Reproductive Health at the Margins
Results from PEER Studies in Southern Laos

Executive Summary

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Foreword

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

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

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

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

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

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Executive Summary

Background: This study took place from November 2007 – January 2008, with the aim of understanding perceptions and behaviour related to reproductive health among vulnerable ethnic communities in Sekong, Attapeu and Saravan Provinces, southern Laos. Findings will inform the design of a UNFPA-led demand creation programme for reproductive health services. The demand creation programme has goals of increasing use of contraceptives, increasing attendance of skilled personnel at deliveries, and reducing early marriage and unwanted pregnancy. The overall aim is to reduce maternal mortality.

The report explores possible barriers to effective use of reproductive health services.

Using the PEER method[1], local women developed their own research questions, interviewed their friends, and fed back findings to the research team. They collected detailed qualitative data on determinants of risk and barriers to accessing services. The PEER method is particularly suitable for gathering data in hard to reach, non literate groups. The report suggests ways in which the community participation initiated by the research could continue into the next phase of the demand creation programme.

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

Study context: Sekong, Attapeu and Saravan provinces are populated by numerous different ethnic groups, each with their own languages and customs, but sharing many similarities: they are largely rice farmers, who practice animist religion, and

[1] Participatory Ethnographic Evaluation and Research

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

Findings: Rather than looking at 'barriers to access' (which implies that people want to access services but are prevented from doing so), the report asks *'Why are ethnic groups not making full use of available reproductive and maternal health services, and what might prevent them from doing so in future?'* From this perspective, numerous factors emerge from the data:

Perceptions and experiences of services

- **Fear of side effects from contraceptives:** women and men feared that contraceptives could damage women's health. Women found little available information. Rumours and stories about ill-effects have spread quickly in communities. Women want to find a method that 'agrees' with them but have limited choice.
- **Perception of providers:** there were fears of unpredictable and unexpected costs at health facilities; many providers do not speak ethnic languages; some providers are said to scold or ignore poor and ethnic patients.

Lack of perceived need for services

- Although there is demand for family planning in many villages**, large family sizes are often seen as desirable** for household and agricultural productivity.
- **Unwillingness to engage in new behaviours** for which there is little perceived need (e.g. attending antenatal care, using IUDs, attending hospital to deliver).
- **Low levels of risk perception** around potentially risky behaviours (lack of skilled birth attendants, early childbearing).

- **Women take pride in their resilience** (e.g. not resting after childbirth), and question why they should change from the ways of their parents.
- **Competing priorities:** food production, other illnesses, and domestic duties compete for time and attention with self-care activities and accessing health care and services.

Historical, political and social factors

- **Introduction of reproductive health services linked to eroding of traditional ways of life:** Behaviour change initiatives, such as promoting family planning or attending health facilities for childbirth, may be perceived as unnecessary attempts at changing their way of life, and may be resisted by some community members.
- **Communities have not been empowered** to participate in managing the introduction of reproductive health services, to articulate their own demands, or to hold providers to account**.**
- **Services new and barely known:** for many communities, technologies such as contraceptives are still very new.
- **Ethnic practices and traditions** such as birthing alone in the forest or making an animal sacrifice before attending hospital may increase risk of adverse health outcomes. However, these practices are not static; there is evidence of behaviour change across the region.
- **Gender norms and dynamics:** men retain decision making power, but many are unwilling to attend village events on reproductive health or gender equality, or do not support their wives in using contraception.

Affordability of services

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

[2] Between US $0.57 - $1.14: at the time of writing, one US $ was worth 8756 kip.

Accessibility of services

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

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

Implications for demand creation programme

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

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

In order to succeed in changing behaviour in these areas, and in line with WHO recommendations, it is strongly recommended that UNFPA and its partners develop **participatory, gender-sensitive, rights-based ways of working** with these

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

communities, with the aim of empowering communities members to improve their control over maternal health and increase their access and utilisation of quality health services. Empowerment is a process of gaining internal skills and overcoming external structural barriers in accessing resources. This is particularly important given the marginalisation of some ethnic groups, and of groups within these communities such as women. Empowerment strategies help to produce sustainable groups, help to build self efficacy and collective efficacy, encourage the adoption of healthier behaviours, and increase the effective use of health services.

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

1 Person Profiles

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

Person profile from Lamam District: 'Noi'

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

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

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

Person profile from Kaleum District: 'Kai'

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

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

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

Person profile from Xanexay District: 'Mrs Keo'

Ms. Keo 36 years old, and is married with five children: one girl and four boys. She is from the Alak ethnic group. She farms paddy fields, and does upland rice farming. She works hard every day: her daily work includes cooking, cleaning the house, feeding her pig, ducks and chickens, growing vegetables, pounding rice, and collecting water. After finishing the housework she goes out to collect firewood or collects long grass for the roof of the house, or finds frogs, and picks wild vegetables and bamboo shoots. She earns money by selling her pigs and chickens, but it is not sufficient for the family's needs.

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

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

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

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

Person profile from Sanamxay District: 'Mrs Pheng'

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

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

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

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

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

2 Implications for Demand Creation Programme

2.1 Prioritising key issues

The PEER study has highlighted three main areas with potential for maternal mortality reduction through a demand creation programme implemented in tandem with quality supply side services.

The three priority areas for demand creation are:

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

2.2 Priority One

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

Rationale: PEER data suggest that demand for family planning is suppressed by concerns about side effects and incomplete understanding of how methods work. The aim of this priority is to reduce the perceived risks that both men and women associate with using contraceptives.

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

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

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

Empowerment strategies: Suggestions for facilitating this process include:

- Setting up confidential one to one sessions where women and men can discuss their experiences and concerns with a health professional (this will require boosting the skills of, and materials available to, health professionals to deal with expected queries and problems)
- **Build capacity of men and women to talk to each other** about their concerns. This should start with a period of single-sex discussion and sensitisation. The aim would be to work through information and issues around family planning including:
    - Basic reproductive biology
    - How contraceptives work
    - Tackling fear of side effects of contraception
    - Countering common misconceptions
    - Supporting correct use of contraceptives
    - Accessing a steady supply of contraceptives

An additional recommended step for the demand creation programme is to address the lack of positive information about family planning and contraceptives in the PEER data, which limits understanding of positive experiences for the demand creation programme to draw inspiration from. One powerful way of working against the

general negative atmosphere in the community around contraceptives would be to **collect testimonials from satisfied users, or to encourage such women and men to advocate directly to their communities**.

2.3 Priority Two

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

Rationale: Although it may sound obvious, strategies around the process of childbirth itself are of fundamental importance to reducing maternal mortality, and should be a central priority for behaviour change and for raising of community capacity to make healthier decisions. PEER data highlight health seeking behaviours, avoidable risk factors, and barriers to care that could be addressed through a demand creation strategy.

Recommended empowerment approaches:

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

- **Establish village level maternal health action group/village health committee as decreed by MoH**. Recruit a wide range of people from the community (including representatives from the aforementioned women's group, local lay experts, village leaders etc) and support the group in identifying local solutions to community-identified problems in childbirth. This could include:
    - Supporting women to go for antenatal care
    - Advice on nutrition, breast feeding, family planning and vaccination
    - Birth and emergency preparedness: diagnosing labour, assistance during labour (companion and skilled attendant if possible), detect maternal complications early, refer maternal complications early
    - Sustainable transport plans: co-operation with other villages, ambulance tractors, saving money communally to deal with issue.

- Community financing: Pooling funds for transport and hospital costs
- Men's role in childbirth: Build on positive male role models as identified by the community.

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

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

Other strategies:

Mass media may be appropriate for:

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

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

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

2.4 Priority Three

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

Rationale: Building stronger linkages and more equal partnerships with health services will be essential to tackle the issue of **'shyness'** around attendance at health facilities. These are the building blocks upon which the ultimate goal of reducing maternal mortality through improved use of services will be built. ANC can also be used to distribute other packages such as anti-malarial drugs or bed nets, nutrition and infant care.

Empowering strategies:

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

Other strategies:

- Increase and publicise the benefits associated with ANC and skilled delivery at health facilities: Malaria treatment, nutritional information and supplementation etc could be offered to boost the benefits associated with these services.
- Provide incentives (travel money, seeds, expenses for a chaperone to travel with the woman etc.). It is culturally appropriate for women to travel with a chaperone through remote areas, so supporting this behaviour would be reasonable.

2.5 What is demand creation in this context?

For demand creation to be effective, it must adopt a behaviour change approach, supporting the empowerment of communities to act for their improved health, together with supply side interventions. It will have to focus on much more than

providing information alone, as information alone is rarely enough to change behaviour.

Components of Demand Creation

Empowering communities

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

Increasing knowledge

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

  = 'informed demand'

Improving access

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

2.6 Recommended approach to tackling marginalisation at district level

The PEER findings show why traditional information and education approaches are unlikely to succeed in meeting the objectives of the maternal and infant mortality programme. The changes required are complex, including challenging fundamental beliefs and practices in communities, tackling the marginalisation of communities (including their lack of confidence in dealing with health providers and their lack of

ability to hold providers to account), and community level inequalities (e.g. women's lack of decision making power).

Empowering communities is not about leaving communities do things entirely for themselves. To challenge long standing behaviours and power structures, skilled facilitation is needed. For example, facilitators may need to ensure the inclusion of vulnerable or excluded community groups. Numerous tools exist to aid programmes begin this process of empowerment of communities. Effective strategies tend to involve small group efforts, and are sensitive to health needs as defined by the community themselves.

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

Participation is an important component of empowerment. It fosters a sense of ownership of activities, and also aims to facilitate people's power to make decisions and to promote higher levels of self-reliance. Due to limited experience for both implementers and communities in participatory approaches, initial levels of participation should be appropriate and feasible, and may be increased gradually over time. The first step of increasing participation is involving affected people by seeing issues from their viewpoint. PEER has demonstrated that it is both possible and productive to work with ordinary community members, including non-literate women from vulnerable ethnic communities, in this task. Higher levels of participation include community members being involved in selecting leaders, participating in monitoring and evaluation, setting programme objectives, and even being able to advocate for policy change.

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

- **Strategic decision making:** Ensuring that strategies and approaches selected are adequate, appropriate, and responsive to needs
- **Development and testing:** Ensuring the cultural appropriateness and comprehension of messages, materials and tools

- **Implementation and monitoring:** Community decision making in incorporating programme activities into local social contexts (e.g. how and when activities are carried out), involvement in monitoring quality (e.g. key informant monitoring, inputs into the definition and design of service quality monitoring tools)
- **Evaluation:** Involvement in analysing the effectiveness of activities, and planning for the future

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

Challenges: Community participation has been set in motion with PEER, and has demonstrated to UNFPA and its partners that participation is possible, productive, and potentially transformative. However, there are many challenges in working with communities to help them play a more active role in determining their needs and working out solutions. These communities are more used to being told what to do than being asked for their opinions. In addition, participatory and empowering approaches have not been widely used in reproductive health in Lao PDR, and national staff and partners would benefit from increased capacity for implementing participatory approaches. Health providers and community workers themselves will need to be empowered to carry out this type of work, for example by upgrading their skills to include participatory facilitation. Mechanisms by which they can feed back regularly to central level to make their concerns and ideas known are also essential.

2.7 Tailored Implementation

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

Villages have different level of familiarity with services and will require different levels of intervention to stimulate demand for services. Communities vary in their attitudes to and experiences of services. For some, family planning has become a widely

recognised part of life, even if some barriers to access remain. For others, such services are still extremely new. To manage this variation, behaviour change communication (BCC) materials and approaches should cover a range of stages of behaviour change (see box below).

Stages of Change

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

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

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

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

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

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

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

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

2.8 Messages, materials and tools

It is important that messages are in harmony with each other across these different channels and among different partners. For instance, posters and radio spots about family planning should have the same key messages, and community based distributors (CBDs) and outreach health care teams and health staff should also work with the same key messages. This means that messages are more credible and likely to be reinforced and remembered.

A 'positive appeal' should be used rather than trying to spread fear.

Positive messages should be written in positive language, avoiding phrases such as 'don't'. Messages can focus on direct benefits such as health, strength, or financial advantages. However, social or emotional benefits may be more effective: persuading people that the benefit is being 'modern', gaining control, feeling safe, feeling trusting, or gaining respect from peers. In most cases promising a direct benefit of 'health' is ineffective. For instance, among ethnic women, it is not ill health they fear as much as not having enough time to attend crops and other duties, or not having the support of their husband if they become ill. The benefits of birth spacing, for example, might be to have more time to work to increase productivity and income, and to have time to participate in social activities. PEER findings support the argument that messages should focus on the healthy timing and spacing of pregnancy, rather than fertility reduction.

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

- What are existing beliefs in the community to reinforce?

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

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

For example, if we were to focus on 'increasing uptake of contraception':
Beliefs to reinforce: women believe they can discuss decisions with fellow women and seek advice from people who know about contraception
Beliefs to change: that contraceptives are dangerous to health
Perceived benefits of changes: be smart like other women and have more time for work, supporting the family, making more income and participating in social activities
Perceived barriers to change: side effects, husband's opinion, lack of choice of contraceptive methods, provider attitudes.

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

2.8.1 Characteristics of a good message

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

Ideally, messages should be developed in partnership with the community. At the very least they should be tested for comprehension and acceptability by ordinary community members. Messages should be attractive and engaging, and incorporate

local interests and influences if possible, such as references to social life or subsistence activities.

Communications should be open about what they are trying to achieve. No one should suspect or fear that the programme has damaging goals, or is trying to get people to behave in a secretive manner. As mentioned several times in this report, it is extremely important that messages are credible and do not make promises that cannot be kept.

2.9 Channels for delivering demand creation

There are numerous ways of delivering demand creation activities. The approach for remote villages will be different from that in towns and villages near roads, which have easier transport links and greater access to education, mass media etc.

The following recommendations apply to all channels of delivery:

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

2.9.1 Interpersonal communications

These approaches consist of:

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

Recommendations for interpersonal communications:

- These communications should include not only information, but also skills building (e.g. role play, communications skills), discussion and debate.
- Dramas and stories should show 'pathways' to seeking help or advice. For instance, how to access emergency funds, how to request services at a health facility, if confronted with a particular problem.

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

2.9.2 BCC and IEC materials

For all materials, it should be remembered that there are relatively low levels of literacy (especially among the most at risk groups) and therefore written materials are not appropriate for many target groups. Materials should clearly depict people from ethnic groups so that people can relate to them. A range of different but authentically dressed images of people (i.e. as people look and dress currently) should be included such that all groups see them as relevant. These must be field tested to ensure communities relate to them.

Suggested IEC materials include:

- **Printed materials for health workers:** Although health workers are literate, this does not mean they want to read long and complicated leaflets (as some current leaflets observed in the area are). Rather than overloading health workers with information, these should be brief and simple, filling specific knowledge gaps.
- **'Frequently Asked Questions'** concerning aspects of reproductive health, with simple model answers and pictures to help explain the answers. For example, questions might include 'why am I having irregular menstruation since having a contraceptive injection?', 'what will happen to me when I go to ANC?', followed by a simple description of the answer, with pictures if necessary, avoiding technical terms.

- **Educational tools:** flip charts, games, cards etc. on priority topics in reproductive health. These should be designed with specific priority areas in mind, e.g. countering misconceptions around contraceptives.
- **Appropriate packaging of drugs/contraceptives:** contraceptive pills and medicine packets were noted to have English labels which no one locally could read. Developing packaging in Lao, which at least someone in the village could read, could be useful.
- **Posters** are very popular in the area but are likely to remain in health workers' and chiefs' houses to decorate the walls. **T-shirts, caps and other give-away items** may help raise the profile of an issue, but have little value in actually changing behaviour. Hence, these materials are NOT recommended for this programme.

2.9.3 Mass media communications

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

2.9.4 Other innovative approaches

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

Maternity Waiting Homes: These need to gain people's confidence, while showing the benefits and reducing the costs of attending (skills-building and vegetable growing are strategies suggested in Eckerman's Needs Assessment in 2006). Invite influential men and women to visit. Build capacity in communities to recognise high risk cases that will benefit most from using this service.

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

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

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

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

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

Adapted toolkit of maternal survival resources – there are many such resources online which can be refined and tested in the communities.

Reducing financial barriers to access

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

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

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

Community involvement in monitoring financial transparency is possible through schemes such as exit cards (where users are asked to evaluate their experience on a simple data collection card, which can be designed in collaboration with community

members who help to define the 'quality' of services from their perspective) or even 'mystery client' visits to health services.

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

Current initiatives to reduce financial barriers to health care in Laos

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

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

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

2.10 Implications for supply side activities

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

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