Family Planning Amongst the Akha & Khmu

"What type of services is necessary?"

Khua District

Lao PDR

A dissertation presented in partial fulfillment of

the requirements for a

Masters of Philosophy
in
Development Studies

at Massey University, Palmerston North

New Zealand.

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2003

Massey University

Development Studies

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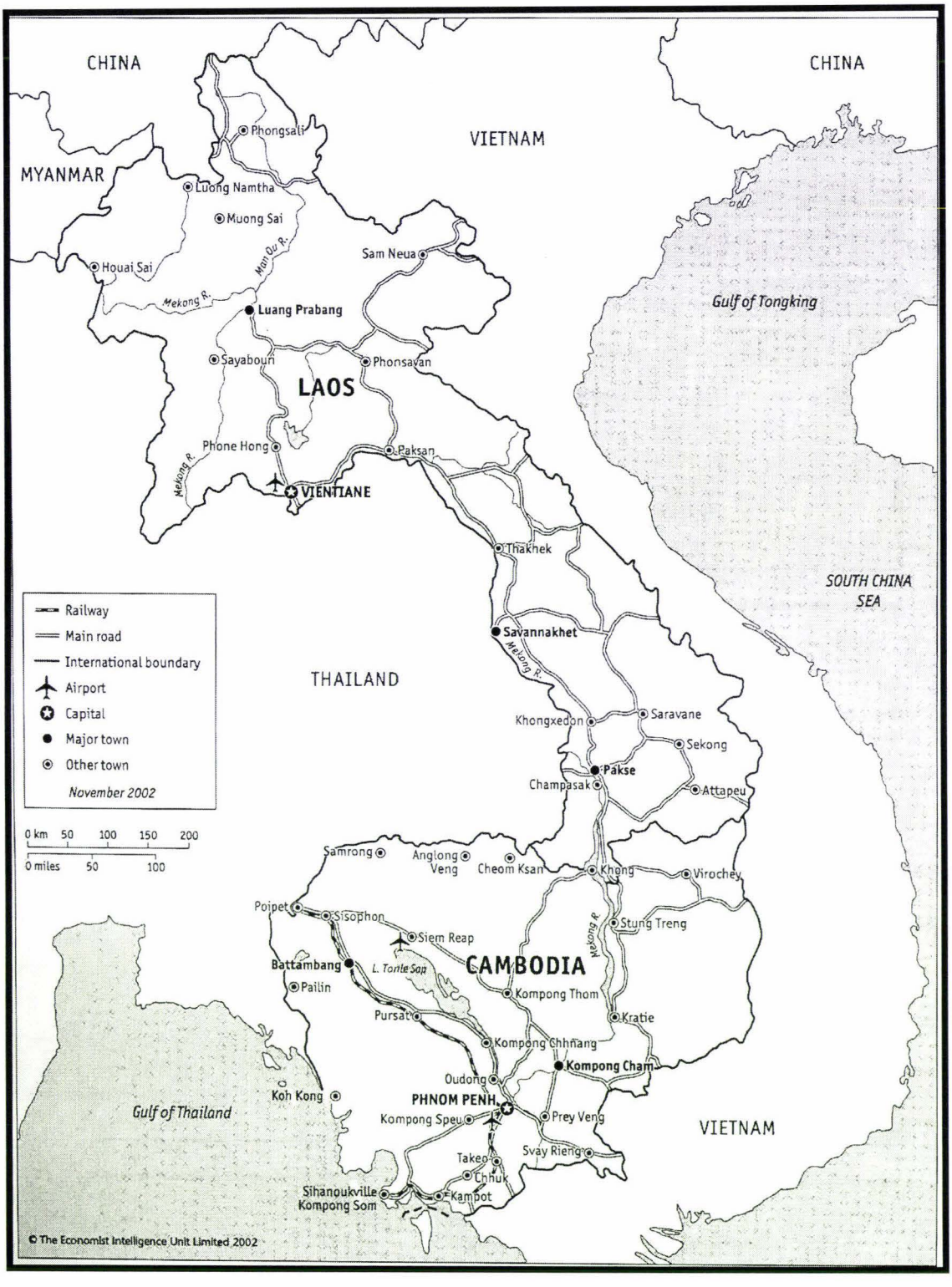
Cover photo: Akha woman and children Ban Houay Phot

Abbreviations

ADB	Asian Development Bank
ARI	Acute Respiratory Illnesses
DES	District Education Service
DHS	District Health Service
EPI	Expanded Programme of Immunisation
FGD	Focus Group Discussion
GOL	Government of Lao
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
MoH	Ministry of Health
Naam Saad	Sanitation and Environmental Health Institute
NGO	Non-Government Organisation
OCP	Oral Contraceptive Pill
PHC	Primary Health Care
PHS	Provincial Health Service
TB	Tuberculosis
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VDC	Village Development Committee
VHV	Village Health Volunteer
WATSAN	Water and Sanitation
WHO	World Health Organisation
WB	World Bank

Map of the Lao PDR



1. Executive Summary

The provision of family planning services can provide women with opportunities to improve their health, mitigate potential health risks, and also contribute to strengthening their socio-economic position.

Women in the remote rural communities of the Lao PDR often make up one of the most vulnerable groups of society. They are vulnerable, through lower social status, poor health, and illiteracy, and lack any real opportunity to improve their economic opportunity.

Access to any of the basic services, such as health, education, or to the market, is difficult. Villages are often in remote mountainous locations, with poor road access, or reliant on sometimes dangerous travel by river.

Due in part to the remote location of the villages, family-planning services are seldom accessed by women in the rural communities. Women instead rely on infrequent trips to district or provincial centres to purchase contraceptives, or even less frequent visits by mobile health teams provided by district health services.

This paper will discuss women's perceptions regarding the importance of accessing family planning services and the need for family planning services to be made available to women in remote rural villages.

2. Introduction

The Lao PDR, a landlocked country, of 236 800 sq kms, with a population of 5,091,100, is situated between Thailand and Cambodia to the south, Vietnam to the east, China to the north, and Myanmar to the west. Lao is a geographically diverse country, which stretches along the Annamite chain to the Mekong River valley. There are 48 ethnic groups in the Lao PDR. The majority of which make up the Lao Loum (lowland Lao).

Lao is one of the few remaining communist countries in the world today. Following the people's revolution in 1975 the Lao PDR was formed by the Lao Peoples Revolutionary Party, which currently remains the only political party in existence in the Lao PDR. Today the Party remains strong with a centralised government, though through a series of political reforms during the 1980s such as the introduction of the New Economic Mechanism the country has opened up to more international trade and investment. Entry into the World Trade Organisation (WTO) is now being considered following a submission made in 2000.

The reproductive health of women in the Lao PDR is one of the top ten priorities of the Ministry of Health's Primary Health Care Policy. To assist with the implementation of the policy a National Family planning Program was established in 1991. While initial implementation of the program focussed on more densely populated areas in the more accessible provincial capitals along the Mekong River, women in remote rural communities are also being targeted. While the policy is to be commended for its aims, the implementation of activities to achieve its aims can at times be hindered by a lack of funding, poor infrastructure and communication and a lack of human resources.

3. The Lao PDR in 2003

3.1 Health

Health services in the Lao PDR are accessible through a network of approximately "700 facilities at central, provincial, district and sub district levels, which allows at least 67% of the population access basic health services" (UNFPA: 2001) However utilisation of health services remain very low, despite 79% of villages located within four hours of a district hospital, (ibid). Again rural villages were more likely to be further from a health centre, with only 54.7% of rural villages less than 4 kilometres from a health centre.

The population of the Lao PDR was estimated at 5.2 million in 2000. If the current annual population growth rate of 2.8% remains unchanged, the population will double by 2025. Over 54% of the population are under the age of 20, and young people aged 15-24 comprise nearly 18% of the total population. The total fertility rate has dropped from 6.5 in 1994 to 4.9 in 2000, but still ranks among the highest in Asia. The contraceptive prevalence rate has tripled since 1995, but remains low at 32%. Life expectancy at birth is 61 for females and 57 for males. The maternal mortality rate is 530 per 100,000 live births, down from 650 per 100,000 in 1995. Infant mortality had dropped as well, from 105 per 1,000 live births to 82 per 1,000. The high maternal mortality rate is attributed to the lack of prenatal care, poor nutrition, anaemia, lack of emergency obstetrical care, abortion related complications, the early age at which girls become pregnant, and the unavailability of family planning services (ibid).

The disparity in health service delivery between urban and rural areas is also evident in the care of the mother during labour and childbirth. The following table highlights how the majority of women in rural areas are assisted in the delivery of their child by a relative or friend.

Percent distribution of women aged 15-49 with a birth in the previous year by type of personnel assisting in the delivery.								
	(n=1126)	Personnel assisting at the delivery						
	No assistance	Doctor	Nurse	Midwife	Traditional Birth Attendant	Relative/ friend	Other	Total
Regions								
North	22.7	7.8	6.6	1.9	6.0	45.2	9.7	100
Central	11.3	15.4	9.1	4.2	10.3	41.6	8.0	100
South	6.7	7.2	7.7	2.4	32.3	30.2	13.6	100
Areas								
Urban	0.0	39.7	27.7	5.5	6.1	14.6	6.4	100
Rural	16.0	5.1	4.2	2.4	17.4	43.9	11.00	100
Total	**13.5**	**10.5**	**7.9**	**2.9**	**15.6**	**39.3**	**10.3**	**100**

(NHS:2001)

Malaria remains the leading cause of death of children under the age of five years, despite over 92% of the population sleeping under bed nets. Malaria also contributes to anaemia in pregnant women and absenteeism from school in children (ibid). Acute respiratory infections, such as pneumonia, as well as dehydration caused by diarrhoea are also major causes of mortality amongst children under the age of five (ibid).

3.2 Health Care Delivery in the Lao PDR

Government supported health care is provided at all levels from central to village level, which takes the form of hospitals and clinics at provincial, district and village level. Health care service delivery corresponds to the respective government administrative level.

3.2.1 "Suksala" – Dispensary

The lowest level health service delivery points are the "suksala" which have an average of three beds. These are the first points of access to health services for the population. They provide basic preventive and curative health services. Vertical health programmes, such as EPI, control of diarrhoeal diseases, ARI prevention and TB prevention operate through some of these health posts. These health posts are financed mainly from user fees. The provinces provide some central funding but most of this funding is earmarked for staff salaries. Each health post covers an average population of 2-3,000 people and is normally staffed by three people, depending on the target population. The head of the health post is

sometimes a doctor but often a nurse/midwife. The staff of the health post refers to the officer in charge at the district hospital.

3.2.2 District Health Service

This includes the District Health Offices, district hospitals and vertical programmes. The structure mirrors that of central level MoH. Each of the country's 125 districts has a hospital with 5-30 beds manned by three doctors/medical assistants. The district hospital is responsible for clinical examination, diagnosing and treatment of patients, implementing preventive/promotive health care, and for training and supervising health post staff. Staff at district level refers to the Provincial Health Office. District health services are funded by the Provincial Health Office from the state budget, and by patient service charges. Each district covers a population of 20-50,000 inhabitants.

3.2.3 Provincial Health Department

The Provincial Health Office oversees health services at district level and below. There are 16 provinces and Vientiane Municipality with five regional hospitals and 13 provincial hospitals, each of which has between 45-240 beds. Each provincial health department is structured in the same way as at central level and includes seven departments. The Provincial Health Office has full responsibility for all health activities, including examination, diagnosis, treatment and referral, as well as preventive/promotive health care, supply of drugs and training schools for lower level workers (assistant doctors, nurses and midwives) and staff of provincial hospitals. The Provincial Health Office monitors health stations at lower levels. Each Provincial Health Office covers an average population of 40-50,000 and includes between five and seven districts.

3.2.4 Central Health Services

The MoH and its services make up the top level of the Lao health system. The MoH is responsible for providing policy direction and technical support to the whole system. In addition, the MoH operates institutes, centres, hospitals and colleges. The departments under the MoH's management are specialised institutions like central hospitals, medical universities, central government pharmaceutical companies and other educational institutions. The MoH also implements a number of vertical preventive and public health programmes. Traditional medicine is part of the state system and is managed by the MoH.

Traditional medicine is considered to be an acceptable alternative method of treatment in Laos.

3.3 Health Expenditure and Financing

During 2001 Japanese International Cooperation Assistance (JICA) conducted a study to assist with the "Lao Health Master Plan", the following key findings were made in relation to health expenditure and financing;

- There has been an upward trend in state spending for health. State spending increased from US$38 million in 1992-93 to US$51 million in 1994-95 and US$72 million in 1997-98. In real terms this is nearly a 100% increase. However, as a percentage of total state spending, expenditure on the health sector has increased from 4.6% of GDP in 1986 to 7% in 2002, with a heavy drop between 1989-1991 due to the effects of New Economic Mechanism and the Asian financial crisis.

- Despite the recovery, health expenditure per person per year from the GoL averages only US$11.5. This is quite low by international standards (US$40 for developing countries in South and East Asia, excluding India and China, for which the figure is US$21). This is hardly enough to pay for an essential health care package.

- The insufficient allocation from government for health has made it impossible to provide equal access to quality health care. The Government has allocated a proportionally higher percentage of the total budget for health care to the mountainous areas where ethnic minorities live. This is partly done through a loan of US$25 million from the Asian Development Bank for improving PHC services. But the GoL has also allocated a proportionally higher amount to curative care in urban areas compared to preventive/promotive health care in rural areas, through the construction/renovation of three major hospitals. This could adversely affect equity.

- In 2002 the government budget covered 15% of the total health expenditure, while users of health services paid 60%. According to the Lao Expenditure and Consumption Survey 1997-98, Lao households spent on average 4.246 kip per month on medical care. This represents 2.2% of total household consumption but

3.3% of monetary expenditure. This translates into 18,080 kip per capita per year or US$6.7.

- More than half of health care expenditure comes out of the households' "out of pocket expenditure". The majority of this expenditure goes on purchasing drugs (92%), mainly in the private sector, while 4.4% is used for payment of user fees and private sector health services.

- The health care sector is funded from a variety of sources: central and local revenues, private payments for medicines and services, compulsory contributions from employers and employees to mandatory health insurance schemes, and donor agencies (about 25% of the total health expenditure). While spending by households and international donors has increased throughout the period, direct spending from the GoL has been reduced and is now at its lowest point in many years.

3.4 Health Care Delivery Issues for Rural Communities

Health care service provision for rural communities remains problematic, poor infrastructure, lack of qualified staff, inadequate facilities and chronic under funding combine to place rural communities at an increased risk of morbidity and mortality. The problem is exacerbated by a government policy of decentralisation, which places the responsibility of funding health care delivery for the rural communities at the provincial level.

The MOH – JICA Study (2001) also noted that, "there are great geographical variations in the spending pattern. When compared across the country, data showed that, on average, households located in the Central Region (which have higher incomes) spend more in absolute terms (4,616 kip) than those in the Southern Region (4,075 kip) and the poorest Northern Region (3,806 kip).

With poor pay and no incentives, few qualified health care professionals wish to work in remote provinces. The National Health Survey (2001) observed that only 51% of rural areas had one health professional (either a doctor, medical assistant, mid level or auxiliary nurse) available to a village. These staff once re-located to a rural location are essentially left to "fend for themselves" with minimal supervision or peer support.

3.5 *A Struggling Economy*

Overshadowed by some of its relative "economic giant" neighbours, Thailand, China and Vietnam, the Lao PDR faces an uphill battle in strengthening its economy. The Lao PDR, relies heavily on donor assistance and loans acquired through international financial institutions such as the World Bank (WB) and the Asian Development Bank (ADB) to support public service delivery, i.e. health and education, infrastructure development such as roads, airports and hydro electric dams and, to finance budget deficits.

Figure 1 Slash and burn agriculture

The Lao PDR is reliant on cross border trade with Vietnam and Thailand. The "main destination of exports in 2001 went to Vietnam (41%), while the majority of imports in 2001 originated from Thailand (52.5%), (Economist Intelligence Unit: 2003). The "principal exports for 2001 were electricity 32%, garments 30.2%, while 49.4% of the principal imports were consumption goods" (ibid).

Poverty is a major issue in the Lao PDR, where approximately 26% of the population attempt to survive on below USD$1 per day (UNICEF 2002:105). Government salaries are insufficient to support staff, resulting in many staff relying on additional forms of employment to supplement their meagre monthly income. In order to achieve the governments goal of "...eliminating poverty by 2020 (poverty is defined in terms of access to a basic supply of food and non-food goods necessary to support a minimum standard of living), the government launched a poverty reduction fund in November 2002, backed by a US$19.3 million loan from the World Bank. The fund's work will concentrate on physical infrastructure (improving roads and water supplies) and social infrastructure (schools and primary health care) at the district and village level (Economist Intelligence Unit 2003:31)

3.6 *Education*

Access to education in Lao is also limited. Several issues impact on the government's ability to provide nationwide coverage of education services to schoolchildren. As with

other government services, a lack of resources, both financial and human, coupled with an often inaccessible mountainous terrain, impedes government service delivery.

Parents are required to pay a small administrative fee for children to attend school, as well as purchase uniforms, stationary and meet the cost of transportation. While in urban areas this may prove less difficult, given greater employment opportunities for parents, in the rural communities these costs can prove prohibitive to families whose sole source of income is through the sale of rice or non-timber forest products.

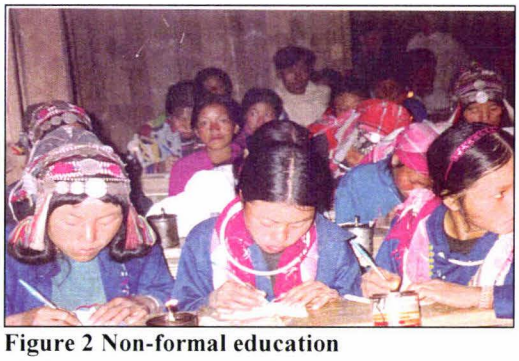


Figure 2 Non-formal education

Consequently many families in rural communities can only afford to send one child from the family to attend school, while siblings are required to assist with gathering food from the forest, and with rice cultivation.

While it is difficult for parents to raise funds to send their children to school, it is equally difficult for the government education services to raise funds, for the construction of schools, as well as to supply teaching materials or teachers. Payment of salaries is often delayed, sometimes for periods of longer than six months. Consequently many teachers are forced to secure other forms of income, and often are only available to attend classes in the mornings, so that in the afternoon and evenings they are able to pursue more lucrative employment opportunities. In a remote rural setting this scenario is complicated further by the fact that it is extremely difficult to attract qualified teachers to relocate to schools, far from urban centres with little access to services or facilities.

Thus in remote rural villages the responsibility to not only secure, but support financially, a teacher for the school falls upon the village development committee (VDC). This is problematic to say the least. Often the most suitable candidate in the village has only finished primary school, and has had no formal teacher training. A further complication is when the school is in a village belonging to one of Lao's many ethnic minorities, who do not speak the official state language of Lao, Lao-Loum, making teaching and learning extremely difficult when all school curriculum's are prepared using the official state language.

Due to the lack of funds, the Ministry of Education is heavily reliant on donor support for the provision of education services. Several donors, such as the WB and ADB have large

nationwide programs, which aim to support the government with the provision of education services at all, levels, from central to village level. Additionally many Non-Government Organisations (NGOs) provide support to the education services, through the construction of schools, provision of teaching materials, training of teachers and in some cases supporting teachers' salaries.

The opportunity for students to achieve in the education system is limited. Even if students do complete high school, entrance into higher education institutions such as the national university, or technical colleges is extremely competitive. Entrance to under-graduate study is often reliant on; "connections" that a family may have with the staff in the admissions office, the influence a senior government official may have, or the payment of additional fees to help facilitate the application process. The impact that this has on students from remote rural communities means that they are essentially excluded from attending higher education as the cost alone is prohibitive.

The following table outlines the disparity between urban and rural centres with regard to attendance at primary school.

Percentage of children aged 6-12 years attending primary school				
(n=8181)		Males *(n=4180)*	Females *(n=4001)*	Total
Regions	North	69.7	60.7	65.4
	Central	78.7	74.5	76.6
	South	66.8	65.9	66.4
Areas	Urban	88.1	88.2	88.2
	Rural	64.1	57.3	60.7
Age	6	38.8	37.1	37.9
	7	61.0	59.3	60.1
	8	70.3	72.3	71.3
	9	84.1	78.6	81.6
	10	85.8	76.8	81.6
	11	87.2	82.3	84.7
	12	82.5	73.8	78.2
Total		**72.5**	**67.8**	**70.2**

(National Health Survey:2001)

Illiteracy is also an issue for development in the Lao PDR. During the National Health Survey the following definition was used with regard to classifying people literate or non-literate, "...people who are able to read "easily or with difficulty" are considered literate" (ibid:2001). Subsequently the study found that according to this definition "...70% of the population over 15 years is literate" (ibid). There is however a substantial difference in literacy rates between urban (85.9%) and rural (60%) populations, and between males (81.7%) and females (59.1%) (ibid).

The link between education and improving a community's health is strong. People require sufficient education to be able to access and understand health promotion materials, including those that explain, the sometimes confusing, information surrounding family planning. This again places the population in remote rural communities at a distinct disadvantage, as not only do all government services weaken the further they are from the capital, but also peoples chances of being informed weaken as well, which has follow on consequences to their health.

Several NGOs and multilateral organizations in collaboration with the Ministries of Education and Public Health are attempting to provide improved health promotion materials directly to schools. Health promotion dissemination has generally been left in the domain of health professionals at all levels from hospitals, clinics and village health volunteers. While this traditional route continues to be supported, an alternative strategy such as the "Child-to-Child" approach is being utilised. This approach places children in a key development role of not only themselves but also their families and communities in general. Children are trained to disseminate health information messages to their friends, families and community. While this methodology is an innovative approach to an "old task", it is limited to more general health information messages such as hygiene and nutrition, whereas issues such as reproductive health still remain the responsibility of health professionals.

4. Contraceptive Services in the Lao PDR.

4.1 National Population and Development Policy in the Lao PDR.

In 1999 a final draft National Population and Development Policy was submitted to the Cabinet of Ministers for approval. The aims of the policy are to:

(1) "enable the people of the Lao PDR to determine the number and spacing of their children based on a couple's economic and social conditions and thus contribute to an improved quality of life that ensures the overall population growth remains compatible with the level of socio-economic development.

(2) promote a balanced distribution of population between urban and rural areas and different regions of the nation while guaranteeing the free movement of people within a the country.

(3) promote the development of the nation's human resources and their full utilization to improve the living standards of all populations sections."(UNFPA;1999:8)

The policy sees the expansion of Primary Health Care (PHC), reproductive health and family planning services throughout the country as imperative in the drive to reduce infant, maternal and total fertility rate while, "...raising the contraceptive prevalence rate to 85% by 2020." (ibid)

4.2 International Support to the Lao PDR

The Maternal Child Health Institute (MCHI) of the MoH relies heavily on international support for implementing its' family planning programme. In particular UNICEF aims to "help the Government to achieve its 2020 goals of reducing the infant mortality rate, under-five mortality rate, maternal mortality rate and malnutrition. UNICEF will continue to support health policy development; the national immunization programme, including vaccine supply; the control of diarrhoea and acute respiratory infections; improved breastfeeding practices; nutrition; and safe motherhood (UNICEF: 2003)

The United Nations Population Fund (UNFPA) proposes to fund a comprehensive population programme covering the period 2002-2006 to assist the Government of the Lao People's Democratic Republic in achieving its national population and development goals. UNFPA proposes to fund the programme to the amount of $9 million,

UNFPA has provided assistance to Laos since 1976. This assistance has included support for data collection, maternal and child health services, and a national fertility survey, which revealed a very large unmet demand for contraceptive services. With UNFPA assistance, the Ministry of Health developed a birth spacing policy and began providing birth spacing services at provincial and district hospitals and health centres starting in 1991. Under the second country programme (1997-2001), family planning and selected reproductive health services were introduced to about 700 primary health-care facilities and referral hospitals. More than 10,000 village health volunteers, in more than one third of the country's villages, received basic training on how to disseminate information to their communities on reproductive health and family planning. UNFPA included HIV/AIDS prevention topics in the nationwide training of service providers and procured most of the English reproductive health commodities for the innovative condom social marketing project of the National

Committee for the Control of AIDS that was carried out in partnership with Population Services International, an NGO.

The UNFPA purchases all contraceptives on behalf of the MCHI. The MCHI is responsible for co-coordinating the disbursement of contraceptives throughout Lao and the monitoring and evaluation of the family planning programme. UNFPA not only provides financial support to the MCHI in purchasing contraceptives but also technical support through technical advisers.

Non-Government Organisations (NGOs) such as the Danish Red Cross and Save the Children Australia provide both technical and logistical support to remote rural communities. This often involves the training of district staff in reproductive health care and logistical support for the delivery of maternal child health services in remote rural communities.

Figure 3 Women's Health Check - Community Health Day

4.3 National Family Planning Programme.

The National Family planning Programme, has made progress in several areas since it commenced in 1995, "...(1) the recent nationwide expansion of selected family planning services to all Government health facilities in line with Government policy, (2) capacity building of MOH service providers achieved through in-service training, and the training of

village volunteers; and (3) a marked increase in the availability of Information, Education and Communication (IEC) materials on family planning methods." (UNFPA 2001:6).

Other key achievements of the programme include:

- "During the past decade the Total Fertility Rate has declined from an average of 6.5 children per woman to 4.9, with an increase in the Contraceptive Prevalence Rate to 32%.

- Basic In-Service Training for MCH staff in all MOH facilities on family planning methods and reproductive health. In year 2000, 925 providers received basic training, and by the end of year 2001, the same number will have received refresher training.

- Basic information and communication training methods, services and reproductive health in 2000, and refresher training in 2001 for 10,600 village health volunteers in 5,100 villages i.e. in approximately 40% of all villages in the Lao PDR." (UNFPA 2001:36)

Selected National Health Indicators – Trends for 1995 - 2010

Indicator	1995	2000	2005	2010
Total Fertility Rate	5.60	4.90	4.05	3.50
Life Expectancy	51.00	59.00	64.90	67.88
Male	50.08	57.00	62.50	65.00
Maternal Mortality Ratio	656	530	390	250
Infant Mortality Rate	104	82	61	40
Child Mortality Rate	170.0	106.9	77.5	57.3
Crude Birth Rate	41.3	34.0	31.0	28.2
Crude Death Rate	15.1	6.3	5.4	4.7

(ibid.)

4.4 Contraceptive Use in the Lao PDR.

While family planning services are relatively new in the Lao PDR, women's awareness of contraceptives, and knowledge of their use is relatively high with nearly "80% of all women having knowledge of at least one contraceptive method" (LRHS 2000).

The Lao Reproductive Health Survey (LRHS) found that of all contraceptives the "low dose combined oral pill is the most popular choice, followed by the three monthly injectable Depomedroxyprogesterone acetate (DPMA). Female sterilisation is the third most popular choice, however there are several factors, which inhibit its wider use. These include: "...a

lengthy administrative procedure in some provinces to obtain the requisite permission from local authorities; (2) cost of procedure where it is available; and (3) under-promotion of the method by MCH service providers." (ibid)

Use of IUDs is limited, primarily due to a lack of availability at provincial and district hospitals, and concern by clients over the quality of care. Condom utilisation is low, and the fact that condoms are both a contraceptive as well as offering protection against STDs requires more promotion throughout the country.

Poor use of contraceptive methods can often be attributed to a lack of knowledge regarding a client's reproductive health and the type of contraceptive being offered. The LRHS found that "90% of women interviewed, found no problems with their choice of contraceptive method." However their were some common misperceptions about contraceptives available locally, including:

1. "the need to be healthy or strong to be able to use contraceptives;
2. inability to work on the farm or perform strenuous work after male or female sterilisation, or by women with an IUD in situ,
3. oral pills will invariably cause headaches,
4. the injectable is a "potent medicine" and thus more effective than other contraceptive methods." (ibid)

4.5 Availability of Family planning Services

Method & Services	Central Provincial District Hospitals 170 sites	Sub-District Centres (Dispensaries)	Villages 5,100 sites
Information on methods	*x*	*x*	*x*
Pills	*x*	*x*	*selected sites*
Injectables	*x*	*x*	-
Condoms	*x*	*x*	*selected sites*
IUD	*x*	*x*	-
Female	*Most sites*	*Selected sites*	-
Male Sterilisation	*some 2002*	-	-

(ibid)

5. Phongsaly Province.

Phongsaly is the northern most province in the Lao PDR. It borders, China to the North and West, and Vietnam to the East. The province covers 16,270 square kilometres of mountainous terrain and has a population of approximately 161, 900 people, equalling a population density of 9 persons per square kilometre.

The province consists of the following seven districts: Phongsaly, Nyot Ou, Boun Neua, Boun Tai, Samphan, Mai and Khua.

There are currently 31 ethnic groups inhabiting the province, and consequently Phongsaly is characterised by a strong ethnic and cultural diversity. In addition there are significant numbers of Chinese and Vietnamese immigrants now living in the province.

Phongsaly is one of the poorest provinces in Lao. The main source of income is through the cultivation and sale of rice. There is limited low land available for cultivation. Other crops cultivated include tea, cardamom and sugar cane, which are traded with China and Vietnam.

There is one provincial hospital, which has 48 beds. Services are limited, though minor abdominal surgery can be conducted. There are an average of ten deliveries per month.

5.1 Status of Family planning in Phongsaly Province

The Reproductive Health Survey (UNFPA:2000) reported the following trends in women's reproductive health in Phongsaly Province:

- women aged 25-49 years reported that the median age of a mother at the time of giving birth to their first child was 20.8 years of age.
- only 34% of currently married women had ever heard of at least one of the following modern contraceptive methods – pill, IUD, injection, diaphragm/foam/jelly, condom, female sterilisation, male sterilisation, or Norplant. The survey found that only 15.4% of all women 15-49 years, and 20.4% of currently married women had ever used a modern contraceptive.
- 5.3% of women had had sexual intercourse before the age of 15, 30.8% before the age of 17, 56.5% before the age of 19, and 72% before the age of 21.

- The mean ideal number of children as reported by all women was 4.2 children

5.2 Background to Khua District

Khua District is the southern most district of Phongsaly Province. It is located on the junction of the road to Mai District, through to Vietnam and the Ou River. The population of the district is approximately 28 000, inhabiting some 130 villages. The majority of the villages in Khua District are in remote mountainous areas, with no access by road available, requiring significant walks to reach them.

Figure 4 Ou River

Currently there are 13 ethnic groups in the district. The main districts are Khmu, Lao Loum, Tai and Akha.

The main agricultural system used is slash and burn. There are approximately 4902 hectares of "slash & burn" rice fields, which are cultivated in cycles of 5-6 years.

After the provincial hospital, Khua District hospital is considered to be the most efficient curative service in the province. The 30-bed hospital, has limited equipment, all staff employed at the hospital are trained health staff, and consequently are able to provide basic medical, surgical services. Health education is also conducted at the hospital though this depends on the availability of IEC materials.

6. Background of the Study Target Villages.

6.1 Ban Houay Phae Ou

Ban Houay Phae Ou is located on the banks of the Ou River. It can be reached by boat after fifteen minutes from the district town centre. The population of the village is 235, of which 126 are women, and belong to the Khmu Ou ethnic group.

The Khmu Ou belong to the Austro-Asiatic family, which consists of 59 ethnic and sub ethnic minorities (Chazee: 1999). This family are thought to be the first inhabitants of Lao, and represent less than 36% of the total population.

Khmu often reside in homes made from bamboo supported by short poles, and engage primarily in shifting agricultural practices. Their beliefs are animistic though incorporate some beliefs and practices from shamanistic religion.

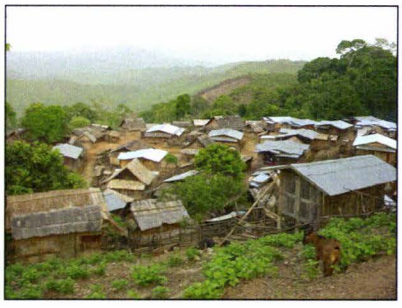


Figure 5 Houay Phae Ou

The Khmu follow a patrilineal line of descent, though sometimes there is a preliminary matri-local probation of some years (between 1 to 3) by the husband working at the house of the wife's parents (ibid). Traditionally parents arrange all marriages, however presently young people can advocate their own choice in partner. Premarital relationships are not condoned, however they are not unheard of. Prior to a wedding, there have been long negotiations, the following is an excerpt from Chazees (1999) study of the ethnic groups living in Lao.

> "...when the boy is ready for marriage, his parents visit the girl's parents with a lao skirt, a piece of cloth, 3 pieces of dried meat and a jar of lao hay (local rice whisky). The preparations are discussed and two buffaloes are given to the girl's parents (formerly 3-5 buffaloes). The wedding meal is organised and financed by the boy's parents, and must include a pig 5 fists high and a jar of lao hay. Six Indochinese piasters and two bars of silver are presented to the girl's parents before the meal starts.
>
> The following day, another meal is organised at the house of the girl's parents. the six piasters and two silver bars presented the day before, as well as a piece of Pakhom textile for each of the girl's female cousins are offered by the boy's family. The girl then takes a package prepared by her mother which includes a bracelet, silver box, wood coal box, clothes, textiles, one bowl, a chicken, and moves to her parents-in-law's house. The following day, to clean *Blusaly* (past sins), the young couple goes to the river, the wife with a fish net, the husband with a knife and a basket."

Contrary to the significant use of rituals during the wedding ceremony, there are very few to be recorded during the birth. The birth itself does not involve any particular ceremony. During the post-partum period the woman's nutrition is modified slightly, and the couple abstains from sex for approximately two months.

Health services are limited in the village. There are currently two village health volunteers (VHVs) who are trained in health promotion only and are unable to provide any curative services. A gravity fed water system and latrines have recently been constructed and have helped to reduce the incidence of diarrhoeal diseases. The local district health service provides immunisations to the village twice a year. No family planning services are available, and residents who want to access family planning services are required to travel to the maternal child health department of the local district hospital.

Education services are also limited in the village. A school has recently been constructed which provides multi-grade education for grades 1 and 2. Approximately 30 children attend the school. Many of the older residents are also illiterate, though are able to attend a non-formal education program, which is conducted in the evening.

The economic situation of the village is also poor. For three months of each year approximately 40% of the residents of the village suffer from rice shortages. In addition to this four families have insufficient rice all year. The main source of income is generated from the sale of non-timber forest products.

Figure 6 Houay Phot

6.2 Ban Houay Phot

Situated on the top of a mountain, over 40 kilometres from the district town. Ban Houay Phot is home to 414 people (211 women) belonging to the Akha-Nyaeuh ethnic group, which make up part of the Tibeto-Burman family. "The Akha represent approximately 50% of the Tibeto-Burman family in with a population nearing 62 000" (National Census:1995).

Chazee records that, "...the Akha live following a unwritten but formally recognised codes of behaviour. Each movement, activity or event thought of individuals must be measured

and balanced in function of the desire, necessity, nature of the day, disposition of the spirits, traditional farming calendar, and ancestors' opinion. The traditional codes vary according to village and family events related to cycle of life and to their geographic position in relation to the village gate. This traditional civic, legislative and behavioural code, often called Akhazan governs the Akha's livelihood system. The code protects communities from acculturation, but its lack of flexibility raises issues of adaptation towards the modern world."

Among the many sub-groups of Akha the following are characteristics common to all:

1. "they reside in a mountainous habitat of between 700 to 1600 metres altitude,
2. the main production system based on the production of ordinary rice through shifting cultivation, opium production, hunting, gathering and small animal husbandry,
3. a patrilineal lineage system with several ethnic divisions and sub-divisions,
4. a complex animistic religion based on spirits souls and different beliefs specific to each ethnic community,
5. the absence of a written language,
6. traditional production of clothes and ornaments." (ibid)

Marriage represents an important ceremony for the Akha. Pre-marital relationships are condoned, and are often seen as a way of the couple gaining experience and a good understanding of each other. Marriages incorporate long and costly rituals. Polygamy is accepted, and is common in the following circumstances; if the first wife is infertile, if the children are all girls, if the husband has important status in the village, if he is rich or if he possesses important land to be developed (Chazee:1999).

As with Ban Houay Phae Ou, Ban Houay Phot has limited access to all district services. Currently there are two VHVs in the village, though again they are only able to conduct health promotion activities, have no drugs and are unable to provide curative services to residents. Only recently has a gravity fed water system and latrines been constructed. Previously residents collected water from a stream nearby, though this often ran dry during April, before the monsoon. Predictably there was previously a high incidence of diarrhoeal diseases. Opium addiction remains a problem in the village with many residents addicted to the drug. The village has also become a target for "drug tourists" to the region. District health services also provide EPI outreach to the village.

Through previous NGO support a two-room school was constructed in 1997. The school provides education to students in grades 1 and 2. Students wishing to continue with higher education are required to travel to the district. Illiteracy is also a problem in the village.

Rice shortages are not uncommon in the village with over 40% of the village experience a shortage of 4-5 months per year. Income is generated through slash and burn agriculture with some sale of non-timber forest products.

7. Study Methodology

The study involved village visits where focus group discussions (FGDs) were held. Participatory information gathering exercises were used during focus group discussions to help stimulate discussion. The decision to utilise FGDs was taken for several reasons. At the time of the study there were limited resources both human and of time to conduct a survey using individual questionnaires. While an individual questionnaire may allow for more privacy given the subject matter this was not feasible given the number of staff available to conduct the survey. By utilising FGDs, more villagers were able to participate in the survey, thus providing an opportunity to increase the awareness of the issues surrounding family planning services.

The study team, of six people consisted of staff from the Khua District Health Department along with staff from the Lao Red Cross and Danish Red Cross. The team had an equal number of women and men, represented different ethnic groups, and had excellent local knowledge and experience. Several of the staff had previously conducted other health surveys facilitated by the Ministry of Health and NGOs.

7.1 Ethics

Within the Lao PDR today consideration for ethics/rights issues is limited; this is evident at both national and local level. At a national level the Lao PDR is a signatory to many international conventions, such as the Convention Concerning Forced or Compulsory Labour (1930), the Convention on the Prevention and Punishment of the Crime of Genocide (1948), the International Convention of the Elimination of all forms of Racism (1965), the Convention on the Elimination of all forms of Discrimination Against Women (1979) and the Convention of the Right of the Child (1989). Laos however is not a

signatory to the following conventions: 1) Convention relating to the Status of Refugees (1951), the International Covenant on Civil and Political Rights (1966), the International Covenant on Social, Cultural and Economic Rights (1966), the Convention Against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (1984) and the Rome Statute of the International Criminal Court (1998).

Consequently at a local level, little consideration is given to the rights of the individual. The Lao PDR is one of the few remaining communist countries in the world today, and support to "the people" is advocated for against individual support "to the person." Within the context of research, the protection of individual rights regarding privacy/confidentiality, receives little attention. Surveys conducted by using individual questionnaires are usually non-voluntary and seldom completed anonymously. Consequently this poses a problem for the research team, as if they require volunteers for the survey it is highly unlikely that the participants involved in the survey have been "volunteered", with full knowledge of the rest of the residents of the village.

In this scenario, FGDs play an important role of protecting the right of the individual, as the notes taken during the discussions are not assigned to an individual with a name. The results of the survey form a consensus of a community's viewpoint toward a particular issue i.e. in the case of this research exercise family planning. A list of the participants was taken however in this case as it was used to provide data regarding the number of children per participant and the level of education achieved by each participant.

7.2 Preparing for the Study

Prior to conducting the visits to the villages a planning meeting was held;

I. to train the study team in qualitative research methods
II. to share experiences of the team in gathering information in the past
III. to plan the study in detail, including selecting the villages to visit and explaining the question guide that would be used for the focus group discussions.

The issue of ethics when conducting qualitative information gathering was discussed. The study team was alerted to a number of ethical considerations, and discussed ways to prevent harm when gathering information. It was explained to the study team that asking probing questions into individual practices may cause embarrassment in front of other

group members. The medical staff on the team prepared Information Education Communication (IEC) materials, to be able answer any questions that the participants may have had arising from the discussions.

7.3 Development of Question Guides

During the development of the question guide, attention was given to ensuring that the questions focussed on obtaining information required to meet the study objectives. Namely, to ascertain what family planning services, if any, did the respective villages require. In addition what was the current knowledge, attitudes and practices that influenced participants in the study, with their choice of family planning services. Consequently the question guide was developed during three stages:

I. In development of the questionnaire for the focus group discussion reference was given to the "Results and Recommendations from a Maternal Health Needs Assessment in Three Provinces of the Lao People's Democratic Republic" a study conducted by the United Nations Children Fund and Family Care in 1998.

II. The study team developed a questionnaire that was appropriate for the different ethnic groups, which inhabit the two villages to be visited. The questionnaire was then translated into two different languages, from third language, Lao Loum (the national language of the Lao PDR). The discussions centred on the group's respective knowledge, attitudes and practices regarding family planning. In particular the issue was discussed regarding the type of family planning services a couple may desire if it were possible to make them available to the village.

III. Following the first focus group discussions held at Ban Houay Phae Ou, the study team met again to share lessons learned and make any further adjustments to the questionnaire before proceeding to Ban Houay Phot.

The questionnaire covered the following topics:

- Family planning
- Pregnancy and prenatal care
- Delivery and puerperium
- Sources of information
- Sources of information

In selecting the villages to hold the focus group discussions, project documents from the Lao Red Cross – Danish Red Cross Primary Health Care Program were consulted, to identify the major ethnic groups in the program target areas. Consequently the following villages were selected.

Ethnic Group	Village
Khmu-Ou	Ban Houay Phae Ou
Akha-Nyaeu	Ban Houay Phot

7.4 Village Visits

Following the preparation for the study, the study team, which consisted of six people, travelled first to Ban Houay Phae Ou, then to Ban Houay Phot. As the national language, (Lao Loum) is neither the first language of either ethnic group visited, district staff were also identified who were able to act as translators. These staff had assisted with the translation of the questionnaire into Lao Loum, and had also attended the planning meeting.

The study team visited the villages for two days, and stayed overnight. At each village the study team:

I. Met with the village chief and explained the purpose of the visit
II. Met with the residents of the village and explained the purpose of the visit and proposed timetable. During this discussion it was explained that the study team were conducting a survey, and that they were not providing, or improving access to family planning services.
III. Conducted the focus group discussions
IV. Met to discuss the findings and prepare the feedback/education session
V. Met with the village and provided feedback on the findings and gave some basic health education, following requests by participants.

7.5 *Focus Group Discussions*

Two focus group discussions each with different participants were conducted in the respective study villages using a questionnaire outlined in Appendix 1

I. Women aged between 15-45 years
II. Men aged between 15-45 years

The villages were selected using the following criteria, distant to district town centre, access to family planning services, economic status. Both of the villages are remote villages in northern Lao, with no previous access to family planning services. The villages are extremely poor, with insufficient rice production to sustain the villagers for the entire year. Access to local markets are difficult requiring a walk of over one hour through mountainous terrain for residents from Ban Houay Phot, and travel by boat, often made dangerous by flooding, for residents at Ban Houay Phae Ou.

The study team divided into two groups. During the focus group discussions one team member would ask questions, one would translate, if necessary and two would take notes.

The discussion groups were held during the month of March, which is in the "dry-season" in Lao, so that potential participants to the discussions would not be occupied with rice cultivation. The discussions commenced early in the morning at Ban Houay Phae Ou, and in the evening at Ban Houay Phot. Both of these times respected the particular differences in the cultural attitudes toward time, demonstrated by the ethnic groups which, ensured that the maximum number of men and women could attend the discussions.

The composition of the discussion groups were as follows:

Village	Ethnic Group	No. of Women	No. of Men
Houay Phae Ou	Khmu	11	38
Houay Phot	Akha	58	61

7.6 Participation in Focus Group Discussions

7.6.1 Ban Houay Phot

Women

Figure 7 Women's FGD

The focus group discussion at Ban Houay Phot was held during the evening at the home of one of the villagers. The discussion group was held in the evening as the interview team had spent most of the day travelling to Ban Houay Phot.

While there were initial concerns that women in the village may not attend given their apparent shyness at times when interacting with visitors to the village, this concern quickly disappeared as 58 women crammed into the upstairs room of one of the houses in the village. What was intended to be a focus group discussion quickly became a social event for the whole village, as children of all ages struggled to squeeze through the doors and windows to view what was unfolding. Again in the interests of cultural sensitivity, and the inability to explain, on behalf of the study team, the concept of a "representative sample group", no woman was refused entry into the discussion. Consequently the discussion proved extremely interactive, informative, and enjoyed by all!

Figure 8 Men's FGD

As with the participants in the other women's discussion group in Houay Phae Ou, the majority of women (36) had not achieved any level of education. Of those women who had attended some schooling one woman achieved the highest level, grade 5. The average age of the women in the group was 22 years.

Men

The men's focus discussion group also transformed itself into an impromptu social event for the village. Every male in the village, it seemed, did not want to pass up on the opportunity to participate and share their opinions and experiences. Again in the interests

of cultural sensitivity, no man wishing to participate in the group was turned away and consequently, in total 61 men attended the discussion. Of this group the average age was 24, and 39 were married. The majority of men (41) had attended some schooling, with the highest level achieved by four men being the third year of secondary school.

The discussion group lasted long into the evening by the end of which time the discussion had turned to more pressing village administrative issues. However the initial group discussion during the earlier part of the evening achieved its objectives, and the questionnaire could be completed.

Figure 9 Women's FGD

7.6.2. Ban Houay Phae Ou

Women

The focus group discussion at Ban Houay Phae Ou was held mid-morning underneath one of the houses in the village. Twelve women attended the discussion. The conversation was lively, interactive and informative. All the women who attended the group were married, though only one had not been pregnant. Four women had experienced a death of their child, while the average number of children per woman was 2. The average age of the participants in the women's group was 30 years.

The majority of women in the group (9) had not completed any schooling, and those who had attended school had only passed grade two.

Figure 10 Men's FGD

Men

The men's discussion group was again held in the morning under a house in the village. As with the women's group it was extremely lively. While an attempt

to limit the number of participants was made at the beginning of the discussion, all hope was given up when 38 men seated themselves down ready to participate. In the interests of cultural sensitivity no man was refused entry, and consequently all of the men in the group participated enthusiastically in the conversation.

The average age of the participants in the men's group was 33. Of the thirty-eight men who participated in the study, only one was not married. Only 5 of the men had not completed any education and of the thirty-three men who had attended school the highest grade reached, second year of secondary school, was achieved by only one person.

Summary of the composition of focus groups in study villages.					
	Average Age	Married	Average No. children	School attendance	Highest grade achieved
Female FGD					
Houay Phae Ou	30	12	2	9	2
Houay Phot	22	39	2	22	5
Male FGD					
Houay Phae Ou	33	37		33	2nd yr secondary
Houay Phot	24	39		41	3rd yr secondary

7.7 Interpretation of the findings

Following the village visits the study team met to analyse the data collected during the discussions. The study team provided corrections, clarifications and additional information. The study team also shared information based on their observations and informal discussions with villagers. Any difficulties, or inconsistencies in the translation were also analysed in relation to the data collected. The data collected during the FGDs for both women and men's FGDs was then collated, and summarised

Figure 11 Leaving the village after the FGD

8. Results of Focus Group Discussion Questions.

8.1 Family Planning

Attitudes toward the idea of family planning.

Do you think a couple should decide whether and when they should have children? What factors might they consider? (i.e. Child-spacing, age of mother, family size, health, and/or economic status).

At the Khmu village of Houay Phae Ou, the families gave little consideration toward deciding when to have children. Family planning is viewed as a natural process, so attempts to control the frequency of births by chemical, or physical means (IUD or condom) are limited. The decision, if any, to have children would be made by the parents, however given the absence of contraception, conception was left more to chance.

With the Akha, "...procreation takes place in the small meeting house before and after marriage, or in the father's house after marriage," (Chazee). Age is a factor, which is considered, though through default more than any other conscious decision, as the average age for marriage amongst the Akha is 18.5 years, and the average age at the first pregnancy is 19.5 years of age.

Health considerations in childbearing.

What do you think is the right age to start having children, and to stop – Why?

The participants of the discussion groups felt that the appropriate age to have children was between 17-18 years, and to discontinue having children between the ages of 30-40 years. The participants in all groups felt that the health of the mother was the main reason to take into consideration when having children. It is believed amongst group members that the younger the woman was in her adulthood, the more likely she will be able to cope with the physical stress of pregnancy, labour and childbirth, in addition the child is more likely to be born healthy.

How much time should pass between pregnancies? How many children do you think it is safe for women to have?

The answer to this question was similar from all groups, both men and women. The average number of children that each family should have should be approximately 3-4, with an average of 2-3 years space between each child. Some of the participants in Houay Phot did not realise that methods had been developed that would allow them to control the amount or frequency of children they had.

Do you know of any women who have had health or other problems as a result of a poorly timed or poorly spaced pregnancy?

The discussion group in Houay Phae Ou, did not share any experiences regarding women who had experienced problems related to poor family planning.

In Houay Phot most of the participants had heard of someone either a friend or relative who had experienced problems from poor family planning. Essentially there were two categories of problems. The first obvious problems experienced by woman were the physical ones i.e. tiredness, and loss of weight. The second category of problems were socio-economic ones i.e. the woman was unable to contribute her labour to rice cultivation, and consequently could face a rice shortage during the year.

Knowledge and use of family planning.

Do women in your community know of ways to avoid becoming pregnant? What are they? How do they work?

The participant's general knowledge regarding family planning was limited. Many of the participants, (both male and female), were unable to explain about menstruation or ovulation, and how family planning methods worked in relation to these two natural events. Some men knew about the use and availability of condoms, through travelling to the district towns that were target area for HIV/AIDS awareness campaigns.

Some women had a rudimentary knowledge of how the oral contraceptive pill (OCP) worked to prevent pregnancies; however there was limited detailed knowledge, and what

information was known was often obtained through word of mouth, and anecdotal evidence.

There was no mention, during the discussion, of the use of any traditional forms of family planning, such as the use of herbs or particular rituals. Some participants did mention the use of condoms, abstinence during a woman's period and sleeping in a separate room from partner.

Do you know of any problems related to family planning?

Participants in the groups were able to describe some physical symptoms related to the use of contraceptives. These included headaches, vomiting, lethargy, decreased appetite, and prolonged periods. Again participants had acquired this knowledge not through personal experience, rather through word of mouth. When questioned further the participants could not provide more detail as to how the contraceptives worked and how they caused such symptoms.

Can people in the community get family planning services? - Where?

Within the study target villages there are no family planning services. The villages are remote, and are accessed by with some difficulty. Consequently access to family planning services, either through pharmacies or hospitals is limited. Family planning services available at either of these providers are not free, as even if the contraceptive method has been provided free of charge to the district hospital, the woman will still incur an administration fee. However if a couple decided to use family planning services they would have to travel a significant distance to access the district hospital. This travel time combined with the actual cost of transportation, administration fee, and the potential loss of daily earnings can be prohibitive for a access to family planning services.

In your community, who decides about family planning? (Husband, wife, both, others?) Who do you think should decide?

Answers given by participants to this question were similar in nature. Most believed that a couple should decide together when they were going to have children. In some cases the parents of the couple were also involved in the decision making process. When the

discussion developed further, some women stated that in situations when the couple could not reach and agreement, men assumed the role of making the final decision.

What factors might prevent people from using family planning? (i.e. lack of services, lack of privacy at clinics, negative attitudes in the community about family planning, opposition from husbands, etc.)

There are several factors, which prohibit people from accessing family planning services. As mentioned, a relatively high cost and distance to services are two obvious reasons that would discourage couples. In addition to this is the fact that there is a lack of privacy available at the hospital for couples, for not only receiving services such as IUD insertion, but also the opportunity to receive counselling regarding contraceptive choice. Women also said that they felt "shy" to discuss their reproductive health needs with strangers, and that often health staff were not very friendly or approachable. Information provided by health staff, was often insufficient or confusing, and there were obvious difficulties related to language barriers. The latter issue was particularly relevant for members of the Akha village of Houay Phot, where most women did not speak Lao Loum, the national language, which is also the language used by health staff. Consequently if the woman wanted more information about family planning, she would have to rely on the ability of her husband to translate for her.

A lack of female health staff was also a reason stated for not accessing family planning services. In the women's discussion groups the participants said they felt more at ease being in the presence of female health staff. While most district health services have women staff for the Maternal Child Health Centre, they were not always available, and as it is not possible for women to make an appointment in advance due to telephone services being unavailable in remote villages, then it is often the "luck of the draw" for women as to whether or not they are able to be seen by a female staff member.

Cultural differences between the ethnic groups of the study villages and the district health staff who are predominantly low land Lao (Lao Loum), also contributed as a factor, which impeded utilisation of family planning services. Villagers from remote rural communities are often seen, by those providing community services at a district or provincial level, as "country bumpkins," who are generally not very well educated and are unsophisticated. Naturally the villagers sense the sometimes condescending attitude of health staff, and coupled with a language barrier, this factor makes it difficult for women to feel confident to access the services, which they are entitled to.

8.2 Pregnancy and Prenatal care.

Knowledge of Pregnancy.

How do women in this community know they are pregnant? (what signs/indications, how pregnancies are confirmed).

Women in the discussion groups were clear in recognising when they were pregnant. All of the mothers could describe how they new they were pregnant by the symptoms they felt, i.e., tiredness, nausea and vomiting, and through the physical sign of cessation of menstruation. The women were unlikely to travel to health services to have a urine test to see if they were pregnant, as aside from the prohibitive cost, loss of time need for earning, women in the group felt that pregnancy and childbirth were a natural process.

Behaviour and customs during pregnancy.

How do women in your community behave when they are pregnant? (Changes in their behaviour, do they avoid certain places, people or actions? Changes in work habits? Change of diet?)

The Khmu and Akha do not share the same beliefs and rituals during pregnancy. In Khmu villages women generally attempt to keep active as much as possible throughout their pregnancy. While extremely "heavy work" such as carrying bags of rice, or bundles of wood, are generally avoided, other domestic tasks such as cleaning the rice, threshing the rice during cooking preparation and looking after the children are still in the domain of duties often assigned to women. This continues for as much as the pregnancy as possible as the women believe that through physical exercise they are helping to strengthen their bodies in order to prepare for the gruelling demands of labour and childbirth. It is also believed that the more exercise a woman has while she is pregnant the "easier" the childbirth will be.

In addition in the Khmu villages the women make some minor changes to their dietary intake, through avoiding foods high in sugar so as to ensure a healthy baby that is not fat.

Within the Akha families, women make similar changes to the Khmu regarding modifications to their lifestyles. Continuing with routine work around the home and village is also seen as a positive way to ensure a healthy baby and a less stressful delivery. What is noticeably different between the two ethnic groups is that the Akha women are 'forbidden" to talk about their pregnancy as it is believed amongst the community that this

will bring bad luck to the mother, child and family unit. Dietary intake is also adjusted slightly with respect to the consumption of meat. For example if a sow gives birth to less than three piglets, then the villagers believe that the pig should be slaughtered and the meat distributed amongst the resident of the village. However women of reproductive age or who are pregnant are forbidden to eat the meat as it increases the risk of them giving birth to twins.

Where do women get advice on their pregnancy and care? Who decides what women should do and what customs they should follow?

Since access to hospitals and clinics is extremely limited for both groups of women in the study groups, they do not seek antenatal care during pregnancy. Doctors or midwives are not consulted as they are unavailable, and ante-natal classes are non-existent. Consequently the responsibility of teaching women about pregnancy and childbirth, is a combination of sometimes painful and frightening discovery, or through word of mouth passed from generation to generation by parents or extended family.

Do pregnant women in this community visit Traditional Birth Attendants, traditional healers, village based health workers? If so, what kinds of advice and care do they receive?

As mentioned above the women in the target villages do not visit village health workers of any description in their village as there are none currently providing services in their villages. The Akha may consult spiritual healers for advice regarding taboos and rituals during pregnancy, though this is not very common.

Knowledge of pregnancy complications.

Have you ever heard of a woman suffering from complications or problems during pregnancy?

All participants in the discussion groups had heard about women who had had complications during pregnancy. Both the women's and men's group could give examples of complications and problems experienced by women during pregnancy namely; headaches, nausea, vomiting, and swollen legs.

Several of the women had either had a miscarriage or stillbirth, in the Akha community this was not uncommon, and of the 58 women who attended the discussion group 16 had experienced the loss of a child. In the Khmu village of the 11 women who attended the discussion 4 women had lost a child.

What do you think causes these problems? How do you think they should be treated?

None of the participants were able to give a clear answer as to what had caused the problems and complications. There was little understanding about the woman's own reproductive health and how complications can occur. Some of the women however saw the connection between receiving ante-natal care, and "going to the hospital" with a healthy mother and child.

Amongst the Akha some participants felt that if a woman had "upset" one of the many spirits that govern her life then this could possibly have been responsible for the complications, or additionally if a woman had broken one of the taboos regarding the consumption of meat from a sow who had given birth to twins, then this could cause complications.

Where do women go for treatment/care if such symptoms were to present themselves during pregnancy? Why? Who makes the decision to go for care or advice in case of complications?

Regarding the treatment of complications, women stated that there were few options available to them for treatment, and only in severe cases would they consider travelling to a hospital for treatment. This was due in part to the prohibitive cost, and the lack of quality of service of hospital staff, as villagers felt that there was no guarantee that the treatment would work. Local spiritual healers would be consulted and advice followed by parents but there was little that could be done at a village level.

The decision to go to the hospital will be taken by the husband. The decision is often based on the availability of finances, cash on hand or the need to sell livestock or material possessions to raise the necessary funds. This often presents a dilemma for the family as they know that there are no guarantees of a successful outcome at the hospital and the family also realises that they will not be able to raise as much funds as they would like through any sale, as the prospective purchaser knows that they are having to sell under

pressure, are consequently desperate for the cash, so will have to accept a lower price or lose the sale.

Prenatal care.

Do women in this community use prenatal care? Is this service important? Why/Why not?

As previously mentioned, no women use prenatal care, for primarily financial reasons. Transportation, accommodation, hospital administration and drug costs are too prohibitive for villagers from poor rural communities. This does not necessarily mean though that women do not think the service is necessary, however essentially they do not have the luxury of choosing or not choosing to utilise the service as the decision has already been taken from them.

Importance of the issue.

Do you think problems during pregnancy are important to women in this community? Why/Why not?

The discussion groups felt that problems during pregnancy are important, as the value of the life of the mother is important. The value of the newborn baby is viewed differently and in the event of the baby dying it will not be given a formal burial. At the same time though, problems can also be seen as normal part of one's life so people are often not proactive in trying to reduce the incidence of the problems.

8.3 Delivery and Puerperium.

Practices during delivery.

What do women in your community do to prepare for childbirth?

The Akha prepare a special place for the delivery either at the fireplace in the home or in a special hut built by the husband. For the Khmu clothes are prepared to wrap the child once born, and these are stored at the place where baby will be born. Men in both communities will prepare extra fire wood, rice, collect water, and ensure that there is plenty

of food available such as chickens to celebrate the birth, in addition both men and women in the villages prepared for the birth by saving any extra money that they were able to as there is little opportunity to earn a living once the baby is born.

Where do most women in the community give birth? Where do you think is the best place to give birth? Why?

The majority of women in the discussion groups gave birth at home. The major reasons for this choice were practical ones, i.e. it is less expensive, it is more convenient, family members are nearby to assist, and the women feel more relaxed.

In the Akha communities women give birth in a special hut, or in some cases in their home. The reason for giving birth in a special hut is that in the event that the there are complications during childbirth or the woman gives birth to twins or a baby with some type of deformity, in order to appease the spirits the building where the baby was born will have to be burnt to the ground. Naturally young couples take the more prudent step of having the birth of their child take place at a site, which will cause less distress and financial burden if it has to be destroyed.

Assistance during childbirth.

What kinds of care do women who deliver at home usually receive?

In comparison to childbirth in western societies, the women in the study villages receive essentially no qualified nursing or medical care. In terms of practical support close family members will assist the woman through labour and childbirth by supporting her through contractions, walking with her, and in the provision of food and water. In the Akha village, (Houay Phot) the paternal grandmother of the child will cut the umbilical cord, however if she is not present then the father of the child will do this. Family members will also take care of any other children the woman may have during the delivery.

What kinds of care do women who give birth in health centres and hospitals usually receive?

At the Khua District hospital there are very limited services available for women in labour. Hospital services can only cope with "normal" deliveries and are unable to perform caesarean sections. In case of a severe emergency the woman would have to travel three hours by bus to the provincial hospital in the province, which borders with Khua District. Care received at the hospital is limited. The women's relatives are responsible for assisting her to wash, prepare food, eat, and care for her during the labour and childbirth as well as care for the newborn. Hospital staff generally see their role as one of diagnosing and prescribing medicine. The concept of integrated management of illnesses or "holistic" care is a foreign concept. The hospital system is part of the government structure and consequently there are no consumer rights, seen at present in western countries. Additionally the Lao culture places a high value on respect, and one should never allow the situation to occur that respect is lost, or someone loses face, especially those people who see themselves as holding important social status such as a doctor.

Why do you think some women might prefer one kind of care to another?

The discussion groups felt that essentially there was no preference as the decision was one that was made by whether the family had access to health care and whether they could afford it. If the district hospital was nearby and provided a service that appealed to women, and was affordable, then women would use the service. In comparison, home birth is cheaper, easier to access, allowing women to remain in an environment familiar to them while being attended to by family members.

Complications during childbirth and the puerperium.

Do you know of anyone who has had problems during childbirth? What were these problems? What happened?

The women in each of the groups could recall times when women had experienced problems during childbirth. As previously mentioned some of the female participants had lost a child during pregnancy and childbirth, given the obvious sensitivity surrounding this issue the study team approach the topic cautiously. In the event of a baby being stillborn,

unless there was any immediate danger for the mother, the baby was buried, without any significant ceremony or ritual being conducted. None of the women could state the pathophysiology behind the complication, which was summed up by the group as the woman not "being strong enough."

Are there any other kinds of problems that women can have after childbirth? What are they and what should be done?

All participants in the discussion groups were able to mention problems that women experience in the post-partum period. Again while the participants were able to describe general signs and symptoms experienced by or seen in women, they were unable to explain how the problems were caused and consequently what would be the best remedy for the problems. At some stage most women experienced tiredness, dizziness and fainting, and in response to this rested as much as possible.

Behaviour and customs after childbirth.

Are there special things a woman should or should not do after childbirth? (i.e. workload, diet, seclusion, special rituals).

Following the birth of a baby in the Khmu village the mother will rest beside a fire inside her house for a period of approximately two weeks. This is to assist the mother to "dry up her blood." The mother does not consume chicken and duck as it is considered "unhealthy". Mothers will breastfeed their children though they do not give the baby the "yellow milk," or colostrum as it is considered dirty milk. The Khmu also observe a period of sexual abstinence of approximately two months.

In the Akha village, behaviour and customs after the birth of the child are somewhat more complicated. When the baby is born the father of the child will kill two chickens. One of the chickens will be used to celebrate the birth the other will be used to name the child. Preparations to cook the birds are different from everyday consumption. The chickens feathers are plucked over a fire instead of being boiled first. Both chickens must be boiled in different pots, then the mother and child must taste the chickens before they are distributed amongst the rest of the family members. The child is named on the same day, by the paternal grandmother, or by the maternal grandmother or grandfather.

Day three following the birth, the mother must leave the house with the child, carrying a bag, which contains an egg, rice and water. The mother must consume these prior to re-entering the house. This demonstrates that the child is able to eat anywhere, not just in the house. Following this, the mother must leave the house again with the child, this time nursing at her breast, carrying a basket which holds an egg, a knife and water. The mother must walk to the village gate, which signifies a departure for the forest, which is part of the child's religious initiation. At the completion of this the mother returns to the home to report to her husband regarding the outcome of these events.

Two weeks post-partum religious ceremonies are held to ensure that the child is connected with the *Amadame* parents' spirits, the *Ikrenue* house spirit, and *Oune* sky spirit. A pig and rooster are killed and during the cooking preparation no one is allowed to talk in order that the child is not disturbed. If the baby is disturbed and begins to cry, this is not a good omen as it signifies that the parents' spirit has not been completely accepted by the child.

Once the cooking is complete, the father of the child cuts three pieces of the body from each animal, a piece of foreleg, a piece of the hind leg and a piece from the head. The pieces of meat are then offered to the spirits, so that the child can receive blessings and protection from the spirits.

A period of sexual abstinence is observed for approximately 3-4 months, though in case of a birth of a handicapped child, sexual abstinence must be observed for a period of 12 months.

Dietary intake is also modified as failure to do so may bring displeasure to the spirits, which may, in the worst cases, bring about the death of the mother. In particular the following foods are prohibited; pork fat, old pork, chilli, mud fish, cow, white buffalo, barking deer, insects, duck, goose, turkey.

The mother will breast feed her child for a period of 18 months with an initial period of at least six months, which is exclusively breast-feeding. The colostrum is not given to the baby, nor is rice for the first six months. The mother and child must not sleep under a mosquito net, as the spirits must see the child.

Domestic duties can be carried out by the mother, however she should take care not to enter another house as the spirits forbids this. If she does, an egg and salt must be placed in he baby's hand, in order that the mother may gain forgiveness from the owner of the house.

The birth of twins or a handicapped baby is a catastrophic event. These children are considered human waste, or children of spirits *Luk Phi*, and most not be allowed to live as the Akha believe they are from the animal kingdom. The Akha village will reject the family, in particular the mother of the child. Ancestral ties will be severed and the family will be forced to leave the village for a period from anywhere between 1 – 3 years. In present day situations the amount of time of time that the family spends outside the village has been shortened and judgement is made on a case-by-case basis.

The family must return to a state of absolute poverty, burn their house and possessions and leave the village. (This is why couples frequently choose to have the birth of the child in another small house, so that their family home will not be destroyed if they have twins). The child or children must be killed as well. The killing is often by stoning or beating. The child or children are spat on and buried in the forest, as they can not be buried in the cemetery. Either the mother or, a person in the village deemed to have no future, i.e. an opium addict will kill the child or children.

The family is then required to live in the forest, taking no possessions with them and have no contact with their village. All of this can be avoided if the family are wealthy enough to purchase a purification ceremony *Loko Shaw*, which is performed by the *Dzoema* religious chief. The ceremony is expensive, including the payment of money, and the sacrifice of 10 chickens, 10 pigs and 10 dogs. Alternatively the parents may try and avoid this custom by killing one of the twins before it becomes known in the village that they were born, or the family may decide to permanently leave the village.

Where did you get this information?

All the discussion groups said that the family had received this information from their families and had observed these practices at other births.

Postnatal care.

Do women in your community go for postnatal care? When? Where? Why/Why not? Is it important?

In accessing post-natal care women faced the same problems encountered during ante-natal care. Again distance, time and cost are factors, which prohibit women travelling to the district hospital for care. If services were more readably available then women would

access them, as they understand that there is more chance of a better outcome for both women and child if they receive some form of professional heath care during the post natal period.

What could be done to improve the quality of services, or to encourage more women to go for postnatal care?

In order to improve the quality of service, then a village health worker would need to be trained in some basic skills of pre-natal and post-natal care. This would be an important first step, as women will not travel the distance to the district hospital. The services would also have to be cheap, and of a significant quality for women to feel confident to utilise.

Importance of the topic.

Do you think these issues are important to women in your community? Why or why not?

Reproductive health was a significant issue for all the participants of the discussion groups. Villagers could see a clear link between a healthy mother and child, with a healthy family, and onwards to direct benefits to their livelihoods and to the village at large. The community needed more awareness of the issues surrounding reproductive health so that they could be more proactive in shaping the type of appropriate services most needed by their village.

8.4 Sources of Information.

Preferred information sources.

What are the most common sources of information in this community? (i.e. Friends, relatives, women's organisations, village meetings)

The participants stated that the most common source of information was "word of mouth", by relatives or friends who were visiting and had possibly just been visiting a health service and would often pass on information. If district health teams visited the villages they sometimes brought posters and other IEC materials and would give a short presentation sometimes during village meetings. As yet there are no regular IEC sessions.

Health workers and counselling.

Who gives talks on maternal health in your community? What do women think of these talks?

District mobile health teams visit all of the villages at least three times a year. These teams though are primarily used for implementing the Expanded Programme of Immunisation (EPI) though often double as general health promoters. Unfortunately they do not carry out health promotion involving family planning activities. Resources used in health information sessions are limited to what can be physically carried by the team into remote locations, thus limiting the amount of information that can be made available to villagers. In general the villagers have responded favourably to the visits, and see them as having a beneficial event on the health of women and children.

Print materials and mass media.

Do women in your community get maternal health information from printed materials? What types? (i.e. books, posters, brochures)

The participants to date have not received any IEC materials on reproductive health.

Do women listen to the radio? What types of programme do they like best?

None of the women in the discussion groups stated that they listened to the radio, as the villages were currently outside of the coverage area for radio transmission.

Would you like to have more information on maternal health issues? If yes, what kind and how could this best be presented?

All groups responded favourably to this question. Many participants suggested methods such as videos, or practical demonstrations on family planning methods. The availability of trained staffed to provide family planning counselling was also highly sort after. Participants also wanted a clinic in their village as they felt that this would provide health information as well as treatment, and again impact favourably on the maternal and child health status of the village.

9. Summary of Findings.

In conducting the focus group discussions at Ban Houay Phae Ou, and Ban Houay Phot, an insight into the knowledge, attitudes and practices of the Akha and Khmu people was obtained which offers information that could be useful in the future development of the villages.

While the focus of the discussions centred around the reproductive health needs of the villagers, especially with regard to the villagers needs for family planning services, other important issues were raised which have significance for development and government staff wanting to work with the two ethnic groups visited.

The women in the discussion groups actively participated in the discussions, and seemingly enjoyed the conversation, which provided a forum that women felt they could contribute too as well as gain new knowledge. After initial hesitation, and in some cases shyness, women soon relaxed and blushes gave way to laughter, and a constructive dialogue between the facilitators and participants were established.

In the men's discussion groups, the commencement of the dialogue between facilitator and participants took a similar pattern to the women's group, where initial awkwardness gave way to good-natured teasing and joking, and the asking of some well-prepared questions. The men provided a different perspective to the discussion, equally as valid, to that of the women, with respect to their experiences.

The questionnaire served merely as a guideline or framework to facilitate discussions that were attempting to gain a better understanding of the Akha and Khmu people. As a result three key findings were identified.

The first key finding was that the overall knowledge of the participants was poor. This lack of knowledge can be attributed to several factors. The first obvious factor is the lack of education offered and subsequently obtained by the participants. The majority of the participants in all groups from both villages had only attended primary school. Many of the participants were illiterate. Consequently the basic skills taught in schools such as how to access information have yet to be obtained by some participants. This is an important initial first step. The analytical skills required to sift through information is virtually non-

existent for participants as at primary level education in the Lao PDR these skills are simply not taught.

Assuming that education levels were substantially improved, amongst remote rural communities, the acquisition of knowledge, at this point in time, would still be inhibited for rural communities as basic infrastructure such as transport and communication systems are at best poor and in the case of communications to Ban Houay Phae Ou and Ban Houay Phot, non-existent. Access to information is critical to learning. When access is denied through a lack of services, or a physical barrier such as no roads or bridges, it interferes with a community's ability to learn.

To take this point one step further, the communities' ability to assimilate knowledge is also very dependent on the quality of information available, i.e. (IEC) materials. Currently in the Lao PDR there are limited supplies of high quality, culturally appropriate IEC materials. Much of the information that exists is out dated, or of insufficient quantity. Additionally the messages in the materials are often confusing. For example the there is a poster, produced by UNICEF of two women. The first woman is surrounded by many children, and looks relatively happy and content, the second woman is surrounded by fewer children, and looks lethargic and sad. Some villagers feel that the woman with fewer children is sad and wants more children, when in fact the poster is to encourage women to have fewer children! Consequently there is a real need in the Lao PDR today for health promotion training for health staff, in the design, production and dissemination of health promotion materials.

The second key finding that the discussions highlighted is the need for cultural sensitivity when dealing with such issues as reproductive health / family planning with different ethnic groups. As has been highlighted in the results of the discussion groups, there are significant cultural differences between the two ethnic groups studied.

While both ethnic groups pay homage to their respective spirit groups, it can not be assumed by any service provider that the cultural practices and religious rites carried out with respect to these religious beliefs can be assumed to be of a similar nature, thus demanding the same response. For example, in an environment where abortions are not available, the care or lack of care of newborn twins demonstrates the need for health staff to be aware that when providing healthcare to the Akha early detection where possible of an imminent birth of twins should be made so that alternatives can be found to allow the

children to live after their birth. This may include, for example, exploring the possibility of searching for prospective adoptive parents from another ethnic group.

The third key finding is that any family planning service provided to remote rural communities should be holistic in nature. This would mean that any services offered to the rural communities, should include both technical services, i.e. medical examinations, diagnosis and treatment, with full access to pharmaceutical supplies as well as incorporating public and personal health messages through dissemination of health messages. Services provided, though requiring the client to incur a charge, could be set at a rate, which while recovering the cost of service and, would not have to be prohibitive. To ensure the maximum coverage of the target population, services could best be delivered as part of a mobile outreach program, thus reducing the economic burden on already poor rural communities.

10. Conclusion.

Family planning services in the Lao PDR make a vital contribution not only to the well being of the mother and child but also to the community and nation at large. Following the Sixth Party Congress in 1996, the Central Executive Committee stated, "the population policy shall be actively implemented in order to make the population growth correspond to the economic growth", (UNFPA: 2001). While the significance of this remark may seem old news to those responsible for heath care delivery at a central government level, or amongst the donor community, it has yet to make any impact at a remote rural community setting.

Far from the policy and strategy decision makers, the people of the remote rural communities of Ban Houay Phae Ou and Ban Houay Phot in Khua District of Phongsaly Province scratch out a meagre existence in their mountain homes. For these communities, the policies and strategies of the Ministry of Health, though admirable, are yet to make any impact in their lives in a practical or tangible way.

These communities are still bound by time honoured customs and rituals, that their respective ethnic groups have practiced for centuries, and have been handed down through generations. It is these customs and rituals that currently have more influence on the status of the communities' reproductive health, than any government policies currently do. In these remote rural communities the villagers are required to be virtually self sufficient, for all of their needs, as given their remote locations villagers are unable to

access government services, including health services. It is in this environment that cultural beliefs flourish and villagers lack the opportunity for quality education and the benefits that such education brings. Included in this is the opportunity to learn more about their health needs in particular family planning.

Education services at the villages are poor and require substantial assistance, both in "hardware" such as school renovations, latrine construction as well as "software" teacher support and curriculum development. Non-formal education services too need to commence to allow older women to continue their education. It is essential that education services be developed as part of the strategy to bring about an improvement of the health status of the villagers.

The health policies of the government combined with government support alone will be unable to meet the needs of the nation especially the rural communities. To achieve such a goal, will require the ongoing support by donor assistance such as UNFPA for the foreseeable future. While donor support may prove unsustainable in the long term, it does provide in the short-term an important buffer or breathing space for Lao women to improve their health status through better access to reproductive health services. Once this goal is achieved in the short-term, women with their improved health status will be better placed to develop and strengthen their economic base through having more time to pursue more lucrative income generating activities.

This process will be an uphill battle as within the health services there are currently insufficient resources available, financial or human to reach those women most vulnerable. The women in the study target villages stated a clear desire for access to quality reproductive health services on a regular basis, a holistic service that meets their physical, psychological as well as cultural needs. While this is not an unreasonable expectation it will be some time, within the present health environment of the Lao PDR, until these needs and expectations are met.

Appendix 1.

Focus Group Discussion Questions.

I. Family Planning

A. Attitudes toward the idea of family planning.
Do you think a couple should decide whether and when they should have children? What factors might they consider? (i.e. Child-spacing, age of mother, family size, health, and/or economic status).

B. Health considerations in childbearing.
What do you think is the right age to start having children, and to stop – Why?
How much time should pass between pregnancies? How many children do you think it is safe for women to have?
Do you know of any women who have had health or other problems as a result of a poorly timed or poorly spaced pregnancy?

C. Knowledge and use of family planning.
Do women in your community know of ways to avoid becoming pregnant? What are they? How do they work?
Do you know of any problems related to family planning? (i.e. Side effects of modern and/or traditional methods, concerns about effectiveness.)
Where do people in your community get information about family planning?
Can people in the community get family planning services? - Where?
In your community, who decides about family planning? (Husband, wife, both, others?) Who do you think should decided?
What factors might prevent people from using family planning? (i.e. lack of services, lack of privacy at clinics, negative attitudes in the community about family planning, opposition from husbands, etc.)

II. Pregnancy and prenatal care.

A. Knowledge of Pregnancy.
How do women in this community know they are pregnant? (what signs/indications, how pregnancies are confirmed).

B. Behaviour and customs during pregnancy.

How do women in your community behave when they are pregnant? (Changes in their behaviour, do they avoid certain places, people or actions? Changes in work habits? Change of diet?)
Where do women get advice on their pregnancy and care?
Who decides what women should do and what customs they should follow?
Do pregnant women in this community visit Traditional Birth Attendants, traditional healers, village based health workers? If so, what kinds of advice and care do they receive?
Why do you think women use the health providers in question 3?

C. Knowledge of pregnancy complications.

Have you ever heard of a woman suffering from complications or problems during pregnancy?

What do you think causes these problems? How do you think they should be treated?
Where do women go for treatment/care if such symptoms were to present themselves during pregnancy? Why? Who makes the decision to go for care or advice in case of complications?

D. Prenatal care.

Do women in this community use prenatal care? Is this service important? Why/Why not?
Where do they go to get this service? Why?
What happens during a prenatal care visit?
How do you think this service could be improved?

E. Importance of the issue.

Do you think problems during pregnancy are important to women in this community? Why/Why not?

III. Delivery and puerperium.

A. Practices during delivery.

What do women in your community do to prepare for childbirth?
Where do most women in the community give birth? Where do you think is the best place to give birth? Why?

B. Assistance during childbirth.

What kinds of care do women who deliver at home usually receive?
What kinds of care do women who give birth in health centres and hospitals usually receive?
Why do you think some women might prefer one kind of care to another?

C. Complications during childbirth and the puerperium.

Do you know of anyone who has had problems during childbirth? What were these problems? What happened?
Are there any other kinds of problems that women can have after childbirth?
What are they and what should be done?

D. Behaviour and customs after childbirth.

Are there special things a woman should or should not do after childbirth? (i.e. workload, diet, seclusion, special rituals).
Where did you get this information?

E. Postnatal care.

Do women in your community go for postnatal care? When? Where? Why/Why not? Is it important?
What advice or service is offered during these visits? (i.e. drugs, examinations, counselling, family planning?)
What could be done to improve the quality of services, or to encourage more women to go for postnatal care?

F. Importance of the topic.

Do you think these issues are important to women in your community? Why or why not?

III. Sources of information.

A. Preferred information sources.

What are the most common sources of information in this community? (i.e. Friends, relatives, women's organisations, village meetings)

B. Health workers and counselling.

Who gives talks on maternal health in your community? What do women think of these talks?

C. Print materials and mass media?

Do women in your community get maternal health information from printed materials? What types? (i.e. books, posters, brochures)
Do women listen to the radio? What types of programme do they like best?
Would you like to have more information on maternal health issues? If yes, what kind and how could this best be presented?

Appendix 2.

Name list of participants in Focus Group Discussion in 2 villages
Ban: Houay Phae Ou
Date: 21/05/2002

No	Name	Age	Education level	Family status	No children	
					die	total
1	Mr. Ngam	30	Primary G1	Married	0	4
2	Mr. ViengKeo	46	G 4	Married	0	0
3	Mr. Chan	38	G 1	Married	0	3
4	Mr. Khammun	36	G 2	Married	1	5
5	Mr. Sing	26	G 3	Married	0	0
6	Mr. Leum	27	G 3	Married	1	4
7	Mr. Leng	40	G 5	Married	0	1
8	Mr. Weng	21	G 4	Married	1	1
9	Mr. Lit	28	G 1	Married	1	2
10	Mr. San	40	G 2	Married	3	6
11	Mr. Nga	37	G 2	Married	3	8
12	Mr. Xienk	38	0	Married	2	7
13	Mr. Rung	27	G 3	Married	1	2
14	Mr. Deng	46	0	Married	0	1
15	Mr. Phet	25	G 3	Married	1	3
16	Mr. KhamPhing	42	G 3	Married	2	8
17	Mr. Phone	28	G 3	Married	0	3
18	Mr. Khan	30	G 1	Married	1	5
19	Mr. Peng	33	0	Married	0	4
20	Mr. Jing	42	G 2	Married	3	6
21	Mr. Pheng	50	0	Married	2	8
22	Mr. Chang	55	G 3	Married	1	5
23	Mr. Me	20	G 1	Married	0	2
24	Mr. Kham	36	0	Married	0	3
25	Mr. Thong	20	G 3	Married	0	0
26	Mr. Chan	18	G 4	Married	0	1
27	Mr. Vanh	30	G1	Married	3	5
28	Mr. Nouk	26	G 2	Married	0	0
29	Mr. Van	36	G 2	Married	0	6
30	Mr. Xing	27	G 3	Married	0	0
31	Mr. Ae	20	Secondary 2	Single	0	0
32	Mr Cheun	30	G 1	Married	2	5
33	Mr. Cher	30	G 1	Married	0	1
34	Mr. Keo	36	G 1	Married	0	4
35	Mr. Son	20	G 4	Married	0	0
36	Mr. Seum	27	G 1	Married	3	4
37	Mr. BounNyun	52	Secondary 1	Married	3	7
38	Mr. Moua	41	G 4	Married	0	3
39	Mrs. Aed	27	0	Married	0	2
40	Mrs. Nyom	29	0	Married	0	3
41	Mrs. Aon	30	0	Married	0	2

42	Mrs. Dee	35	0	Married	0	2
43	Mrs. Daw	26	0	Married	1	0
44	Mrs. Nang	30	0	Married	0	3
45	Mrs. Nang	30	G 2	Married	0	1
46	Mrs. Sone	28	G 2	Married	2	3
47	Mrs. Tai	46	G 2	Married	1	3
48	Mrs. Mone	22	0	Married	0	0
49	Mrs. Bua	35	0	Married	0	1
50	Ms. Keo	22	0	Married	2	2
Ban: Houay Phot						
Date: 22/05/2002						
No	**Name**	**Age**	**Education level**	**Family status**	**No children die**	**total**
1	Mr. Pake	21	G 3	Married		0
2	Mr. Kham Pai	19	G 3	Single		0
3	Mr. SayKham	19	G 3	Single		0
4	Mr. VanDee	21	G 2	Married		1
5	Mr. BounChan	18	G 2	Single		0
6	Mr. KhamMun	16	G 3	Married		0
7	Mr. BounPheng	26	G 2	Married		2
8	Mr. ThongSy	19	Snd 3	Single		0
9	Mr. PeeCher	29	0	Married		2
10	Mr. LawPha	30	0	Married		3
11	Mr. Mai	23	G 3	Married		1
12	Mr. KoPu	38	G 2	Married	2	6
13	Mr. KhamChan	18	G 3	Married		1
14	Mr. PuSa	21	G 2	Married		2
15	Mr. SomChit (A)	15	G 3	Single		0
16	Mr. ChanSouck	19	G 3	Married		2
17	Mr. EerKae	22	0	Married		2
18	Mr. HuMa	18	G 3	Married		1
19	Mr. ChaSa	26	0	Married		1
20	Mr. XaiBoun	20	Snd 3	Single		0
21	Mr. KhamPeng (A)	15	Snd 2	Single		0
22	Mr. KhamPheng (B)	16	G 2	Single		0
23	Mr. EerJer	38	G 3	Married		1
24	Mr. BounMee	20	Snd 3	Single		0
25	Mr. YaeKho	28	0	Married	2	4
26	Mr. MaeLo	22	G 3	Married		3
27	Mr. KhamXai	18	0	Single		0
28	Mr. NoyMa	24	0	Married		2
29	Mr. ChaeJa	15	G 3	Single		0
30	Mr. ChaeMu	29	0	Married	3	5
31	Mr. ChaJae	22	G 3	Married		0

32	Mr. LaKa	15	G 3	Single		0
33	Mr. EerKho	27	G 1	Married		2
34	Mr. SaLo	36	G 3	Married		8
35	Mr. KhamKeo	18	G 3	Single		0

36	Mr. SaKo	30	0	Married	1	4
37	Mr. EerKhae	40	G 2	Married		1
38	Mr. KhoPu	18	G 3	Single		0
39	Mr. KhoLo	16	G 5	Single		0
40	Mr. SaMae	37	0	Married	1	6
41	Mr. SaCha	23	0	Married		1
42	Mr. ChuMa	23	G 2	Single		0
43	Mr. ChuHu	26	0	Single		0
44	Mr. EerChae	28	0	Married		4
45	Mr. KhuayMu	30	0	Married		5
46	Mr. EerPhew	35	G 2	Married	1	4
47	Mr. PhiHu	21	G 3	Married		1
48	Mr. LawJu	23	0	Married		1
49	Mr. LoYae	26	G 3	Married		2
50	Mr. MaChae	29	0	Married		2
51	Mr. PhiSor	17	G 3	Single		0
52	Mr. PeyMu	34	0	Married	3	3
53	Mr. LoNya	21	G 2	Married		0
54	Mr. LoJa	19	G 3	Single		0
55	Mr. LoCheh	16	G 5	Single		0
56	Mr. PhuChea	28	G 3	Married	1	4
57	Mr. PuKho	30	0	Married	3	5
58	Mr. JaeSheh	29	0	Single		0
59	Mr. JaeSor	23	G 3	Married	1	1
60	Mr. SaCher	23	G 2	Married		1
61	Mr. KheaNya	21	0	Married	1	2
62	Ms. MewCha	37	0	Married		1
63	Ms. KhoJu	22	0	Married		3
64	Ms. LuCher	22	0	Married	2	4
65	Ms. LuCha	15	G 3	Single		0
66	Ms. ChaePer (A)	25	0	Married		2
67	Ms. ChaeTor	18	G 1	Single		0
68	Ms. EerPer	27	0	Married	3	5
69	Ms. EerPu	22	0	Married		0
70	Ms. ChaJu	17	G 2	Single		0
71	Ms. LoEer	26	0	Married		2
72	Ms. LoPhu	16	G 1	Single		0
73	Ms. ChaePer (B)	38	0	Married		8
74	Ms. KaJer	20	G 2	Single		0
75	Ms. MuChu	32	0	Married	1	6
76	Ms. ChaePher	38	0	Married		1
77	Ms. HiYae	33	0	Married	1	4

78	Ms. Eerpa	23	0	Married		1
79	Ms. YaePher	22	0	Married		1
80	Ms. KoPher	15	G 1	Single		0
81	Ms. LuPher	28	0	Married		4
82	Ms. CheaPu(A)	28	0	Married	1	4
83	Ms. PaEer	31	0	Married		5
84	Ms. KoPu	15	G 1	Single		0
85	Ms. EerJae	21	0	Married		1

86	Ms. PhiSha	22	0	Married		0
87	Ms. EerPhu	23	0	Married		2
88	Ms. EerYu	18	G 1	Single		0
89	Ms. KhoYer	27	0	Married		2
90	Ms. PhiMor	19	G 1	Single		0
91	Ms. JaeNu	18	G 1	Single		0
92	Ms. LoCha	15	G 1	Single		0
93	Ms. PuChu	30	0	Married	2	5
94	Ms. KheaPhu	29	0	Married	2	5
95	Ms. MotSor	21	0	Married	1	1
96	Ms. CherCho	16	G 2	Single		0
97	Ms. ChaePu(B)	16	G 1	Single		0
98	Ms. EerOr	21	0	Married		1
99	Ms. EerNor	20	0	Married	1	2
100	Ms. ChanKeo	16	G 1	Single		0
101	Ms. KoPer	17	0	Married		0
102	Ms. EeCha	25	0	Married		2
103	Ms. KoYer	15	G 1	Single		0
104	Ms. HuOr	20	0	Married		1
105	Ms. YaeCher	15	G 1	Single		0
106	Ms. UoMer	25	0	Married		3
107	Ms. ChaEer	22	0	Married		2
108	Ms. BuaPeng	16	G 5	Single		0
109	Ms. OnKeo	15	G 2	Single		0
110	Ms. KhoMer	18	G 2	Married		0
111	Ms. PhewPer	17	0	Married		1
112	Ms. JuChu	15	G 2	Single		0
113	Ms. KhoCher A	18	G 2	Married		1
114	Ms. UoPer	23	0	Married		2
115	Ms. CheaEer	21	0	Married		1
116	Ms. PiChu	17	0	Married		1
117	Ms. EerJu	35	G 2	Married	4	9
118	Ms. KhoCher (B)	16	G 1	Single		0
119	Ms. KoMer	20	0	Married		2
120	Ms. MaeCher	20	0	Married		0

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