER studies with men. The study concentrated on women for the following reasons. In these communities, it has been difficult to hear women's voices using conventional research methods. In addition, men in several villages had been recently interviewed by the supply side team. It was still possible to examine gender dynamics looking

only at women's data. For instance, data reveal what women *think* that men think, which in itself influences behaviour and decision making.

### 4.3.2 Peer Researcher Training Workshop



Peer researcher training workshops were held as residential courses due to the wide geographical spread of villages. Informed consent for participation was obtained from all peer researchers, and they were paid a per diem and transport and subsistence costs. During the four-day workshops, peer researchers:

- Discussed and identified important issues in their community (with an emphasis on women's health)
- Drew pictures on three different topics to guide their in-depth interviews, shaped by what they felt to be the most important issues (see Appendix 2)
- Practiced asking open-ended questions, probing, and asking for stories
- Practiced and were observed asking for consent from their friends to take part
- Learned about 'third-person interviewing' (using no names, and asking about 'what other people say' rather than personal questions)

As most peer researchers were not literate, pictures rather than written prompts were designed, and peer researchers were not instructed to take notes during interviews. Experience of PEER in many countries has shown non-literate groups to be highly skilled at remembering stories they hear when interviewing friends.



### 4.3.3 Data Collection

After the training workshop, peer researchers returned to their villages and carried out in-depth, conversational interviews with two of their friends on three different topics, using picture prompts to guide the conversation. Data were collected from peer researchers by supervisors from the research team at regular intervals.

Frequency of de-briefing sessions was determined by geography: some peer researchers were debriefed three times, while others could only be visited once (these peer researchers were de-briefed for a longer period to ensure all data were collected). All peer researchers successfully remembered detailed information from their friends, some requiring very little prompting from the research team.



#### 4.3.4 Data Analysis

Data were analysed in two stages:

**By peer researchers:** In the districts where it was possible to bring peer researchers back together in a central location, peer researchers discussed and analysed their findings in a final workshop at the end of data collection. The main output of their analysis was the ‘peer profile’ described in the research summary.

**By the research team and social scientist:** Narrative data were entered into Microsoft Word in English, translated from supervisors’ notes which were in Lao. Data were read and re-read, and key themes were identified. Analysis of Sekong data was led by the PEER advisor, who worked with the research team to build capacity to manage and analyse qualitative data, in preparation for PEER studies in two other provinces. Data were thematically analysed according to the pre-existing analytical framework (developed according to the objectives of the research). Emerging themes and insights were incorporated into this framework.

## 5 Background: Reproductive Health and Ethnic Groups in Laos

Globally, a woman dies in childbirth or from complications of pregnancy every minute. Many women in Lao PDR also die during pregnancy or childbirth, causing significant costs and reducing the ability of the country to work towards prosperity. The government of Lao PDR has made substantial progress in the past 20 years to improving maternal health. The government estimates that the maternal mortality ratio (MMR, the indicator used to measure maternal deaths) has declined since 1995 and was estimated to be 405<sup>10</sup> per 100,000 live births in 2005. Important policies supporting the reduction of maternal deaths have been passed, such as the Reproductive Health Policy and the National Policy on Population and Development. Yet despite this encouraging progress, the MMR in Lao PDR is still one of the highest in the region.

There have been few qualitative studies of maternal and reproductive health in the ethnic groups of southern Laos. In 2005, a study was conducted in three provinces, including Saravan, on 'Gender and ethnic issues that affect the knowledge and use of reproductive health services' (Thomas and Louangkhout 2005). A Needs Assessment was carried out for the maternity waiting homes project in 2006, visiting the Saravan, Attapeu and Sekong provinces (Eckerman 2006).

These studies found wide variation in treatment seeking, use of family planning, and childbirth practices in different ethnic groups and villages. However, several common findings emerged, including:

- Messages delivered using uniform materials were not understood, unless delivered in ethnic groups' own languages. Lao is not widely spoken or understood.
- Sickness and wellbeing are believed to be related to spiritual forces.
- There are low levels of knowledge about reproductive health.
- Early marriage, from 12 or 13 years old, is common in many areas.
- Many groups are unable or unwilling to access ANC and maternity services.
- Breastfeeding for at least 6 months is the norm although babies' diet is often supplemented with sticky rice.

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<sup>10</sup> Lao PDR Census 2005 reports 405/100,000 while global estimates of Lao PDR MMR are as high as 660/100,000 births

Quantitative data are also scarce. The National Statistics Centre's Committee for Planning and Investment<sup>11</sup>, supported by UNFPA, conducted a Reproductive Health Survey (LHRS) in 2005 with the following key findings for southern Lao. Women in the Southern region have the highest fertility rates at 4.84 children per woman, compared to 3.07 in Central and 3.37 in Northern regions. Although the Southern region has the lowest contraceptive prevalence rate of currently married women (22.8%) compared to the national level (27%), the LHRS indicates a significant increase in currently married women using contraceptives (from 19.2% in 2000 to 26.6% in 2005). The three most frequently cited reasons for not using contraceptives were health concerns (13.7%), lack of knowledge (11.9%) and husband's disapproval (10.7%). Almost six percent of currently married women also gave the reason that contraceptives were hard to obtain. Demand for family planning in the Southern region was reported to be almost 60%<sup>12</sup>. The LRHS shows that 91.2% of the births in the Southern region were at home and 52.0% of live births were assisted by relatives. The main reason women gave for delivering at home was that it was not considered necessary to deliver in a hospital, accounting for 78.9% of births. Other important reasons given for non-skilled attendance included long distance from a hospital (32.2%), and costs associated with delivery at a hospital (10.7%).

The maternal mortality rate is thought to be twice as high in rural areas than in the country as a whole. Yet even in high risk areas, due to low population density, maternal deaths are rare: Eckerman (2006) reports that only one maternal death had occurred in the previous year across the 18 villages included in the survey. Maternal mortality may therefore not feature highly in people's perceptions of risk. The same report describes widely varying contraceptive prevalence rates in different villages: ranging from 3% to 54% of women of reproductive age. This suggests that there are either differences in access to, and availability of, contraception, or social differences in the demand for and acceptability of using contraceptives.

In many respects ethnic groups in this area differ from the Lao Loum majority. They are largely animist, speak their own languages, and often do not speak Lao. Many have a mode of subsistence that relies heavily on the resources of the upland forests, growing upland rice and hunting and gathering (Alton and Rattanaovong,

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<sup>11</sup> In December 2007 the National Statistics Centre's name was changed to the Department of Statistics, and the Committee for Planning and Investment was changed to the Ministry of Planning and Investment

<sup>12</sup> This includes met need and unmet need for contraceptives

2003). These ethnic groups are seen to have special needs and vulnerabilities. Whilst not denying that certain groups do have particular needs, drawing excessive attention to cultural differences, as is often done in the literature on ethnic groups in Laos, may help perpetuate the perceived gulf between ethnic groups and the rest of the country. This gulf may contribute to the mutual mistrust and occasionally fear that is said to exist between the groups.

Taking an historical and political perspective when analysing the situation of the ethnic groups is important. Many groups have a history of migration and living at the margins of countries including Laos, China, Thailand and Vietnam. The last few decades have brought many challenges and changes for them. Slash and burn agriculture as practiced by upland ethnic groups is now discouraged. The government has initiated formal education and relocation policies to move villages out of remote forest areas. The building of a new dam in Kaleum district will displace thousands of people by 2010 (Lang 2007). Bombing by the USA in the 1960s left the area strewn with unexploded ordnance, and surveys are still being carried out to evaluate the extent of chemical contamination. In sum, many of these groups have been, and continue to be subject to forces beyond their control. Throughout these turbulent times, ethnic groups, whether relocated or not, have continued to survive relatively self-sufficiently in a very demanding environment and with little state support or access to services. These groups might be said to exist in a position of 'marginality': they are entirely dependent on the will of the state as they can be removed from their land at any time, and have high levels of need, but at the same time many villages are almost self-sufficient and could be seen as resisting aspects of the state, such as not using maternity services or continuing to hunt in areas where it is forbidden.

There is little documentation of the effects of relocation in southern Laos, but these changes are likely to affect how health services are perceived, as they are delivered by the same state who is initiating these changes. For instance, it would not be surprising if behaviours such as birth spacing and attending ANC are resisted if they are seen to threaten existing practices and cultural identities.

## 6 Findings

*The following section of the report describes findings from the PEER study in Sekong province. Findings are illustrated with quotations from the large dataset created by de-briefing peer researchers' about interviews they carried out with their friends and neighbours.*

### 6.1 Study context

This section examines livelihoods and social life, which are important factors in understanding reproductive health behaviours and outcomes.

#### 6.1.1 Sekong Province

Sekong province is mountainous, forested, and crossed by numerous rivers and streams. It is inhabited by 13 officially recognised ethnic groups. Sekong town was established in 1984 as the new provincial capital. There is a large market, a provincial hospital, secondary school, local government offices and a radio station. Peer researchers came from two districts within Sekong province: Lamam and Kaleum. Sekong town is within Lamam district, so peer researchers from Lamam were generally closer to health facilities, metalled roads etc. However, even within Lamam there were differences in the accessibility of villages. Some were located alongside the main road, whereas others had to be reached by canoe or by unpaved roads which are inaccessible in the rainy season. Lamam has both lowland paddy and upland rice farming. There is also employment in rubber and coffee plantations, brick factories and government positions (e.g. teaching).

Kaleum district is more remote. Kaleum town is located 75 km from Sekong town along an unpaved road in a densely wooded, hilly area. It has a district hospital and small market. The journey from Sekong to Kaleum town can take over 6 hours by car if the road is in poor condition, and during the rainy season the road is impassable. The town can also be reached in around six hours by boat. From Kaleum town, villages are only accessible by foot. The furthest villages are five days walk away. Although there is widespread poverty across the province, Kaleum is a poorer



district than Lamam, with little formal employment. Upland rice is the principle subsistence crop, with foraging and hunting for wild foods forming an important part of the diet.

Even though these villages are relatively difficult to reach, it would be wrong to think of them as cut off from the outside world. People make regular journeys into town to sell scrap metal from bomb shells, buy tobacco or MSG, or get a family photograph taken at mobile Vietnamese stalls. Some children go to boarding school in town, and some adults travel to work on plantations. Even remote villages are visited by traders and NGOs carrying out sanitation projects.

Each village has an elected chief with official duties such as reporting data from the village (e.g. births and deaths, livestock, crop yields). Most people are animist (hold the belief that souls inhabit objects such as trees, stones, animals etc). Villages have a nucleated structure, with extended families sharing houses. Households in villages contain around 7-20 people, with sometimes more than one family. Coverage of electricity and adequate drinking water is still sparse. Basic sanitation is not in evidence in most areas and several villages reported failed sanitation projects (e.g. construction of pit latrines that were never used and fell into disrepair).

### **6.1.2 Health Services**

Health providers in both districts face enormous challenges in delivering essential services to disparate communities with only limited resources and personnel. In addition to services in health facilities, health personnel visit remote villages several times a year to provide vaccinations, health education and even contraceptive services (see box 8 below).

### **Box 8. Summary of health services in Kaleum and Lamam districts**

#### Mobile services:

- EPI team: conduct vaccinations and recently started contraceptive pill distribution. Visit each village four times a year. Staffed by district health personnel.
- MCH team from district health department. They do not visit all villages, they visit less regularly (3-4 times a year), and are currently unsure of future outreach activities.
- Community based distributors of contraception: three in Kaleum with 6 villages each (18 out of 87 villages in Kaleum covered) and 5 new CBDs will be trained in 2008.
- No CBDs in Lamam (one will be trained in 2008).

#### Fixed services:

- District hospital: Kaleum
- Provincial hospital: Sekong town (in Lamam)
- Village Health Volunteers (in some villages: 8 VHVs in Kaleum and 4 VHVs in Lamam district)
- Health centre: one in Kaleum and four in Lamam district

Some villages have a village health volunteer (VHV) who may or may not have a basic drug kit. The level of VHV education is not necessarily high; in one village, the VHV had never been to school and had been taught to speak Lao and read and write by her husband. VHVs also refer people to hospital and assist when health education events take place in the village. VHVs in some villages provide family planning information and services in their respective villages. Each village is also meant to have a representative from Lao Women's Union and Lao Youth Union. These organisations work with Lao PDR government at the national level, but they also have a community level focus.

### **6.1.3 Ethnicity and language**

Sekong province is ethnically diverse, a patchwork of different ethnic groups, often sharing villages with each other. Many villages had a mixture of ethnicities and languages, sometimes the result of village relocations:

This village has always been here, but two other ethnic groups moved in about ten years ago. There were some issues over land: this village said how much land it could give to the newcomers, but they said that they needed more and wouldn't be happy.

The government made this village move from a more remote area. The Oy village was there first, the Katu came to join them, and then both moved here together. They have the same language; the Katu took on the Oy language when they joined them.

Intermarriage between groups was reported in some villages, though the consent of parents was needed. Additionally, if young men went to study or work elsewhere they might marry a woman from a different ethnic background. Not all people spoke their own ethnic language.

### 6.1.4 Livelihoods

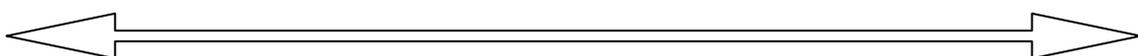
Each village had a slightly different economic strategy, according to available resources such as land, water supply and income generation opportunities. Most livelihoods were based on rice farming, supplemented by livestock, wild foods, non-timber forest products and limited cash generation. People engage in complicated, multi-pronged subsistence strategies, exploiting many different commercial, farming and natural resource opportunities. Households rely on labour for productivity in their rice fields and gardens: peer researchers often explained, for instance, that ‘families that don’t have enough labour can’t grow vegetables’. Productivity of the household is seen to be linked to the size of the household, so the number of children a family has is important. Depending on their location, the livelihoods of villages fell somewhere between the two scenarios in the following scheme:

#### **Mountainous, further from town**

Upland rice farming  
 Wild animals, including large game, important part of diet  
 Fishing, snails, frogs etc. major part of diet  
 Selling scrap metal and resin from forest for cash  
 Livestock and vegetables mainly for own use  
 Little or no formal employment

#### **Nearer towns and roads, lower altitude**

Lowland rice paddy farming  
 Foraging and hunting/fishing important but harder to find wild foods  
 Casual employment in brick factories, rubber and coffee plantations, saw mills  
 Selling surplus vegetables, goats, chickens etc. in marketplace  
 Mechanical help for rice farming (tuk tuk tractors)  
 Starting to use chemical fertiliser in rice fields



These subsistence agriculturists who hunt and gather wild foods are rapidly becoming subsumed into the modern cash economy. Despite this, even in communities relatively near towns and roads, foraging and finding 'natural' foods is still an important activity. This is a long-established way of life, and an activity central to people's identity. Wild foods are more highly valued than vegetables grown in the garden or animals raised at home. A large range of foods were gathered from the forests, rivers and fringes of fields.

There's a river near here where they fish, and look for shells. All these bits they do, they get enough to feed the family and to sell. They go into the woods with the dogs and hunt large lizards. They can always sell the lizards, they just put them by the side of the road and someone will stop to buy it.... They rely on the foods that they forage for their own consumption, whatever else you get, you can sell.

Yet even in more remote villages which participate less intensively in the cash economy, access to money is increasingly important as health care, education and staples now require cash. Farming is also changing in ways that reinforce people's participation in a more industrialised cash economy. Tractors are now used in paddy rice farming in some areas of Lamam. As they reduce the labour in ploughing and harvesting, so the buffalo which used to do these jobs are no longer used, and no longer fertilise fields with their dung, so people have to buy chemical fertiliser. Additional income sources may mean less dependence on subsistence farming:

Only a few families grow enough vegetables to have for themselves; others would rather labour and earn enough money to buy vegetables these days. Farming is very hard work and there may be other alternatives now.

Natural resources are under increasing strain. Forests surrounding villages are increasingly coming under government protection for environmental reasons and people are not allowed to hunt in them. In addition, lowland areas are becoming more densely populated. In some areas people perceive there to be fewer wild foods available than in the past, or in comparison with the sparsely populated upland areas where they used to live:

Bamboo shoots can be found quite near the village all year round. Nowadays you get fewer and fewer fish – sometimes you have to fish for the whole day

to get enough for the pot. We don't tend to hunt frogs as there aren't a lot of them, so food isn't really plentiful here, not even crickets and things. Apart from bamboo there isn't much to forage. There aren't even monitor lizards or squirrels in great numbers: there used to be a lot more.

In upland areas still surrounded by forest there were no complaints about availability of wild foods:

There is quite plentiful foraging near the village, you never go without food as long as you're not too lazy to go looking, hunting or fishing. Sometimes people make more than enough and sell: during the rainy season, they sell a lot of tadpoles.

Villages moving from upland areas are confronted with new modes of subsistence and much greater interaction with the market economy, resulting in numerous changes to their lifestyle and having to adapt to a different social as well as geographical environment:

We used to live in small houses thatched with straw, which needed to be changed every year, but we learned that we could save money to get a proper house with a tin roof. We also learned that we could cut more wood than we needed, and sell the extra to get money.

In all areas, rice yield was vital to the household economy. Yields varied widely from up to seven tons per family, down to a yield that would only last the household for two months of the year. Such families would have to do extra work to earn money. Those with excess rice could sell the surplus and further enrich the household. Some villages are clearly more prosperous than others. This village, on the main road near Sekong town, was able to produce ample rice, and took part in lots of other economic activities:

We do lowland rice farming, very little upland rice farming, and most people produce more than enough to sell. On average they make 4 tons per year, which is a decent yield, per household. The village has a large farming area and plenty of manpower too. They grow peanuts, and have enough vegetables in their gardens to feed the family. There is banana and sugar cane for sale to get extra income. They also grow the wood to make mat walls

(lam loy)... Some grow more than enough to feed themselves but are too shy to go and sell things in the market.

The further away from markets, the harder it is for villagers to earn cash by selling surplus products such as vegetables:

They also grow vegetables, but only enough to eat themselves. Even if they grow more they don't want to take it to the market as the road is too far away.

Weaving is a fairly peripheral activity in most communities, such as in this village near Sekong town, due to the preferences of people to do more sociable work:

The traditional weaving is all for sale, they don't actually use it for themselves, but only a few families do it. Most families don't have time to do it, they prefer to do other things, although they know how to do it if they want. They prefer to do other work which is more communal, rather than just sitting on their own.



Men, women and children could also earn money through hiring out their labour. Men could join the army. Very few people were reported to have left their villages to work in cities or abroad. Children could work from 10 years of age in a large new rubber plantation recently established near Sekong town.

Men cut logs and make planks to sell, women weave or hire themselves out as labourers on building sites, or go to the rubber plantations, or hire themselves out as labourers to clear the land.

Laziness was regularly mentioned and criticised by informants, with hard work and productivity being highly valued:

Most grow enough rice to last the year, but some families don't produce enough, usually due to being lazy, for example if a wife doesn't help her husband. Families with a lot of children help to do more. In some families only

the women works the rice field and her husband just goes to drink and doesn't help.

Almost all families kept some livestock and poultry, but it was a precarious and risky venture due to disease:

About nine families have buffalo, two have cows, seven have goats. Goats tend to die from foot and mouth disease. Last year someone had 30 goats and they all died. Another woman had 20 pigs in the past, but they mostly died and only seven or eight are left.

A household's assets consisted of their animals, land, access to labour (including children), as well as social networks such as extended family or neighbours who could provide social support. Households kept their accumulated capital in assets rather than cash. For instance, they might sell buffalo or cows for medical expenses, or to buy motorbikes for their children to continue schooling (boys were said to demand transport and would not walk to school), or to pay for higher education which would require sending children to another provincial town (Pakxe) for several years:

About half the village has cows. They are commodities: they show the wealth of the family. Animals are for their own use, or they might sell them in emergencies such as having to go to hospital and needing money.

Families in the village help each other out if the yield isn't enough for the year, but only a few kilos of rice are given. These are families who can't plough enough, as they don't have the manpower, and not enough low land. Big families tend to belong to people who are able to produce surplus rice and can sell it. This village doesn't have enough land now, they have tried to grow a hardier rice on the upland fields, but it's rain dependent. If you can clear enough land, you're OK.

## **6.2 Social life**

This section describes the social context of Sekong Province, including education, gender dynamics and marital patterns.

### 6.2.1 Schooling

Although most (if not all) villages now have rudimentary primary schooling, very few ethnic children complete primary or attend secondary school. In many villages the school had only been established for a few years and often only covered the first three forms of primary school. Leaving school was usually related to lack of funds (for transport to school, uniform, registration fees or stationary), long distances to secondary school, parents wanting their children to work at home, marriage, and for girls, shyness in front of male teachers. Some felt that a lack of opportunities after school and the fact that girls would just get married anyway meant that it was not worth staying at school.

It tends to be poorer families whose parents can't afford to buy them a motorbike to send them to school. They tend to hold girls back as they'll just get married anyway.

Most children go to school. Only some families can't afford the registration fees. Only a small number of people go on to study elsewhere [secondary school]. Most stay in the village. Some become teachers, or work with the government. Those with no money will not get a post – you have to pay a bribe to officials.

The quotation above does not constitute evidence that bribery actually happens. Rather, it is the *opinion* of a peer researcher's informant. It shows that the perception of the value of education is affected by the *perception* that there is not a fair job market. This shows how it is important to improve *perceptions* of services as well as the quality of services themselves.

'Laziness' was commonly mentioned to explain why children did not finish school:

Some just don't attend school at all; mainly girls don't go. Parents encourage them to study but girls are too lazy, they just hang around in the village, and work in the planting season in the fields.

Although such girls might have been described as 'lazy', their non-attendance makes more sense when considering norms of early marriage, and the existence of few opportunities after finishing school aside from marriage and farming even if children

do attend school. It is important to understand perceptions of education and future opportunities, as this has implications for desired family size. It is thought that one reason behind fertility declines in many countries is that parents invest more resources in bringing up and educating fewer children, because of the future opportunities and benefits associated with education. If ethnic communities do not perceive benefits associated with education, because they believe jobs are only available to those who pay bribes, or because girls 'just get married', then this powerful motivator in fertility decline is unlikely to be operating strongly.

Although in many villages it was reported that girls had the same opportunities to go to school as boys, it is likely that fewer young women remain at school on reaching adolescence: *'if they finish primary school and have already grown breasts, girls tend not to go to secondary school', 'those that don't go to school at this age, it is because they are too shy, they feel like they are too big to attend school'*. Yet in some villages, boys were reported to be less successful at schools than girls: *'boys play truant more, and go around drinking in gangs, and don't get up in time'*. Shyness, or feeling that continued schooling is not appropriate, partly reflects the lack of precedents for adolescents remaining in school in many villages where schools are new: continued schooling is simply not the norm.

Efforts are being made to encourage ethnic children into secondary schools: some subsidised boarding schools exist, and a programme of scholarships is being investigated. It is difficult to suggest an alternative to this model of bringing in young people from remote areas to more central areas, however this has implications in terms of equity of access for boys and girls.

### **6.2.2 Marriage**

Marriage was almost universally said to be 'for love'. A dowry (money from the wife's side to the husband's side) or bride price (money paid in the opposite direction) is almost always paid, depending on the ethnic group. Whether the newly married couple live with the man's or woman's family also differs by ethnic group. In most places parents claim to lack influence on the timing of marriage and choice of partner, though they might exercise influence indirectly (see quotation below). The typical age at first marriage varied a lot: in one village near Sekong town it was reported to be about 23 for women and 29 for men, whereas in other places:

Age at marriage is 14-15. Because they love each other, young people want to get married. Parents don't agree, they think they are too young, but children insist, and threaten to commit suicide etc if they can't. A couple just got married and had to pay a large dowry – 4 million kip (\$440), the girl was 19 and the boy 16. Bride price depends on the parents: if they want to discourage the marriage they will set a very high price, if they don't approve much. It's quite common for women to marry men who are quite a bit younger than them. They don't get a chance to get out of the village much, and it's very rare for someone to leave the village and live elsewhere, so they tend to marry within the village.

An exception to voluntary marriage was found in the most remote village visited, 30km from Kaleum town deep in the forest: *'A woman in this village was married at age 11 in an arranged marriage: her family were very poor and his were rich with rice and buffalo'* (it is important to note that when a very young woman marries, she does not necessarily have sex with her husband until she has started menstruating). Yet even in this village marriage was typically a little older:

Age at marriage is 13-14 up to 20 years old. Some have arranged marriages especially if a family have a lot of children and want someone to take the girls off their hands, a willing man who will pay bride price. Two to three men in the village have more than one wife. This age of marriage is just a normal thing, they have always done it, if they love each other they see that they might as well just do it.

The nature of marriage seems to have changed recently in most places:

In the olden days parents would usually search for a wife or husband for the children, but nowadays marriage often happens due to love. Most parents won't put up any resistance to them marrying.... The marriage ceremony happens at the boy's home, the buffalo to be eaten during the marriage is tied up on a pole in front of the boy's house, and there are melon seeds, pumpkin seeds, and corn, to denote the future prosperity of the couple.

In Kaleum town, where there was more migration and there were more 'outsiders' in town, marriage had taken on a different character:

Many girls marry out-of-town boys here, then are left to bring up children on their own after these men leave the village. There was a girl who lived near here, her husband left after she got pregnant. These out-of-town boys tend to be favoured by parents as they think they have a lot of money.

For the marriage ceremony they usually eat cow or buffalo, they also have rice wine. Dowry is one buffalo, and then they have to pay the costs for breast milk to the mother of the bride (500,000 kip). This is what has always been done. Previously it was the girl who went to live with the boy's family, however nowadays they live where they want to and parents don't force them.

Both of these quotations shows how there are incentives for parents in having children who go on to marry: families receive bride price or other money (e.g. for having fed the bride when she was young), and one of the families receives new members into their household (the spouse and their future children), who will contribute to the labour force.

The implications of the current situation around marriage are firstly that it is unlikely that parents can exercise direct control over the age that their children marry, though they may have some influence. Therefore efforts to encourage young people to wait until an optimal age to marry and begin childbearing must involve young people themselves as well as parents and older people. In addition, it is important to recognise the continued benefits associated with having children that are perceived in this area.

### **6.2.3 Gender dynamics**

Increasingly, reproductive health programmes recognise the importance of understanding gender relationships, as they shape decision making, treatment seeking behaviour, and health outcomes for men and women. According to the peer researchers, the main problem with gender imbalances in southern Laos is that women have to work much harder than men. Among these women, there was universal awareness and demand for change in gender roles and status: *'women don't want to do all the hard work'*. Laos Women's Union, working to improve the status of women and children across the country, have been carrying out community based activities for some time, encouraging men and women to share their responsibilities more equitably with varying success:

Younger men help out with chores now but older men still don't. They have had trainings, discussions, talk about gender equity, and have seen how hard their wives work. LWU comes once a month to hold discussions in the village hall to talk about these things.

Men and women share their work out, this has changed from previous generations when women worked more than men. Now they help each other, even with housework: men have been seen to wash their own clothes and the clothes of their family.

Women work harder, they do all the housework: pounding, looking after children, and cooking. They have asked men to help but they refused because they see all these as women's work. Men tend to do heavy work, such as logging and house building; however, women actually carry firewood.



Men just won't do what they consider to be women's work. Even unmarried boys don't help; they just copy their father.

The fact that several villages report improvements in gender equality suggest that some communities are receptive to ideas about social change and that the LWU have an existing network with means of communicating directly with communities.

Looking at cases where the activities of LWU have contributed to positive change, and how they delivered their message in these cases, will be useful in learning about how to initiate persuasive communications with these communities. Although representing a national body, LWU representatives are drawn from



their own communities, and as such represent an important opportunity for programmes wishing to talk directly with ethnic groups. However, the case of campaigning for more equitable gender relation also demonstrates that sometimes behaviour change initiatives can have unintended and unwanted consequences: in this case, the women ending up doing even more work:

Mostly women work, carrying water, caring for the kids, pounding rice, cooking and cleaning, foraging for bamboo, clearing the forest to plant rice. If it's not the season to clear the fields, men sit around and drink. In the olden days, men always cleared the fields, then women started saying that they should do work equally, so now they just do the men's work on top of their own work. Women can't just not do their work, otherwise who else will feed the children? And men would then just walk out and divorce you.

It is important to monitor the effect that demand creation activities may have, as they may produce unintended and undesired consequences. In some villages where there is antipathy towards gender equality messages, LWU representatives might not be the ideal vehicle for delivering reproductive health messages, as people may have preconceived ideas about them.

Visiting villages once a month to deliver behaviour change activities, as reported in one village above, is perhaps too frequent to expect the whole village to attend each time, as people may tire of hearing the same messages. It may be more effective to target monthly activities to particular groups (e.g. unmarried women or older men), or to reduce the frequency of visits to quarterly visits.

In all but one village visited, women were responsible for managing household finances. There was little incentive to keep cash around the house, as women preferred to invest in household assets. Women were frequently concerned about men drinking excessively, as they felt it led to irresponsible spending of money, and arguments or violence at home.

Usually women can make decisions around the household, as long as they have money – in fact, they tend to buy a lot of things, because if they keep money around the house, their husband will just come and take it from them. Men sometimes run up a tab on drink even if they don't have any money, and the woman will have to go and pay for it.

Gender based violence was not mentioned directly in Sekong data, and investigating the issue further was beyond the scope of the study. However, Appendix 1 contains examples of what peer researchers in Attapeu Province said about violence at home.

In general, villages closer to towns appeared to have taken more steps towards gender equality. In one village, women held leadership roles (including village chief). In more remote villages women appeared to have less decision making power and fewer opportunities for education. Social and economic changes are also likely to affect gender dynamics. For example, in some relocated villages, traditional roles for men such as hunting in the forest are no longer as viable.

### **6.3 Reproductive health**

This section examines findings relating to reproductive health: pregnancy, childbirth, infertility, immunisations, STIs and family planning.

#### **6.3.1 Pregnancy**

In most areas women are expected to work hard during pregnancy, carrying out most if not all of their usual duties. In some villages pregnant women are excused from heavy work, which may be a relatively recent development: this is another area in which behaviour change is reported. A woman's workload depended on whether there was someone else to help her:



During pregnancy if you have no one to help you at home you have to do the heavy work yourself. Now they do less because they now understand that heavy work is not good for them and the baby.

Most women don't do heavy work during pregnancy, however if there aren't enough people to work in the field, then they would have to do it regardless of whether they're pregnant or not.

Most work during pregnancy – it's only if the wife is also a government worker that they don't work hard. From 4-8 months pregnant they still carry on the heavy work, such as rice pounding, carrying water, working in the fields, and foraging... This is because there is no one else to help. Even in some families with a lot of people helping, women still end up working.

Pregnant women work hard, that is normal, due to the kind of life that they lead, to find food for the family. Although most of them don't work too hard, occasionally there are people in the village who work really hard because they don't have people to help.

Most women work very hard when pregnant, pounding rice, collecting firewood, because they think it's their job, and if they don't do it, they won't get anything to eat. They normally work until the birth of their child. For three days after the birth they have a rest, but after that they go back to hard work. Except for those who are government workers; they don't actually have to work hard. But ordinary villagers all have to work like this.

There was a large amount of data on work during pregnancy which suggests that this was an issue of particular concern to women. Heavy labour may be risky during pregnancy, but at present women see little alternative. With this sort of health issue, initiating discussion and problem solving within the community is the most effective way of creating opportunities for change. It would be ineffectual to promote a message of 'avoid heavy labour during pregnancy' without offering practical and alternative solutions for who will do the work, such as, for instance, co-opting men to help with particular duties, or establishing a network of women who help each other during their respective pregnancies. However these types of solutions have to come from the community, as only they know what is appropriate and feasible.

Smoking tobacco pipes during pregnancy is also widespread in many villages: *'women smoke all the time, during pregnancy – there are just a few women who get adverse effects from it because of pregnancy'*. Smoking increases the risk of low birth weight babies, and raising awareness of the risks of smoking during pregnancy could be included in this programme. There are local beliefs that smoking makes you feel stronger and less hungry, which will be difficult to counter. However, health promotion messages around the dangers of smoking have been initiated recently in Lao PDR, which could be built upon.

Attendance and attitudes towards ANC differed widely depending on distance to services, and whether women experienced problems during pregnancy. 'Shyness' was a particularly important issue, discussed below:

Some women would go, some not, some wait to see if there is something wrong before they go, if there is pain or not. (*Village close to health centre*)

Because of the proximity of the hospital, most women will attend ANC. Only some refused to come due to shyness... Women now appreciate being looked after and attend ANC once a month. Those that don't come are really shy about showing their stomach to a health worker.

There are some people who won't go at all because they've never been, even though they may have 3-4 children. Because they are too shy of the health worker. It doesn't matter if there's been some health education about it, they just aren't interested because they just feel too shy. (*Village two hours walk to health centre*)

Women have never been to ANC, and don't know anyone who has ever been, and are afraid of showing their body... The mobile team explains that we'll feel your stomach, help you if you have a breach delivery, but they don't care, they still say they're too shy... even if they're ill or not feeling well they still ignore it... They also think that their parents have never attended ANC, so they don't go either. And if anyone goes, they consider it very embarrassing.

It is interesting that if women accept the idea of ANC, they are reported to attend more frequently than one might expect:

Most people will go to Ban Phone health centre for ANC, a small number will go to the provincial hospital. Women will often go once a month, and if her pregnancy is not good, she even goes twice a month.

Those who don't attend are those who are too shy and they don't think they have any problems so they don't go. Those with problems go twice a month, and those who are normal go once a month.

Shyness appears to be a key factor in women not attending. It is worth considering exactly what 'shyness' means, and how it might be overcome. The shyness described in the PEER studies seems to be the result of exposure to completely new behaviours: having to travel to an unfamiliar place, negotiate an alien hospital system, while not speaking the language of the hospital system (Lao) well or at all,

and being expected to behave in a way that is unprecedented within their social group. Feeling shyness, and even shame, extends to attending market for some of these communities: 'They don't sell vegetables because they feel ashamed'. Marketing is not a traditional subsistence activity for many of these groups. It requires venturing into town. Going into town, rather than receiving a check up, appears to be the principal barrier to accessing services in some cases, as several peer researchers reported that pregnant women were happy to be checked up by mobile teams but did not want to go to ANC in town, 'because they have never been'. This shyness in interacting with unfamiliar institutions such as hospitals or markets may result in social awkwardness, much like the children who are reported to be 'ashamed to go to school with poor clothes'. It is both a chronic lack of confidence in attending the service, and a feeling that these services and institutions are not for 'people like them'.

'Shyness' will not be overcome by simply providing health education. It is perhaps best overcome by witnessing or participating in an activity *in a manner that feels safe*, such as with a group of friends, and being reassured by the experience. If an activity can be done successfully once, this builds confidence to do it again.

The act of interacting with outsiders in itself is not a key barrier to access. Women were not shy to talk to outsiders in a community setting: in the villages visited for this study, women regularly approached the research team to request advice about their health, and used mobile services.

Some communities relatively near ANC had transport and money problems which stopped them attending. Another factor that discouraged attendance at ANC was low risk perception around pregnancy and childbirth. Several women pointed out that some women go to ANC and have a difficult birth, whereas others do not go to ANC and give birth without any problems:

Women who actually attend ANC are those with a vehicle. Those who don't attend, it's because they don't have a vehicle or money. It's not just ANC, even if they're ill they don't go to hospital. In this village some women haven't been to hospital for ANC, but when they give birth, the mother and child are healthy and strong, as opposed to someone else who went to ANC, but died when giving birth. And also another woman who went to ANC, she was

around 15-16, but she gave birth to a really small baby who lived for a week and then died.

Most people don't go because they are shy, they don't have money, they don't have transport. Those who went to ANC, their delivery was easy, the baby was healthy, they are not ill all the time, and they tend to go and give birth at hospital. However, some that give birth in the hospital have difficult births too. And those who don't go and give birth in hospital sometimes end up having difficult birth, but some have no problems.

For many communities the sheer distance to ANC makes it unfeasible and even unsafe for women to attend. Paths leading to remote villages are narrow, steep, and uneven, with dense vegetation. Fallen trees block the path in places. It is not necessarily sensible to encourage pregnant women to make this journey. One of the many risks involved is that if a woman is on her way to hospital and gives birth on land belonging to another village, a fine is imposed.

### **6.3.2 Childbirth**

There were only 26 births in Kaleum district hospital from October 2006 – October 2007: the vast majority of women give birth at home or near home or the rice fields in a specially constructed hut. In Lamam, more women give birth in hospital but it is still likely to be a very small proportion (the 2005 LRHS reports that 6% of births occur in a health facility in southern Laos and it is unlikely to be much higher than this in Lamam). Peer researchers occasionally described traditional birth attendants (TBAs) attending births, but husbands, relatives and neighbours were more commonly said to attend deliveries, which is consistent with findings from survey data.

In these ethnic animist groups, pregnancy and childbirth are closely linked to the success of the rice harvest and yield. The location of childbirth is thought to affect the quality of the harvest, so during harvest time women may have to give birth away from the village. Only a few groups actually give birth in the forest, and do so only at certain times of the year. All peer researchers said that obstetric emergencies were sent to the hospital, but only after two to three days of labour, and often only after an animal sacrifice had been performed. However, groups furthest away may not do this: this study did not include women from the most remote villages, who are the least likely to use hospital services even in case of emergency as they may be five days walk away. Giving birth at home remains the norm. The fundamental reason

why women are not keen to deliver in hospital is that they simply do not see the need.

If women are out in the field, they give birth in the forest. If they are at home, they stay at home. But if they give birth at home, they have to sacrifice a pig (if they give birth in the main room), or a chicken (if it is in the kitchen). It's just a tradition to do this – you have to appease the spirit who protects the house. In the forest, you build a small hut big enough for the husband and wife, and other people if they come to help. The husband has to make sure that the birthing hut is there.

Difficult cases of childbirth are sent to town, but they have to skirt around the edge of the village, with the woman carried on a stretcher. After the harvest, they are able to give birth at home, but not during. This belief comes from the old times, when during harvest if women gave birth at home the yield was reduced, so it became a tradition to avoid doing this.

Women give birth in the village, it's mainly the TBA that helps with delivery at home. If it's around September – November (harvest time for rice), then they have to go and give birth in a hut next door because if anyone gives birth around these three months it's against the tradition of the village, and you have to sacrifice a pig. You rest for three days after giving birth and can then come back to the house. If you give birth in a hut, then it's also the TBA that goes to help, and also the family, and if it's a difficult birth, then they would carry the person to the hospital after doing a sacrifice.

Some conditions were recognised as needing hospital attention, although a great deal of faith was also placed in the power of sacrifice:

Some women when they give birth at home they have retention of placenta and lots of bleeding, and then they get sent to hospital.

There was a woman who had a difficult birth. After three days in labour they took her to the hospital [30 km away, over four hill ranges and crossing a river by boat]. She gave birth OK but afterwards she bled a lot because of a torn uterus. However, they brought a pig into the hospital, and actually slit its throat there as a sacrifice, and the woman stopped bleeding straight away.

In one village it was reported that, *'there is a TBA but she's not confident to help to deliver, and also there's not enough equipment'*. In this case, the woman selected to be formally trained as a TBA was the daughter of the village chief, an unmarried woman with no children of her own, which meant that neither she nor other women felt she had the skills to attend births.

There was no concept of 'preference' about where and with whom to give birth. This contrasts with how women talk about contraception, when women talked about finding a method that suited them. When trying to ask a peer researcher about whether women in her village preferred giving birth in the field or at home, she could not understand why women might prefer one place to another: women just behaved according to usual practice. This has implications for trying to change birthing practices and locations (such as the introduction of MWHs), as women are not used to having choices or alternative practices for childbirth.

Another factor deterring or delaying hospital intervention is financial costs:

ANC, iron supplementation and vaccination is free. For delivery it's about 40,000 kip, but if you lose blood, and need stitching, and need fluids (a drip) it can be up to 100,000 kip... Those who don't live here [Kaleum town] don't come to the hospital at all, partly because it's far away and partly because they don't have the money. Even the people two hours walk away don't come unless it's a complicated delivery. They are just scared that the costs will rise too high. You have to really beg the hospital to let you pay them back later, they will ask for the money up front.

As well as the hospital being seen as far away, unnecessary in most cases and expensive, the social support a mother and baby receive is an additional perceived benefit of giving birth at home:

Most will give birth at home, often because it's easier, and there are village elders who can help. For cutting the cord they use bamboo, they don't actually boil it, they just make it sharp. Afterwards villagers come and provide warmth and support and come to the house and welcome the newborn.

Poor women don't get enough to eat. Sometimes other villagers help out; would bring them sugar, milk, and other gifts depending on their relationship with the newly delivered woman.

Women also fear being given treatment they do not want at hospital. In the following cases, the belief that post-partum bleeding is necessary to clean a woman internally meant that they feared being given an injection to stop them bleeding:

When they give birth in hospital they get an injection which helps the womb contract, then they don't bleed for 2-3 days, but then suddenly they bleed, and they don't like that, they want to bleed normally.

Once they've finished their proper rest period, after about a month they can eat normal food, because they are still so scared that it will make them bleed if they eat other things, and force them to go into hospital and doctors might give them an injection, and they understand that if you get that injection, it makes the blood stop, and they would have bad blood in their body.

These findings have implications for the MWHs, which are being opened across the region. They are likely to face a similar lack of demand to ANC due to factors such as lack of perceived need, geographical distance, and shyness. However, these factors are likely to be much more pronounced, as staying at a MWH will require women to be away from home for days or weeks. This will mean being away from their domestic duties, and away from the social support that would otherwise surround them.

In summary, women believe that it is rarely necessary to attend hospital to deliver, and even if complications are suspected, attendance is delayed by geographical barriers, trying to solve the problem by sacrificing an animal first, fears of mounting and unaffordable costs, and fear of unwelcome medical interventions.

### **6.3.3 Post-partum period**

The 'quarantine period' after birth is of importance because behaviour during this time may affect the health of mother and child. The period typically includes:

- Time resting on a 'hot bed' (a bed over or next to a fire) ranging from days to weeks (in a lowland village this was 18-20 days, compared with as few as 3 days in an upland village)
- Dietary restrictions to avoid 'allergic reactions' to certain types of foods, which varied between villages
- Drinking large quantities of warm water, often containing herbal medicines (thought to stimulate milk production)

Peer researchers described the post partum period in their communities in detail:

They have to boil the water, they have to have hot water for the bath, using this particular leaf, and have to bathe at least 2-3 times per day, and at night they have to drink a lot, and rest a lot. They have to drink 7-8 pots of water a day (each pot is at least a litre of water).

They don't tend to come back to the doctor if they aren't producing enough milk, they use traditional medicine. The husband's job is to find the right plants, he is told by his father what was used in his day: certain plants his father used to use for his mother all the time. They just learn about the plants from each other, sharing knowledge with other families, saying 'this worked for me'.

During the quarantine period when they keep close to the fire, they eat grilled chicken and dried galangal. They only eat the chicken meat, they don't eat the innards and offal which they give to other people to eat... After the quarantine period they have to eat boiled banana flower, morning glory, other vegetables, and then they can eat all the parts of the chicken as well. However, there are some foods they try to avoid for a few months after birth, such as fish with red tail, cat fish, pork, white buffalo meat, and if they eat any of these, they tend to get this allergic reaction, which is treated with traditional medicine.

In their village, there was one woman who died from this allergic reaction because she ate venison, and her baby was three months.

Women in some villages were said to compete with each other over who was out of bed and back at work soonest after childbirth. Being seen as lazy was to be avoided

because strength and hard work were so highly valued, and necessary to succeed in this demanding environment.

Only complicated cases come to the hospital. They stay on the hot bed for only three days then have to get up and carry on with heavy work. Women refuse to stay longer in bed because this is the tradition. They don't want to be branded as lazy.

They rest for six days on the hot bed after the birth of first child, but with later children have fewer and fewer days of rest. Once the quarantine period is finished they go straight to work.

Husbands are often actively involved in the childbirth process, even if not necessarily attending the birth. They construct the birthing hut, carry water for their wife while she is resting on the hot bed, and may gather traditional medicines.

In most villages it did not appear that dietary exclusions would have a significant impact on the nutritional wellbeing of mother or child as only a small number of relatively unimportant food sources were excluded; though in one village it was reported that mothers only ate rice with salt for several days.

Perhaps most importantly, these post-partum practices have implications for the development of the MWHs. Women from different ethnic groups have different practices following childbirth, and to ensure their comfort it would be necessary to accommodate diverse requirements.

Breastfeeding practices were also discussed. Peer researchers in several villages reported that practices have changed in recent years: *'in previous years they expressed the milk first and threw away the colostrum but they don't do that any more'*. Findings from PEER are consistent with the other studies in this area (Eckerman 2006 and Thomas and Louangkhhot 2005) that breastfeeding is universal, although there is some supplementation with sticky rice or water in the first six months. There is still some way to go towards achieving exclusive breastfeeding for the first six months of the baby's life as the latest guidelines recommend (WHO 2003). If this is unfeasible due to work commitments, then advice on ensuring optimal hygiene in infant feeding practices (e.g. boiling water) could be provided.

### 6.3.4 Demand for family planning

Desired family size and the role and meaning of children in social life are important determinants of demand for family planning. Children are central to social life and play a vital role in helping the household produce and find enough food. Having no children was feared. When one peer researcher was asked what happened if people got ill, and could not farm or forage, she replied:

They just stay as they are. There is this family that has no animals or garden or any produce to sell; they just stay as they are. They subsist on rice and cassava and produce from their small garden. They have no children so they have no help at all.

Infertility is therefore a concern for people as family support is crucial. Some women as well as men wanted to have a large family:

The village chief's wife has nine children, and he wanted her to stop having them, and use the IUD. But she refused, she wanted to keep having children, so she pretended she had forgotten to take her pills. She's always busy, always in the field or garden, but just enjoys having children. She thinks that when they are grown up her life will be easy with lots of children to look after her. She has one son, the rest are girls, so she probably wants more sons. She'll get lots of bride price with lots of girls.

While traditional contraceptives do exist in some areas, they were not frequently reported in Sekong province; in fact quite the opposite:

Traditional medicine is used to encourage fertility, not to stop them from having children. Traditional contraception doesn't exist. It's very expensive to get fertility drugs; it costs up to a million kip... There is a specific way of taking this medicine – avoiding certain foods, it's quite complicated. Then after 2-3 days you dream you have a chicken or a pig, and that means you'll conceive.

Although there was demand for a large family size among many people, there was also interest in and demand for contraception to space births. There was no evidence for any cultural or ideological barriers against contraceptives *per se*, apart from this single quotation:

Others say they believe in providence: if you're meant to have ten kids, who are you to interfere and try and control the number? Usually young men say this, men who want a certain number of children.

Demand for birth spacing or limiting family size was usually linked to the economic difficulties of providing for a large family:

It's decided between husband and wife, because they understand that if they use it they wouldn't have children, and it would help them in their daily life because they don't have enough to feed their family.

They want to use birth spacing, but they are scared of illness. They want to do it because life is hard, and after having children you and your husband can't really work for a while and there won't be enough food. Most women want to use it but are too scared.

In Lamam, where family planning services have been more widely available for a longer time than in Kaleum, there is evidence that the idea of planning pregnancies is widespread, such that women who do not practice family planning are teased and seen as old fashioned:

There's another woman who is 45 and is from a poor family. She wants to use contraception but is scared that it's going to be painful. In the end she got pregnant. Other villagers would tease her about it, saying that she's too old to have a child, she should learn to plan her pregnancies. Other people said to her that she's not modern, and tease her about having a number of children.

As the following section describes in greater detail, the main barriers to using family planning concern the inaccessibility of services and fear of side effects rather than an aversion to the idea of birth spacing or family planning. There is evidence that many women and couples are interested in family planning, but that this demand is stifled by fear and lack of reassurance:

Her sister was using pills to space her births: her kids are aged ten, six and one. But she is afraid of the white discharge she believes it has caused. She wants reassurance that the discharge won't kill her. She wants to get

sterilised. Her husband wants reassurance that sterilisation won't have any bad effects for her either.

### **6.3.5 Perceptions and experiences of family planning**

**Limited coverage of services:** Contraceptives are available from hospitals, some community based distributors in Kaleum (all are male), and the mobile teams who carry out vaccinations. There is increasing focus on delivering these services to remote villages, although coverage is still sparse. Consequently those who cannot easily access hospitals or do not have an equipped VHV must wait to be visited, and their choice of methods is restricted to pills and condoms. For mobile delivery of contraceptives to be effective, a regular, predictable and long term supply needs to be achieved. Some women remarked that the MCH team had turned up once or twice and not come back again, and others said that women who ran out of pills before the mobile team came back had to go to the hospital for a supply. The delivery of contraceptives is still in its infancy, especially in some areas of Kaleum:

They get information about contraceptives from MCH officers. They listen to radio broadcasts from Vientiane. Mobile team comes sometimes, but not often enough, so they only get one month's worth of pills, then go into Kaleum to get more... They only started hearing about these things last year.

**Cost of services:** Providers are not meant to charge for contraceptives but stories of fees were reported in almost all villages. If communities are told that contraceptives are going to be free, and they visit the hospital to find that fees are charged (even if it is just a small amount for a record book), this is perceived as a broken promise between the provider and user which may have long term negative consequences.

Normally they come to the hospital for injection and pills – they pay 15,000 kip for the injection but nothing for the pills. Some people aren't happy about having to pay – health workers come around telling them that they should use them, but then charge them when they come to use it. The reason women have to pay is that the hospital needs the money to buy the drugs. Some people are willing to pay it because they want to space births. But with this situation, you have everything to lose: you have to pay, and you don't get a baby either!

**Preferred methods:** Pills and injections were the most commonly cited and preferred contraceptive methods: in some villages the injection was preferred, and in others the pill. There was some reported use of IUD but not in Kaleum. It seems there have been some efforts to teach fertility awareness methods often known as the calendar or rhythm method (with a high failure rate compared with modern contraceptives). There have been very few cases of vasectomy in Laos, so it is not surprising that none of the peer researchers mentioned this method. Sterilisation was only said to be used by women in government workers' families, or by rich people in towns:

Most people know how to use contraceptives. The preferred method is the injection, other methods they also know about are pills, IUD, sterilisation, condoms. The reason for not using IUD is because they are scared that they can't do heavy work. The reason for not using pills is tendency to forget, dizziness, feeling drunk, and losing weight. They go to the hospital to get contraceptives. There are two women who have had sterilisation done already, they are from government workers' families. The first woman had four children, and the second woman had three children.

There are two or three women who had sterilisation done in the village. For those who don't want to have sterilisation done it is due to two things: firstly, they don't have enough money, and secondly they are scared that they can't do heavy work.

Most will take pills, a small number use injection. Women don't like the injection because they are too scared of the needle, and following the injection it also stops their period, and they don't like that either. For the IUD they are too shy, and if anyone knew that a woman has had an IUD inserted it would be the most embarrassing thing for that person. They think that the IUD is for people in cities, not in villages.

What method they use depends on whether their body agrees with that method, and those whose body doesn't agree with it just leave it and use the traditional method. In the village, preferred methods are pills and injection, because often they agree with the body, sometimes they use the traditional method meaning that they count the dates, this they learnt from the providers at the hospital and from the mobile team.

Not remembering to take the pill was one of the reasons it was less popular in some places. Other medicines such as antibiotics were reported to be taken incorrectly in some villages (such as all at once rather than over several days). Many people may not be 'literate' in how western pharmaceuticals work and may need intensive encouragement and explanation to enable them to take the pill effectively.

On the few occasions when condoms were mentioned it was to say that men would not use them. Induced abortion was only mentioned once, in this case a woman felt that all her other options were exhausted:

In this village there is a woman who wants to use contraception. She can't take the pill, because when she takes it she becomes thin and weak and goes black. When she uses the injection she has similar problems. She can't use the IUD because her uterus is low. She uses the natural method and also wanted to use condoms but her husband won't participate. So every time she gets pregnant she has an abortion. She has done it already four times, two times with the doctor... She wants to be sterilised but she's too young, she has only had two children and the doctors won't let her.

**Side effects:** Fear of side effects was a significant problem, discouraging women from trying contraceptives, leading to high discontinuation rates, and discouraging men from supporting their wives in using contraceptives. Some villages reported a drop in contraceptive prevalence, following a fairly enthusiastic uptake when the services first became available, due to perceived side effects. Women worried about contraceptives not 'agreeing' with their body, and different women could be affected in different ways by the same contraceptive.

After the birth of the child, they get conscious about contraception, and choose either the pill, injection or IUD. If your body agrees with the pill, and you eat and sleep well, then there's no problem. If your body doesn't agree with it, and you get thin and lose weight, and you find the same with the injection, you might try the IUD. But you can have a really painful pelvis – a few people in this village have had to have it removed, again, it doesn't agree with them.

Fear of side effects has not yet been effectively tackled by health services. The level of explanation and reassurance required to counter such fears is not available, partly because of difficulties in health personnel regularly visiting villages or contraceptive users visiting clinics for advice, and partly because some health personnel do not possess the requisite technical skills to explain and reassure, particularly as they are unsure themselves about the mechanisms at work. Inadequate handling of side effects has implications for supply side activities. There is a risk that widening the delivery of contraceptives through relatively unskilled VHVs and CBDs may actually be counterproductive. Without sufficient support and reassurance, people may stop using contraceptives, and may also add to the widespread stories about the dangers of contraceptives. Although their training includes management of side effects, it appears that health personnel are not currently equipped with the skills to tackle high discontinuation rates and dispel rumours circulating in the community.

It should be recognised that some side effects associated with contraceptives may be genuine problems, such as menstrual disruption, weight gain, and skin complaints. Women may have to try different methods, including different types of pill, before they find the best method for them. However, for these ethnic groups, very little choice is available.

**Confidentiality:** Informants seemed to have good idea of which women in the village were using contraception, which methods they were using, and the effects they had suffered:

There are 15 women in the village who use pills now. Before there were more women using them. They are scared of heavy bleeding and sometimes white discharge so they stopped. They became thin and lost their appetite so they stopped.

In many villages, peer researchers were able to state readily how many women were using contraceptives, as though it were a matter of communal concern (the number of cattle and plots of land in a village are similarly enumerated as a bureaucratic requirement of village life). While women may not receive or expect confidential services at present, this state of affairs should not be reinforced by UNFPA and its partners. In small, tight knit communities, lack of confidentiality presents problems for women who want to use contraception but who face the disapproval of other individuals. PEER revealed numerous stories of women wanting to use

contraceptives in secret. Although open and honest communication about birth spacing should be promoted, women's right to access contraceptives without anybody else's consent or knowledge must be respected. All services must work towards confidential services as a basic reproductive right.

**Decision making:** In most villages it was said that men and women agreed on the decision to use contraception together. However, there were several stories of women using contraception secretly. In the stories reported in PEER, such women always ended up in trouble with their husbands, suggesting that secretive use is seen as a risky choice. In another village it was said that women initiated discussion on birth spacing but had to get their husband's agreement. In one village it was said to be entirely the man's decision.

Decisions on contraception rest with men, who take their wives to hospital to get them. Men who don't want their wives to use them forbid them. Some women she knows have used it secretly. One woman didn't want any more children, but after using the injection secretly she bled a lot, got tired, lost weight, fainted, so she stopped and got pregnant again. Her husband was angry with her when he found out afterwards. He said 'if you don't listen to me, and go ahead, I won't be responsible for you'.

There were several reports of men with an attitude towards their wife of, 'if you use contraceptives, I won't be responsible for you if you get sick'. Being ill is not only uncomfortable but has serious implications for the whole family:

With contraception, women know that if they take tablets, they will stop having children, but they're so afraid of becoming ill, because if they're ill, there'll be no one else to work, and they don't like hospital. Women with a large number of children are still afraid to take them for fear of becoming unwell. They don't become ill as such, but they lose their appetite, become thin, and have white discharge.

It is useful to understand how people weigh up various risks, as their perceptions of risk may differ widely from medical ideas of risks. In this case, the risks of ill health associated with contraception are seen as far graver than any risks associated with having another child. One danger of ill health is that it can lead to an inability to work,

and subsequent impoverishment. Breaking the link between contraceptives and ill health will be vital in increasing uptake.

**Communications:** Mobile teams and MCH officers say they have been talking about contraception when visiting villages for several years, but the idea of family planning is still relatively new. Talking about contraception to large groups alongside other general health issues may not be the most effective approach. Programmes may want to think about more targeted approaches, whereby different target audiences meet to discuss the issues in smaller groups. Different groups have different informational needs and may be persuaded by different approaches and messages.

### **6.3.6 Sexually Transmitted Infections**

STIs, including HIV and AIDS, were not mentioned by any peer researchers. If an issue is considered important in a community, it would almost certainly have appeared in the PEER data even if a direct question was not asked about it. This absence therefore reflects low levels of awareness, or possibly (although less likely) extreme sensitivity around the issue. The closest reference was when informants mentioned white discharge, which need not be linked to STIs: *'they use these traditional herbs for white discharge'*. The lack of data suggests that there is very little knowledge, or risk perception (or both) around STIs. Any demand creation programme would have to initiate dialogue with no assumed level of understanding. Discussions with health providers might be required to give a rough indication of STI prevalence.

### **6.3.7 Immunisation**

Vaccines were widely accepted when delivered by mobile teams:

Most people would have the whole course of vaccinations, children and adults, and usually it's carried out by providers that come to the village. But if they don't come, then they don't go to the hospital to be vaccinated. There are one or two families who don't want to [get their children vaccinated] as they think that it gives their children fever and they are scared of that.

They don't mind vaccination, even for tetanus they would do it. When there's a mobile clinic they all come to be vaccinated. They aren't embarrassed or afraid.

They will all bring their children to be vaccinated according to the plan. However there are some groups who aren't interested because they say that even if you've had the injection you can still get the disease, and they think that the injection makes their children become handicapped.

Most villages depend on the EPI mobile teams for vaccination, and report that if the mobile team does not come, they would not take their children to hospital to be vaccinated. This highlights the importance of maintaining regular, reliable mobile services.

## **6.4 *Perceptions of illness, health and treatment seeking***

This section examines wider beliefs and practices around health and illness.

### **6.4.1 Treatment seeking**

Illness is often thought to be prompted by social or spiritual disruption, such as committing infidelity, or offending spirits. In these cases, traditional solutions would be tried before seeking medical advice:

In the case of infidelity, something usually happens to a family member, like children or parents or someone close to you, so people ask around, 'who has been sinning?' and if you don't own up then that person might die. Sacrifice might be made to appease the spirit for your sin. The minute someone is ill, people start asking around to see who has been sinning to make the spirit angry. Then they must carry out a special ceremony to absolve the sin.

There is reported change in treatment seeking in some villages. In this case, sacrificing an animal is no longer the first course of action:

More often than not they will wait until they are really, really ill to go to hospital. If it's just a minor ailment they go to the village health volunteer, who can check blood. If they are not really ill they just go to the hospital and buy medicine and take it at home. Previously if someone was ill they would sacrifice an animal first before going to the hospital.

Self-medicating with pharmacy medicines, vitamins or traditional medicines was also common:

For minor illnesses, villagers tend to stay at home and find their own cure. They go and get medicine from the VHV and if symptoms don't improve or worsen then they will do their sacrifice first, before even considering going into hospital.

Most villagers prefer or tend to use traditional medicine first before going to the VHV. The ones they like to use tend to be tree roots, bark, and leaves, and they tend to boil it and drink it like a tea. Herbal stuff, bulbs of plants, they either eat them straight or boil them, usually for stomach ache, for stomach ulcers, and they tend to help, they are really good. And if these don't improve the symptoms, they go to the VHV to get modern medicine.

Villages did not have traditional healers but rather gained knowledge from older people and neighbours about medicinal plants, which are either picked in the forest or grown in the village.

#### **6.4.2 Financial barriers to access and provider attitudes**

Even if people want to see a doctor, several barriers to access are apparent that may delay or prevent treatment seeking, the most obvious and consistent being financial barriers. Lao government policy is to make health services available to all regardless of ability to pay. The government has issued a decree stating that people who cannot afford the cost of treatment need to present an official certificate from their village chief to certify that they are poor, in order to be exempted from payment<sup>13</sup>. In spite of this, peer researchers reported that people *perceived* that they would not be treated if they did not have sufficient funds. To give an idea of the significance of the following costs, a day's labouring typically earns 15,000-18,000 kip, and a chicken can be sold for 30,000 kip:

If people are unwell or have a headache, some women would go straight to the doctor to find help, but others won't go anywhere near a doctor at all, mainly because of money. That's because if you don't have money, they don't treat you, even if you are really sick. Others, even if they do have money, don't feel like spending it and just hope that the problem goes away. Providers are nice, and ask nicely. For most people who come, the language problem is that the providers only speak Lao, and not the ethnic languages, making it really difficult. Sometimes there's an interpreter, but usually there is

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<sup>13</sup> The Decree of Prime Minister No 52/PM on Medical Services dated 26/6/1995

no one. The trouble is that people don't know the procedure. You get different things at different places at the hospital: where you register, see someone, and get drugs are different places. You need to get someone to come with you who knows the system.

When they arrive at the hospital, if they don't know anybody, the doctors don't tend to take much interest. But if the patient looks like they have some money, or a present to give, then they get a better reception. Only a small number of doctors would be nice to them... When you attend hospital you spend a lot of money, before you are even seen and get medicine. For an ultrasound, you have to pay upfront 22,000 kip before you get seen, and people who have no money wouldn't be able to afford it. Doctors, when they see patients from villages, they don't want to look at them, they don't speak nicely to them, they shout at them, and these are the reasons why patients don't want to go to hospital.

The reason why they don't go to the hospital is because it's expensive, they have to pay 500,000 kip, sometimes up to 1 million, to deliver a child there. Not only do they have to pay for the services in hospital, they have to buy presents for the doctors as well, otherwise they won't get seen or won't get treated properly.

Financial barriers did not always just reflect a complete lack of money, but also an unwillingness to spend money or assets, and not wanting to go into debt because it was difficult to know how much the final bill would be:

There's a hospital registration fee of 2,000 kip, but some people don't even have that, and you have to pay it up front. You can't do it on credit, the hospital won't allow it. There are costs involved with blood tests too, and to buy medicines, so it could mount up, and it's unpredictable how much you might have to pay.

In cases of illness people don't go to hospital, they would rather die here and don't want to go into debt. They are too scared of having to pay. If they can buy medicine they'd rather just buy it and treat themselves. Even when hospitals allow them credit they still don't want to be in debt.

Whether hospitals offer credit or not seems to depend on whether users can persuade the staff. Varying fees and uncertainty about credit do not help users make an informed decision about going to hospital. In some cases it was possible to get a fee waiver from the chief to present at the hospital. However, many people have assets such as animals and land, and are thus not the poorest of the poor, but they are unwilling to sell these assets as this will lead to increased vulnerability to hardship in future. Selling assets to pay for health care costs is a major factor in increasing household poverty and vulnerability.

One of the challenges of delivering new services is managing people's expectations by making deliverable promises, because if services do not live up to expectations this can lead to discontinuation of use and negative stories spreading in the community. Breaking promises about services can lead to great disappointment:

When her mother was ill, they took a tuk-tuk tractor to the hospital and had to pay 5,000 kip parking fee even before she entered the hospital. Someone with TB had heard all these campaigns saying that if you have TB and go to hospital you don't have to pay, but when they actually got there, they were told to pay. They were told that the money would go towards buying tablecloths and everything else to equip the hospital, so the patient wasn't happy about having to spend 100,000 – 150,000 kip.

Services in hospital aren't the same as the mobile clinics in the village: the mobile clinic speaks nicely, villagers get interested, and they are always told that if they are ill to go into hospital. But when they go to the hospital, doctors are not interested.

There were no negative reports about mobile services. There were some positive reports of hospital services which described a good reception from providers and how people were 'directed' where to go (indicating the perceived need for guidance in negotiating the hospital system). People did not always think there was differential treatment between those with or without money:

When they arrive at the [Provincial] hospital, providers usually welcome them, they get good services, they are directed to various places for tests and stuff, to go to pay registration, to buy a follow up book (so that next time they come they have their records). They are directed to various departments where they

need to go. If they have to stay in hospital they are looked after well, are given health education about food and taking medicine. Those with or without money get the same treatment.

Even initially positive feedback of hospital services was followed by examples of when service was poor:

When people go into hospital, the reception is good, however, only some providers are really nice, there are some who are not interested in villagers at all, the way they speak is not nice to the ear. All they want is money from patients, making patients reluctant to go to hospital again.

Most providers give good services when they attend hospital, such as asking about symptoms, examining, giving advice and medicine, so all of it seems good, even when they have to stay in hospital. However there are some providers who always tell patients off, when you are really ill and you come into hospital, mostly they tell them off about cleanliness, when patients dirty the room, or make themselves dirty. Those who don't have any money, they can get a waiver from the hospital.

Being 'told off' by health personnel for coming to the hospital too late, and for dirtiness, were consistent themes. This indicates the significant power imbalance between hospital users and the medical personnel. It should be noted that hospitals are trying to deliver services in very difficult circumstances. In Kaleum, the hospital only had running water for half the day. It is difficult to recruit staff to remote areas, salaries are low, and it is hard to maintain equipment and supplies with meagre resources.

## **6.5 Communications**

**Radio:** In Kaleum, there were few radios in villages, and even in villages with radios, women often reported that they did not listen. Most of the broadcasts would be in Lao, which is not widely understood, though there are some specialist ethnic channels. Some villages were out of range of FM radio signal.

Only older people listen to the radio, other people just want to listen to music, and turn it off when they hear things about health promotion. They don't even like educational songs. With the recent measles vaccination campaign, some

women turned up at the hospital three days early because they had heard about it on the radio but hadn't listened to the message properly. Other women are the same: they hear the radio, but they don't really listen. It isn't that they don't understand – they hear it, but they just don't take it in.

Radio communications are unlikely to be an ideal solution for communicating with remote groups. There appears to be widespread reluctance to listening to health promotion programmes; people resent being lectured to. There are many examples of innovative approaches being effectively used in other parts of the world, such as integrating reproductive health story lines into soap operas and dramas, so that people do not necessarily realise they are learning about a health issue.

**Posters:** Although peer researchers did not mention posters in their findings, it was possible for the research team to observe the distribution and topics of health related posters. They were popular in village halls, and the homes of health workers, health volunteers and village chiefs. However reproductive health and family planning topics were entirely missing from these poster collections. Unexploded ordnance, avian flu, and vaccination were the most common topics.

**Interpersonal communications:** Until recently, direct communications with villages were made by mobile health teams and LWU/LYU representatives, in the form of presentations to groups summoned to meet at a central location in the village. Certain villages were designated 'target villages' for health education by UNFPA in their previous programme, so it is worth investigating what messages this campaign used. Arriving with completely different messages may confuse people: it is preferable to build on what has already been done. However, there is a certain amount of ambivalence towards these meetings, especially from men:

When health promotions happen, only the women go. Their husbands don't listen to them when they come back with information. In fact, for all village meetings, only the women go. The men just push the women to attend, saying they're too busy. Then the women are meant to go back and tell their husband what happened. Especially with government workers' families – the men just don't bother.

Women are very busy with domestic and agricultural work and do not have much free time to attend events. In addition, in many areas people do not live in their villages for

parts of the year, staying next to their rice fields instead. During other times of the year, such as if their rice supplies have finished, people may be busy with other types of work to supplement their income and diet. During these times, it will be difficult to find people at home in a village, and activities often have to wait for the evening.

In the evenings, women in the village wait for the kids to go to bed, then meet up with their female friends to smoke a pipe and gossip. They may sometimes stay up until midnight. But they get up at 4am to pound rice. During harvest times they are busier so don't have as much time to relax.

Chatting to friends is an important way for women to relax and share information. Small facilitated discussion groups about reproductive health issues may work well in such a setting.

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## 8 Appendices

### ***Appendix 1. PEER results, Saravan and Attapeu Provinces.***

The following data were collected using PEER, replicating the method used in Sekong Province, as described in the main body of the PEER report. Analysis of findings revealed that social context, livelihood strategies, treatment seeking behaviour, and barriers to health and reproductive health services were remarkably similar to those in Sekong Province, despite differences in ethnicity and geography. This suggests that underlying issues are very similar across the provinces. These key issues include disempowerment of communities in relation to health service provision, unwillingness to access services, financial barriers to services, and low levels of perceived risk around maternal mortality. In spite of these similarities, it remains important to tailor communications and activities to specific areas, by translating materials into the appropriate language, and ensuring that visual representation of ethnic groups is accurate.

Due to the similarity of main findings, in order to avoid duplication of the main body of the PEER report, Attapeu and Saravan data are summarised in this appendix. Key quotations are accompanied by explanatory notes highlighting when they differ from Sekong findings, or when data support conclusions in the main report.

**Evidence of commercial sex work.** This subject was not raised in Sekong Province. While this does not mean that transactional sex is not taking place in other areas, it suggests that in some communities people are more aware of the issue or are more able to articulate their awareness. The following quotation was taken from a village 30km from Saravan town accessible by a very poor logging road. The supervisor collecting the data noted that the girls in the village, including the peer researcher, did not have any knowledge about STIs or HIV/AIDS:

For extra work...there are young girls in the village who sell their services for cash with foreign men (Vietnamese). These are loggers/labourers coming to cut logs and ship them out. They pay the girl around 40,000 – 50,000 kip to sleep with them. She thinks that the men use condoms. (Saravan)

**Early marriage:** Several villages in Saravan reported earlier age at marriage than any peer researchers in Sekong. There were also villages in which young girls were given to their prospective in-laws at the age of ten to be looked after before being married at age 14 (reported for the Pako ethnic group). They were also reported to practice cousin marriage.

**Family planning:** Two peer researchers in different villages reported that husbands went to collect contraceptives for their wives. Concerns about side effects and discontinuation without seeking an alternative method of contraception are similar to those found in Sekong:

Some women use modern methods such as pills. Their husbands would go and get the pills for them, but many women stopped using them because of illness. Other women showed side effects (such as dizziness, feeling sick) so they would stop taking them. When they talked to the health workers and were informed that the feelings were normal they would restart the pills again. However, some women just stopped completely and didn't ask health workers about it. (Saravan)

Contraceptive use in one village appeared to be opportunistic, suggesting that there is not a reliable supply nearby: 'Some [women] even buy their own pills, if they happen to be in town' (Saravan).

Peer researchers in some villages reported limited knowledge and understanding about modern contraceptive methods:

There are very little uptake of pills in this village. One woman took the pills, but still ended up having two children. She has now stopped. There is another one still taking pills. The general consensus is that people still don't know much about them and are scared of taking them. (Saravan)

As in Sekong, there was an apparent lack of confidentiality in women's contraceptive usage in Attapeu:

The village also has more than 10 cases of sterilization and one case of using intrauterine devices (IUD). There are no records on condom use. (Attapeu)

There is a small group who practice oral medicines. One person is reported to use IUD; there are no cases of sterilization. (Attapeu)

A similar scenario was reported in all three provinces of initial interest in modern contraceptive methods, followed by discontinuation, often accompanied by doubts and rumours:

At first, many women wanted to practice birth spacing, but now they heard that doing so would create cysts or other sicknesses. The rumours are growing that some women who took pills developed pain in the lower abdomen, irregular menstruation, got cysts, or other sicknesses. The concern is how they will get money for treatment. Therefore, it is better to go the natural way, which means letting women reach menopause so they will not have children anymore. (Attapeu)

Part of the high rates of discontinuation may be explained by patchy or unreliable services:

A few women in the village took the pills, became ill and stopped... A mobile clinic came to promote family planning, but then did not come again (Saravan).

They will see the VHV or go to the hospital if the VHV runs out of contraceptives (Attapeu)

The importance of sustained services is illustrated by this peer researcher: 'many women in the village use pills. They don't fear them. There is good follow up from the health workers' (Saravan).

Several peer researchers in Attapeu reported women having to pay for a urine test at the hospital before they could be prescribed contraceptives (this is presumably a pregnancy test) and being charged up to 10,000 kip for this.

Another common factor between the provinces that may limit demand for contraceptive methods or lead to high discontinuation rates is the experience or fear of side effects. In the following story, contraception is blamed for the ill health of a seventeen year old with three children:

After getting the contraceptive injection, some people gain weight, some get irregular periods. For example, there is one person in the village, who is 17 years old, and has three children. After using contraception, her health condition was not good; she became thinner, fatigued, and unable to eat well. After stopping taking contraception, she became healthy again. (Attapeu)

The following quotation shows the dilemma faced by people who are told that family planning is beneficial to their health, but who also fear ill health if they use them:

People want to use family planning, in the past there was no family planning campaign, but nowadays people want to have two to three children, because they are afraid of diseases, lower abdominal pain, and tumours. Some people are allergic to contraceptives, which creates symptoms like dizziness, blurring eyes, feeling cold when bathing, and being unable to eat well. (Attapeu)

Fear of damage to fertility or future health was also associated with contraception:

Some think that they will have big health problems when they want to have babies if they practice contraception. (Attapeu)

In several villages in Attapeu and Saravan women were said to use herbal roots to prevent pregnancy, which was not mentioned in Sekong province.

The issue of 'broken promises' whereby people are promised a service that does not materialise was also raised in relation to permanent family planning methods:

Villagers want to have sterilization, but they can not afford it. Once they heard an announcement that there will be free sterilization, but they had to pay 200,000 kip for medicines. (Attapeu)

Another barrier to using contraception faced by women Attapeu, which was not mentioned in Sekong, was their husband's fear that their wife would be more likely to be unfaithful:

All women in this village need permission from their husbands before using contraceptives. Many husbands don't want their wives to use contraception

even if they already have many children, because they are afraid that their wives won't be faithful, and their wives may get hurt and there is no money to pay for treatment when their wives are sick. (Attapeu)

Health messages tend to associate birth spacing with health or prosperity, but in some communities peer researchers said that 'people want to space their children, or don't want too many children, because they are poor' (Saravan). This difference in rationale suggests that messages from health providers do not necessarily reflect the reality of people's lives. Due to the paucity of positively framed accounts of family planning in the PEER data, one recommendation of this study is to seek out positive testimonials from satisfied users, in order to build a foundation for the creation of positive messages for family planning demand creation strategies.

**Gender:** As in Sekong, there was variation in perception of gender relationships and power in different villages. However in several villages there was little perceived evidence for changing gender relations:

Women work harder than men. Men plough the field and not much else... Men even ignore crying children when women are busy. Men sometimes weave baskets, but they don't fetch that much money. Women carry firewood home from the fields... Men get drunk using the money gained from selling animals or resin. They don't share the money. Women sometimes sell animals, but they use the money for the family, not personal use. All housework is done by women... Men make decision about children's marriages and education. If there were limited funds, only boys would be sent for further education. (Saravan)

The following quotation gives further insight into the strong work ethos of women, found in all three provinces, which persists into pregnancy and childbirth:

Women work as usual during pregnancy. It is believed that hard work will help women deliver easily. They have to avoid lying around; otherwise they will retain the placenta. (Saravan)

**Economic context:** In all three provinces, peer researchers reported that people have very limited cash supply, especially in places far from markets where they could sell produce, or where they could work as daily labourers:

Natural fertilizers are used and do not produce as high a yield as chemical fertilizers. Villagers want to use chemicals but have limited cash to buy them. Those that don't have enough rice have to buy it to supplement. They sometimes borrow from their friends or relatives or beg. (Saravan)

In one village there was evidence for the increasing appeal of aspects of 'modern' culture, a reminder that ethnic groups are not static but are undergoing continuous changes in behaviours and aspirations:

Women weave 'sinn' [traditional skirt] but they exchange them for a more modern batik 'sinn'. (Saravan)

As in other provinces, subsistence patterns have changed for villages resettled from highland areas. The resulting subsistence pattern is perceived to be vulnerable and precarious, and is often contrasted with past times living in remoter locations with access to plentiful wild foods:

Chicken die on an annual basis (sometimes twice a year) due to diseases you cannot prevent. They are also stolen by other villagers... Villagers forage around the nearby river for vegetables, frogs etc. They usually find enough for the pot [enough to eat themselves] but not to sell. Men don't hunt because they don't have guns: the authorities confiscated them all. (Saravan)

The World Food Programme provided rice for the first three months [after the village was relocated]. Now that project has been finished for three years. Some villagers discontinued working in the rice fields since they do not produce enough rice to consume... No families in the village have enough rice for the whole year... Because of the new settlement, the area for paddy fields is limited. To subsist, the villagers must rely on nature to get vegetables and small animals such as frogs and squirrels from the forests. (Attapeu)

**Domestic violence:** This issue was not raised directly in Sekong Province. However, peer researchers from Attapeu province spoke about men's excessive drinking habits, often linked to neglect of domestic responsibilities and aggression, on several occasions. The following story tells of how a man must pay retribution to his wife after attacking her:

In some families, the husbands like to go out for a drink, and do not help their wives... For example, a husband went out drinking, and when he came back home, his wife and children had already had dinner and left nothing for him. Therefore, he hit his wife until she was bleeding. The next day, he had to beg for forgiveness with a jar of homemade alcohol, boiled chicken and money. This is the tradition and the rule that all villagers must obey. (Attapeu)

**Treatment seeking:** There is evidence, supporting findings from Sekong, that easy physical access encourages demand for services even in communities where there had previously been low perceived need for services:

[In the past] only in cases of ill health would a pregnant woman go for a check up. However, now many women actually go to the Health Centre since last year, because it has just been established three years ago near the village. (Saravan)

The following quotation shows a local model of treatment seeking:

When the villagers are sick they are not confident to go to the hospital if the traditional ceremony has not been done first. The ceremony is called the 'God of the House' and includes killing a pig and chicken... During the ceremony family members are not allowed to go out for three days and outsiders are also not allowed to enter their house. The patient will be taken to the hospital if they do not get better after the three days. (Attapeu)

The model of treatment seeking in this case is to withdraw into the house and perform ceremonial activities that the family controls themselves. Rather than making contact with outsiders, they exclude them from the house. This model is fundamentally at odds with the pattern of behaviour health providers want to promote, which often involves leaving the house, travelling a long distance, and making contact with strangers, at a time of vulnerability and sickness.

**Financial barriers:** The high costs perceived to be associated with health care, described for Sekong, apply equally in this province:

If villagers are very ill such as having high fever, they will go to hospital. If it is something they consider minor, they would just buy medicine and treat themselves. People are scared of hospital fees. They have to sell their animals to pay for medicines. Intravenous fluid costs 15,000 kip per bag. (Saravan)

While some health centres reportedly had a credit system or exemption for payments, others were thought not to:

Once at the hospital, health workers treat them well. They have to pay, usually for medicines. It can be anything from 100,000 kip up to a million, depending on the illness. Villagers stay in hospital until their money runs out, then they return home to wait for death. Cash is obtained from selling animals. If there's nothing to sell then they would just wait to die. The hospital does not have a credit system to allow repayment at later date. (Saravan)

While staying in the hospital, doctors conduct visits regularly. In case patients don't have enough money, doctors advise relatives to get a written statement from the village headman to get health treatment free of charge. (Attapeu)

The following quotation illustrates how a story circulating in the community can inspire fear in people of financial problems in attending hospital for delivery, whether or not the story is based in fact:

If patients don't have money, they can just sleep at a hospital and will not get any medicines or injections. A hospital will not take credit. For example: there was a patient from this village who had a difficult delivery, she had to sell a buffalo to get money so she was able to give birth at a hospital but the money was not enough, so during her hospitalization she had to escape from the hospital, but the hospital sent people to ask her to pay for the rest. (Attapeu)

Patients with money were also thought to suffer from lack of financial transparency:

When doctors and nurses see patients who have money, they will charge them unfairly. (Attapeu)

These accounts show the diversity of perceptions of reported experiences of health care. They show how important fairness, transparency, and access for poor people are to the community.

**Perceptions of services:** Differences in the quality of care between clinics/hospitals and mobile teams, as reported in Sekong, are also reported in Saravan:

Reception is not often good when arriving at hospital (district). Providers don't speak nicely to patients... Their attitude is that they did not want to touch or examine villagers... When the mobile team comes to the village they are very nice, but when villagers go to hospital they are not treated so well. (Saravan)

The level of human resources at health centres was poorly perceived by the following peer researcher's informant:

It's only if illness is considered serious that people go to hospital. They try traditional medicine first, and then do a sacrifice. If that doesn't work then they go to the hospital. They usually go to the District hospital since the Health Centre doesn't have anyone around. (Saravan)

This story of reported bad treatment at a hospital apparently led to the whole community losing trust in its services:

If they are poor patients, they will get little attention from doctors and nurses. For example, a family took their child with malaria to the hospital. The doctor prescribed for that child but never followed up. One day the child complained of hand pain. The mother twice went to ask doctors to come to help but they never came, and finally the child died. The mother cried with sadness. A doctor pulled the needle from the child and told the mother to take her child's body home. Before she left she had to pay the hospital 30,000 kip, but she could pay only 10,000 kip because that's all the money she had. She had a debt to the hospital of 20,000 kip. After that incident no one wants to go that hospital. Many villagers cross the border to get a medical care in Vietnam; they pay the same but get more attention. (Attapeu)

Equally, a body of positive regard can be generated from positive experiences of services:

In one case of malaria, the patient was sent to the hospital after traditional healing had failed. The doctor prescribed medicine appropriately and treated the patient well, which increased trust that the villagers had [in the hospital]. There are many cases of stomach pain being cured by medical treatment at the hospital. (Attapeu)

**Maternal mortality:** In data for all three provinces there was only one story of a maternal death, suggesting very low risk awareness. Note this story is also introduced as being 'in the past', suggesting a further perceived distance from risk:

In the past there was a woman who had retention of placenta. It was her sixth child. She bled a lot and died after two hours of giving birth. There was not enough time to take her to hospital. (Saravan)

## Appendix 2. Peer researcher prompts



### Topic 1 – Everyday life (middle column in photograph above)

- Jobs, occupations, and earnings (woman bending over gardening)
- Extra work (vegetable garden) to earn money
- Making a living – getting food - sustenance (fish)
- Raising animals (bird)
- School (picture of school building)
- The work of men and women (two people and some trees)

### Topic 2 - Women's health (left hand column in photograph above)

- Age of marriage (two hearts)
- ANC (lady walking down a path to a building)
- Vaccinations (pregnant woman and syringe)
- Work during pregnancy (pregnant woman and two buckets on a stick)
- Nutrition and how women take care of themselves postnatally (fire, woman, food)
- Breastfeeding (baby in arms)

### Topic 3 – Health services (right hand column in photograph above)

- Access – whether they go to hospital - why not? (building with cross on it)
- Providers: How people are received (someone arriving at the hospital)

- Places for delivery
- Use of traditional medicine (leafy plant)
- [Knowledge of] family planning methods (what methods they use and any side effects) Where they access family planning (pills and injection)
- Where do they get information from about these things?

### ***Appendix 3. What is a rights-based approach?***

An approach which is based on international human rights standards and aims to promote and protect human rights. The standards are those contained in the wealth of international treaties and declarations. A rights-based approach should include the following:

- **Express linkage to rights:** the objectives of the programme should be clearly linked to human rights, in this case, the right to health, the right to a family life etc.
- **Accountability:** identifying claim-holders and their entitlements, and duty-holders and their responsibilities.
- **Empowerment:** rather than charitable responses. Emphasize human person at the centre of development. Give people the power and capabilities to improve their own communities.
- **Participation:** should be active, free and meaningful.
- **Non-discrimination and attention to vulnerable groups:** guarding against reinforcing power imbalances e.g. between men and women, or between service providers and users.
- **Equality and equity**

Adapted from [www.unhcr.ch/development/approaches-04.html](http://www.unhcr.ch/development/approaches-04.html)





UNFPA – LAO PDR  
Ban Phonesavanh Tai  
Vientiane Lao PDR  
P.O. Box : 345  
Tel : (856-21) 315547, 353049  
Fax : (856-21) 353051  
Email:unfpa.fo.laos@undp.org