Baseline Situation Analysis in Three Southern Provinces, 2002 (BSA 2002)

UNFPA Project LAO/02/PO7: Strengthening the Data Base for Population and Development Planning

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List of Acronyms

AID	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARH	Adolescent Reproductive Health
BCC	Behavior Change Communication
CBR	Crude birth rate
CEB	Crude ever born
CDR	Crude death rate
CPC	Committee for Planning and Cooperation
CST	Support Team for East and South-East Asia
E ⁰	Life expectancy
EOC	Obstet Emergencies
FP	Family planning
RH	Reproductive health
HC	Health Center
HIV	Human immunodeficiency virus
ICPD	International Conference on Population Development
IEC	Information Education and Communication
IFA	Iron-folate Acid
IMR	Infant mortality rate
CMR	Child mortality rate
U5MR	Under-five mortality
IUD	Intrauterine device
LAO/02/P01	Strengthening of RH services through the Primary Health Care Network
LAO/02/P07	Strengthening the Data Base for Population and Development Planning
LRHS 2000	Lao Reproductive Health Survey 2000
MCH	Maternal and Child Health
MCHC	Maternal and Child Health Center
MMR	Maternal mortality rate
MWRAs	Married Women at Reproductive Age
NMR	Neonatal mortality rate
NSC	National Statistical Center
OVIs	Objective Verifiable Indicators
PDS	Population and Development Strategies
PNC	Post Natal Care
PoA	Programme of Action
RH	Reproductive health
RTIs	Reproductive tract infections
SA	Situational Analysis
SPDs	Service Delivery Points
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TBA	Traditional birth attendant
TFR	Total fertility rate
TT	Tetanus vaccine
UNFPA	United Nations Population Fund
VHV	Village Health Volunteer

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Foreword

We are pleased to present to you the 2002 Baseline Situation Analysis (BSA), conducted by the National Statistical Centre (NSC) in close collaboration with the Maternal and Child Health Centre (MCHC) of the Ministry of Health (MOH). The BSA was conducted in November 2002, with the support of UNFPA. Technical assistance was provided by the UNFPA Country Technical Services Team (CST) in Bangkok.

The study was undertaken with the purpose of providing baseline information on current heath services for mothers at service delivery points as well as knowledge and use of services by community members in three southern provinces: Saravane, Sekong and Attapue. It covered three provincial hospitals, 14 district hospitals, 64 health centres and 154 sample villages. Within the villages, 1,540 couples were interviewed. The study examined adequacy of supplies and equipment, staff capacity, facilities, knowledge and capacity of village health volunteers (VHVs) and traditional birth attendants (TBAs) on the delivery of RH services, and the knowledge and utilization of those services by clients. Data processing was provided by the NSC with technical assistance from UNFPA. The report was prepared by the NSC with the assistance from MCHC/MOH and the Department of Planning, Committee for Planning and Cooperation (CPC).

The report was prepared 4 months after the data were compiled and checked. It provides useful information for policy makers and programme managers to plan and manage quality RH service provision in the southern provinces. The BSA results highlight what needs to be done for the provision of high quality maternal health services and for improving physical conditions of facilities, where weaknesses exist in the supply system for equipment, medicines and contraceptives, and what kind of training is needed for service providers and volunteers to upgrade their capacity at all levels. They also point to the need to increase the knowledge of community members and to design information and education programmes to inform them about the available services and how to utilize those services.

We thank all of those dedicated individuals who have assisted in conducting the survey, analyzing and interpreting data and writing the 2002 BSA report. They provided us with this important information for improving reproductive health services for Laotians.

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1. Introduction

1.1. National context

In 2003, the estimated population of Lao PDR was 5.5 million, spread across the 18 provinces. This number included the various minority groups of ethnicity (see Map 1). The rate of growth between the 1995 Census and the Reproductive Health Survey 2000 was estimated at about 2.8 percent per year. This relatively high rate growth rate has resulted from a slow decline in the birth rate and a rapid decline in the death rate. About 45 percent of the population is under the age of 15 years, while almost 55 percent is younger than 19 years. The population is young and will remain so until the Total Fertility Rate (TFR) declines significantly from its present high level of 4.9. While the population density is low, the high population growth rate presents several challenges, such as providing basic social services and raising the quality of life among the Lao population.

The population of Lao PDR would be even higher today if there had not been any Government birth spacing and family planning services. These services have been incrementally introduced through the Ministry of Health (MOH). The introduction of selected birth spacing services started by establishing two Maternal and Child Health (MCH) clinics in Vientiane in 1989 (at Setha and Mahosoth hospitals). Later, these services were extended into a national strategy and network of MOH, aiming to provide selected family planning services through all government health facilities, from village to provincial levels.

Government policies that support the phased expansion of family planning services include:

- the MOH Birth Spacing Policy 1995;
- the MOH Safe Motherhood Policy 1998; and
- the National Population and Development Policy (NPDP) 1999.

The family planning services are widely implemented throughout the country. One of the main objectives of the Government family planning programme is to raise the mother's age at her first pregnancy, which should contribute to fertility reduction and also to improve maternal and child health.

The MOH strategy for improving maternal and child health has been successful in increasing interest in family planning choices, and in meeting some of the demands and needs for reproductive health services. 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, covering more than one third of the country's villages, received basic training on how to distribute information to their communities on reproductive health and family planning.

The NPDP was developed by the Government in June 1999 to address issues of population and development in response to the International Conference on Population and Development – Programme of Action (ICPD/PoA) 1994. The NPDP provides a framework to implement the supporting MOH technical policies that address the provision of reproductive health, including family planning services. In particular, the policy highlights the need to extend reproductive health care, including family planning services, as part of primary health care throughout the country and particularly to the rural areas, to reduce maternal and infant mortality rates and TFR, and to increase contraceptive use.

Through the NPDP, the Government aims to increase access to health and reproductive information and services with the active participation of the private sector and communities throughout the country. Such services will give people the knowledge and power to decide the size of their family, according to their social and economic situation. The policy makes special reference to adolescents who need opportunities to access health and sexuality education. This is important in terms of reducing the number of early pregnancy among girls less than 18 years of age, and in preventing the transmission of sexually transmitted diseases (STDs), including HIV/AIDS.

In order to monitor and improve national programmes, policies and plans, the following sample surveys that relate to RH and MCH were conducted:

- The Fertility and Birth Spacing Survey 1994
- The Multiple Indicator Cluster Survey (MICS) 1997
- The Multiple Indicator Cluster Survey (MICS) 2000
- The Lao National Health Survey 2000
- The Lao Reproductive Health Survey 2000

1.2 UNFPA-supported Country Programmes

Since the beginning of the first Country Programme to Lao PDR (1993-1996), UNFPA has provided support and technical assistance to the MOH for its national Maternal and Child Health (MCH) Strategy. UNFPA has taken a leadership role to procure and promote only the safest, international-quality contraceptives for Lao PDR.

Under the second Country Programme (1997-2001), UNFPA included HIV/AIDS prevention topics in the training of service providers, and procured most of the reproductive health commodities for the condom social marketing project of the National Committee for the Control of AIDS. This action was carried out in partnership with Population Service International (PSI).

From experiences over past years, UNFPA, together with the Government of Lao PDR, learnt much in terms of programme implementation. The key areas that were identified as requiring special attention included:

- focusing on a selected core package of reproductive health services, based on resource availability;
- staff training in logistic management information systems;
- ensuring a continued supply of contraceptives;
- ensuring that educational materials on population and sexual health are less theoretical, and more friendly and relevant to the users' own life-skills;
- winning broad-base support for the implementation of the NPDP;

building capacity, particularly at decentralized levels, to analyze and interpret the implications of population dynamics for economic and social development; and

• incorporating findings and data into national and sectored planning.

UNFPA, through its third Country Programme (CP III), aims to support the Government of Lao PDR in achieving the goals of improving the quality of life and sustainable, social and economic development in the 5th Socio-economic Five Year Plan (2001–2005), and Development Strategies to the Years 2010 and 2020, by contributing to:

- improved RH status of women, men and adolescents;
- reduction in gender inequality; and
- sustained balance between population, resources and socio-economic development.

The UNFPA assistance during the CP III period specifically aims to:

- support the expansion of family planning nationwide while, at the same time, focusing on three poor, under-served southern provinces for integrated reproductive health services;
- provide reproductive health information and selected services to women, men and adolescents through community outreach and peer education;
- support the integration of sexual and reproductive health and population issues and life skills in schools and out-of-school education programmes;
- institutionalize and strengthen coordination mechanisms for population and development;
- promote integration of population factors in national and provincial planning and implementation of the NPDP and its action plan;
- expand partnerships for advocacy, especially for adolescent reproductive health and improving the status of women, awareness raising and population research and data collection;
- promote dissemination and utilization of research findings and data in policy development and programme planning; and
- build capacity of partner institutions in programme management, technical skills and advocacy.

The CP III is being implemented jointly with the following partners:

- (1) Ministry of Health (MOH) (LAO/02/P01);
- (2) Lao Women's Union (LWU) (LAO/02/P02);
- (3) Lao Youth Union (LYU) (LAO/02/P03);
- (4) Ministry of Education (MOE) (LAO/O2/P04).
- (5) Committee for Planning and Cooperation (CPC) (LAO/02/P05);
- (6) National University of Lao (NUOL) (LAO/02/P06); and
- (7) National Statistical Center (NSC) (LAO/02/P07).

In order to monitor its implementation and progress, the CP III has identified a number of objectively verifiable indicators (OVIs) to be used to measure progress and assess performance, and data for these indicators will be collected through various means such as surveys, situation analysis, analysis of routine data, focus group discussions and interviews and rapid assessments.

1.3 Purpose of the Baseline Situation Analysis

This Baseline Situation Analysis (BSA) is part of the overall monitoring framework of the CP III. Two situation analyses are to be conducted in the three southern provinces to monitor and evaluate performance of UNFPA-supported projects with MOH and LWU; one at the beginning and the other at the conclusion of the programme. The first one is to serve as a baseline study, providing the data and information needed to start and monitor interventions related to reproductive health services and information, and the second one to serve as an endline study to compare and assess the achievement of the interventions.

The BSA examined the situation of the reproductive health service availability, the capacity of staff and Service Delivery Points (SDPs) to deliver accurate information and high-quality services, including the physical conditions and the availability of basic medical equipment, supplies and contraceptives that are needed to provide a core package of RH services, and the knowledge and use of services among community members. It provides policy makers and programme managers with information for improving service delivery and health communication.

The National Statistical Center (NSC) was entrusted to carry out the BSA in 2002. NSC worked very closely with other implementing agencies, such as Maternal and Child Health Center (MCHC), Committee for Planning and Cooperation (CPC), Lao Women's Union and Lao Youth Union, in various stages of the BSA.

The main objectives of the BSA were to:

- assess the readiness (in terms of equipment, facilities and staff) of SDPs to provide the core and basic package of RH services and counseling in the selected SDPs;
- identify training needs on the knowledge and skills of providers including counseling, behaviour change communication (BCC) and gender considerations;
- assess knowledge, accessibility and affordability of RH services and counseling from the perspectives of potential clients (married women, their husbands, adolescents/youth, including ethnic groups).

The BSA was also intended to provide data for the following OVIs to assess the progress of the CP III:

• percentage of provincial and district hospitals that provide the core package of RH counseling and services,¹ in accordance with service delivery guidelines, including sensitivity towards the needs of ethnic groups;

¹ eleven items such as family planning, ANC, PNC, normal delivery, assisted delivery, distribution of IFA, TT vaccination, caesarian section, post-abortion, treatment of complications, syndromic management of RTI/ STIs and prevention of HIV/AIDS

- percentage of health centers that provide basic RH services² and counseling, in accordance with service delivery guidelines, including sensitivity towards the needs of ethic groups;
- percentage of public sector SDPs (provincial and district hospitals and health centers) that have sufficient quantity of RH BCC material for distribution to clients;
- percentage of service providers who were trained on providing BCC on RH issues;
- percentage of clients who were referred for obstetric complications and received treatment within two hours of arrival at provincial and district hospitals;
- percentage of clients who received counseling among clients who came for RH services;
- percentage of public sector SDPs that provide at least three modern FP methods and counseling; and
- percentage of public sector SDPs and other facilities that experienced contraceptive stockouts.

1.4. Methodology of the Baseline Situation Analysis

The BSA consisted of two surveys: a facility-based survey and a community survey. The facility-based survey investigated the functioning of the SDPs, through observations and interviewing service providers in areas of service delivery subsystems, such as logistics supplies, functioning of infrastructures and facilities, staffing, competency of technical staff, supervision, information, communication and education (IEC) and record-keeping systems. The community survey collected information on the knowledge, accessibility and use of services among community members using individual questionnaires.

Measurement level

The BSA was conducted for SDPs and staff of SDPs at three different levels and for potential clients.

Service Delivery Points (SDPs): Inventory was taken from different levels of SDPs, such as provincial hospitals, district hospitals and sub-districts. All SDPs provide family planning services.

Staff of SDPs: All levels of staff working at SDPs were interviewed to assess capacity, in terms of knowledge and skills to provide accurate information, quality counseling and services. Categories of staff include: doctors, medical assistants, nurses, midwives and Village Health Volunteers (VHVs).

Potential clients: Within the villages where RH services are supposed to be provided under the UNFPA-supported project, interviews were conducted across a sample of married women of reproductive age (between 15-49 years) and their husbands.

² ANC, PNC, normal delivery, resuscitation and referral of complicated cases, provision of injectables, pills and condoms, syndromic management of RTI/STIs and prevention of HIV/AIDS

Sample design and sample size

The selection of three southern provinces, and districts within the provinces and villages, was pre-determined by the Ministry of Health/MCHC, based on the project coverage for RH services. All 82 SDPs within the three provinces (3 provincial hospitals, 14 district hospitals and 64 health centers) were included for this study. All staff of SDPs that provide RH information and services were also included in the sample (i.e. without selection), while VHVs were selected for interview if the village was selected for a community survey. If there were more than one VHV in a village, one VHV was to be selected randomly. However, no village had more than one VHV. See Annex 2 for the list of sample provinces, districts and villages.

For the community survey, married women of reproductive age (between 15-49 years) (MWRA) and their husbands were selected for interviews, applying a systematic random sampling method as follows:

First stage: selection of 30 out of 64 Health Centers (HCs) in proportion to the number of HCs in each province.

Second stage: selection of one or two village(s) around the selected HCs, using a random sampling method.

Third stage: selection of 20 households from each selected village, applying a systematic random method.

Fourth stage: selection of all MWRAs from the selected households and their husbands who were automatically selected for the husband survey.

Questionnaire design

The survey questionnaires were designed by reviewing the Population Council's recommended standard questionnaires. In consultation with various implementing agencies involved in the UNFPA-supported RH projects, the questionnaires were adapted to the Lao PDR situation. The draft questionnaires were presented in a workshop organized at NSC, Vientiane, in cooperation with UNFPA Country Support Services Team (CST) Bangkok, and discussed among the representatives of participating agencies, including staff of MOH/MCHC and UNFPA Vientiane.

There were four different types of questionnaires (or instruments) used for the BSA. The questionnaire for staff was combined with the inventory questionnaire, as both were administered at the SDP. These questionnaires are:

- 1. inventory quesionnaires for SDPs: provincial hospitals, district hospitals and Health Centers;
- 2. questionnaire for staff interview;
- 3. questionnaire for VHVs; and
- 4. individual questionnaires for MWRAs and husbands with the household list.

Inventories for SDPs include the following information:

• infrastructure

- registers
- RH counseling and services
- IEC/BCC materials
- equipment and commodities inventory
- commodity management
- staff in position and training
- medical examination facilities.

Some parts of the questionnaire were administered in different sections of provincial and district hospitals. These hospitals have sections such as RH/FP section, gynecological and obstetric ward, and laboratory. All these sections provide services related to RH/FP.

The questionnaire designed for VHVs collected information on their background characteristics, responsibilities as volunteers, training received and knowledge and skills concerning RH/FP, including knowledge on the prevention of STI/HIV/AIDS. Individual questionnaires administered to MWRAs and husbands included background characteristics, knowledge, attitudes and practice, questions relating to family planning, knowledge on the prevention of STI/HIV/AIDS, and knowledge regarding consequences of alcohol use, drug abuse and trafficking.

All these questionnaires were first pre-tested in non-sample areas. Results and experiences gained during the pre-test were used to finalize the content of the questionnaires.

Data collection

In each province, two main groups used the questionnaires to conduct the fieldwork for information collection. The first group was responsible for collecting information from provincial and district hospitals, while the second group interviewed MWRAs, their husbands and VHVs in different districts and villages. Each group split into small teams, which included one supervisor and one enumerator.

The number of staff that participated from different agencies during the fieldwork is as follows:

Agencies	Number (persons)
MOH	3
NSC	9
Provincial CPC	12
District statistics office	9
Provincial Maternal and Child Health Unit	8
District Maternal and Child Health Unit	12
Total	53

The supervisors were trained in Vientiane for three days. The training for enumerators was conducted for five days in each province, which included one day for field practice, followed by another day for discussions on problems identified during the fieldwork. The fieldwork for data collection took two weeks (7–20 November 2002). The team needed two days to complete one village, excluding travel days. The time taken to complete one district was about 12 days.

Response rates

With regard to SDPs, all three provincial hospitals and 14 district hospitals were enumerated. On the other hand, only 77 percent of the total number of HCs was enumerated. While more than 97 percent of VHVs were interviewed, less than 95 percent of MWRAs and their husbands were interviewed. MWRA and her husband were interviewed separately. Table 1.4.1 shows the targeted and actual number of SDPs, VHVs, MWRAs and husbands contacted.

During the fieldwork, due to changes and errors in names, villages belonging to a different district and villages not found, there were difficulties in locating villages. Also, the survey team found that 15 HCs were not operating at the time of the visit. For details, see section on data quality.

	Saravane		Sekong		Attapeu		All	
	Actual	Targeted	Actual	Targeted	Actual	Targeted	Actual	Targeted
	number	Number	number	Number	number	Number	number	Number
Inventory								
Provincial hospital	1	1	1	1	1	1	3	3
District hospital	7	7	3	3	4	4	14	14
Health centers	24	26	10	16	16	23	50	65
TBAs/VHVs	25		33		32		90	
Household		330		610		640	1536	1580
MWRA	330	330	571	610	598	640	1499	1580
Husbands	324	330	564	610	558	640	1446	1580
No, of villages covered	33	33	58	61	64	64	155	158

Table 1.4.1: Targeted and actua	l numbers of SDPs	, VHVs, MWRAs	and their
husbands			

1.5 Data quality

Ensuring data quality by supervision during fieldwork

During the fieldwork phase, the supervisors needed to play various roles to facilitate the data collection process. Firstly, they organized training for the interviewers at the respective province. Then, during the interviewing process, they supervised and provided directions and/or instructions to interviewers. At the same time, they also kept contact with the local administration and followed the team to the villages. All questionnaires were checked at the site. If some questionnaires were not completed, or were not filled out properly, the supervisors asked interviewers to redo them before leaving the site. The supervisors also observed the interactions between

interviewers and respondents. If any problems arose, the supervisors intervened and solved them.

Ensuring data quality during data entry and data editing

There were only minor problems with data entry and coding. A few inconsistencies were found during the editing and processing of data. For instance, a case was found with the number of living children exceeding 60, and another case with the number of pregnancies exceeding 20. These cases were checked against the questionnaires and found to be data entry problems.

It was important, therefore, to be careful during coding data to avoid errors in coding, particularly with the date of birth and certain numeric responses. In order to check the data quality for wild codes and consistencies between two or more variables, special frequencies and cross-tabulations were run.

Problems in questions during translation and interpretation

During data processing, it was found that there were some questions which had been translated incorrectly from English to Lao language. For example, the question on stock-outs in the last six months could not be used because, when translated, the question asked whether any of them have been supplied in the last six months. Instead, the stock-out information was analyzed using the current quantity of supplies at the time of survey as a proxy to the stock-outs; but the information is reflected only as stock-outs at the time of survey, *not* in the last six months.

In the health center inventory questionnaire, question No. 14 (commodity management) did not appear in all questionnaires. It was added a week after the survey team was in the field. Similarly, the questions about the facility and staffing of HC were not included.

Another problem appeared in the individual questionnaires of MWRAs and husbands about the use and knowledge of contraceptives. The questions on the use were asked first, followed by the set of knowledge questions. Because the sequence of questions was reversed, readers are advised to take caution while interpreting the contraceptive use and knowledge information.

Limitation and difficulties encountered during the fieldwork

The survey fieldwork was planned during August 2002 but was rescheduled to November as August is in the rainy season. (During the rainy season, it is difficult to travel long distances, especially to remote villages.) In addition, the preparation of questionnaires took longer than expected as more time was needed for development and revision.

Although November is in the dry season, it was still difficult to conduct fieldwork as the survey team had to travel long distances in rough terrain, with hazardous road conditions. The survey team needed about two or three days to travel from one village to another. Some of the villages that were difficult to reach were: Jienghieng, Phiengvang, Bane Beng Sivilay and Phonsaad. For these villages, it took about six or seven days to travel from respective district centres. Since there was no road, sometimes the team either walked to the village or rowed a small boat.

Some enumerators seemed to misunderstand the objectives of the survey, and interviewed women whose ages were lower than 15 and higher than 49. However, these problems were identified during data editing, and the cases were deleted from the analysis.

2. Results

Findings of this BSA are presented in three sections. The first section deals with the functioning of SDPs in terms of service availability, the actual facility, workload, availability of supplies and equipment including IEC/BCC materials, and management aspects of SDPs. The second section deals with staffing of SDPs and staff competency. Staff competency is measured through interviews. Staff were questioned about their knowledge of particular services or types of family planning methods. Reporting of information about SDPs is based on the inventory questionnaires that were prepared especially for provincial hospitals, district hospitals and HCs. The third section touches upon some important aspects of potentials clients (MWRAs and their husbands) in the communities or villages where RH services are likely to be intensely provided during CP III.

2.1 Functioning of Service Delivery Points

Availability of health facilities

The study included 3 provincial hospitals, 14 district hospitals and 64 HCs. The survey team found that all provincial and district hospitals were open but only 50 out 64 HCs. In other words, 15 out of 64 HCs or 23 percent of the HCs were closed and the community did not have access to these facilities (see Figure 2.1.1).



Availability of RH services

Of those SDPs that were opened during the survey teams' visit, all provincial hospitals were providing these services to their communities: family planning (FP), antenatal care (ANC), tetanus toxic vaccination, distribution of iron-folate acid (IFA) tablets, normal delivery, assisted delivery, cesarean section, post-abortion services, sexually transmitted infections (STIs) and treatment of complications (see Figure 2.1.2).



On the other hands, only services of FP, ANC and distribution of IFA tablets were provided at 100 percent of district hospitals. In the case of HCs, 94 percent, 74 percent, and 68 percent provided FP and ANC services and distribution IFA tablets, respectively. Only 58 percent of HCs were providing normal delivery services.

Core RH services at SDPs comprised of 11 items such as FP, ANC, normal delivery, distribution of IFA, TT vaccination, caesarian section, assisted delivery, PNC, post-abortion, STI/HIV/AIDS and complications treatment.

Table 2.1.1 indicates that none of 3 provincial hospitals and 14 district hospitals provided all elements of core RH together. Only 4 percent of 50 HCs provide 9 elements of basic RH together.

	% availability	No. of SDPs
Core RH services (11 items)		
At provincial hospital	0.0	3
At district hospital	0.0	14
Basic RH services (9 items)		
At health center	4.0	50

Table 2.1.1: Core RH services availability at SDPs

Basic RH services include provision of FP (oral pills, injectable and condoms), ANC, PNC, normal delivery and syndromic of RTI and counseling and IEC for HIV/AIDS. The program should ensure that these services are available at all SDPs including HCs.

Availability of FP methods

Figure 2.1.3 indicates the extent of FP services available at the time of survey. The survey found that 100 percent of provincial and district hospitals provided services of oral pills (both microval and microgynon) and injectable, while about 80 percent of HCs provided oral pills of both types and less than 75 percent of HCs provided injectable.



At the provincial hospitals, services of IUDs and condoms were available. However, not all district hospitals provided IUDs. It is ironical that condoms were not provided at all in district hospitals and HCs. The study found that only half of the HCs provided condoms. Getting services of permanent FP methods such as female sterilization seem very difficult in Lao PDR. The study indicates that only two of the three provincial hospitals provided services of female sterilization. Services of male sterilization do not seem possible to get, as neither provincial nor district hospitals provided the services.

All provincial and district hospital had at least three modern methods available and HCs had only 82 percent of the SDPs. In total, 87 percent of SDPs had at least three modern methods available. (See Table 2.1.2).

SDPs	Number	Percent
Province	3	100.0
District	14	100.0
НС	41	82.0
All	58	87.0

Table 2.1.2: Percentage of SPD with at least 3 modern methods available

Availability of FP counseling services

Providers and clients need to exchange information. The client should be encouraged to think and talk about her or his concerns, circumstances, and FP needs. According to service guidelines, the provider must describe available FP methods, their risks and benefits, and, when a client chooses a method, describe how to use it. In a good counseling situation the provider not only gives accurate and clear information but also establishes a relationship of trust and confidence with the client.

Figure 2.1.4 shows the percentage of FP counseling offered. In all, 100 percent of SDPs at provincial hospitals provide FP counseling, while 92 percent of district hospitals and 30 percent of HCs provide counseling services to FP clients.



Elements of the physical infrastructure assessed in this study include: piped running water, electricity, working toilets for clients, sufficient seating for clients, refrigerators and laboratory facilities. As shown in Figure 2.1.5, there is a wide variation among the provincial hospitals in the availability of basic facilities. In many district hospitals, basic facilities were generally not available. No district hospital under study had a laboratory facility. HCs also lacked some basic facilities. Working toilets for clients were not available in the majority of SDPs. If the quality of care for the clients is to increase in Lao PDR, the programme needs to change focus from provincial hospitals to HCs.



Conditions of SDPs

A lack of privacy may have inhibited some clients and providers from participating freely during the counseling process. Figure 2.1.6 indicates the physical features of medical examination areas in the SDPs. The study team observed that the SDPs had no auditory privacy. Also very few SDPs had visual privacy (33 percent at provincial hospital and 14 percent at district hospitals). While adequate light and adequate water were available at the provincial hospitals, less than 50 percent of the district hospitals have such a facility. Cleanliness was maintained in two out of three provincial hospitals and half of the district hospitals. Facility information was not

collected by the study team. It is urgent that hospital management focus on improving the cleanliness.



Visible signs and IEC/BCC materials

The study teams noted whether there was any visible sign of service availability at the SDPs to direct FP clients to the FP clinic. At provincial hospitals, the study teams observed that 100 percent of the SDPs had a visible sign both outside and inside on the day of visit (Figure 2.1.7). Among the district hospitals, 43 percent did have not a sign of service availability, nor did a large proportion of HCs (62 percent).



Health education and information, education, and communication (IEC) activities are crucial elements of quality reproductive health care programs. IEC activities are also needed to create awareness about recognizing danger signs and symptoms during pregnancy, delivery and the postpartum period. Health education can teach women about how to prevent health problems and avoid life-threatening complications. It can also help ensure that appropriate RH services are used at the right time, keeping the cost of treatment as low as possible. In addition, health education can promote a supportive, helpful community environment and address socio-cultural obstacles that can negatively affect women's health.

At the provincial hospital visited, the study teams found that all of them had FP and ANC/PNC flipchart (Figure 2.1.8). One provincial hospital (33 percent) had all

IEC materials (flip charts, brochures/pamphlets and posters) for all categories. Two provincial hospitals (66 percent) had both FP brochures/pamphlets and posters, but there was a wide variation in the quantity of FP posters across the provinces.



The majority of district hospitals have more IEC/BCC materials related to FP than for any other categories. At the district level, some IEC materials such as related to child welfare, ARH and delivery services were found to be available in less than 20 percent of SDPs (See Figure 2.1.9).



At the HCs, the study teams also recoded the quantities of FP flipcharts, brochures/pamphlets and posters that were available. They found that between 8 percent and 72 percent of the HCs had IEC materials available (Figure 2.1.10).



Service utilization

Ideally, integrated maternal health services should be routinely available at all levels of the health system, from referral level (i.e. hospitals) to the community (i.e. HCs). Such services include, for example: antenatal care (including treatment of anemia and tetanus toxic immunizations), normal delivery assistance, treatment of complications, postpartum care, post-abortion and family planning services. The comprehensive approach to sexual and reproductive health services including ARH as advocated by the ICPD POA and by many international health experts, suggests that related reproductive health services, such as detection and treatment of RTI/STI, should also be offered routinely.

Table 2.1.3 shows the average number of clients in the last six months per SDP. In addition to the number of clients by different types of services, clients under age 24 were counted for family planning, ANC, counseling and the treatment of RTI/STI and minor ailments as ARH.

The highest number of clients who visited provincial and district hospitals and HCs was found to be in the area of family planning (572 cases, 364 cases and 61 cases, respectively), followed by antenatal care (200 cases, 126 cases and 5 cases, respectively). The proportion of clients under age 24 was higher at district hospitals and HCs than that at provincial hospitals.

Туре	Average number of clients visited				
	Province	District	HC		
ANC	200	126	5		
Delivery	127	32	5		
Complications	102	19	2		
Post-abortion	75	15	1		
FP	572	364	61		
RTI/STI	130	24	14		
ARH*	432	685	114		

Table 2.1.3: Average number of clients visited the SDPs in last six months

*number of men and women under age 24 who visited for FP, counseling and ANC service and treatment for RTI/STI and minor ailments.

2.2 Availability of Supplies and Equipment

Availability of FP supplies in stock

The availability of contraceptive commodities at an SDP is an obvious prerequisite for good service delivery, and for the choice of methods that a provider can offer. On the day of visit, the teams found that there was no stockout of any contraceptive methods at the 3 provincial hospitals and 14 district hospitals, with exception of IUDs at some district hospitals. At the sub-district level, stockouts of injectable, OC-microval, OC-microgynon and condoms were observed at 24 percent, 24 percent, 18 percent, and 42 percent of the HCs, respectively. The stockout of IUDs at HCs reflects that the services were not available at that level. Figure 2.2.1 shows that the level of supply of contraceptives has to be improved at the sub-district.



The re-supply methods, such as injectables, OC-microval, OC-microgynon, IUDs and condoms are required to be in stocked at SDPs for those clients who want to get re-supply. The study team counted supplies in stock at each of the SDPs. Table 5.2.1 shows the average quantity of supplies in hand at the time of study per SDP and the supplies needed according to the MCHC statistics. For contraceptives needed especially at the SDPs, including in the HCs, refer to the MOH policy and statistics on contraceptives.

Table 2.2.1: Average quantity of FP supplies in hand and in need for a month

Items	Average quantity in hands			Average quantity in need			
	Province	District	HC	Province	District	HC	
Injectable	173	158	17	160	22	0	
OC-microval	77	129	13	110	15	10	
OC-microgynon	211	109	17	280	39	20	
IUD	993	13	2	10	3	0	
Condom	310	480	60	400	100	50	

Availability of FP kits

Basic equipment includes FP kits, ranging from equipment for IUD insertion and removal, to equipment for female sterilization. The teams found that all three provincial hospitals had IUD insertion and removal kits, minilaporatomy and tubaligation kit (Table 2.2.2). All the 14 district hospitals also had IUD insertion and removal kits. On the other hand, some supplies were found to be at the district hospitals, although they were not expected to have them. The second panel of the table shows that IUD kits are needed in the provincial and district hospitals, but not in the HCs. Kits for sterilization are needed in the provincial hospitals. This indicates that the distribution system needs to be improved so that the right supplies are distributed to the right SDPs.

Tables 2.2.2: Average FP kits quantity in hands per SDP and average quantity in need

Items	Average quantity in hands			Average quantity in need		
	Province	District	HC	Province	District	HC
IUD insertion and removal kit	5	10	-	4	2	
Minilaporatomy kit	1	-	-	-	-	
Tubaligation kit	1	-	-	2	2	

Availability of FP equipment

Tables 2.2.3: Family planning equipment availability in hand

Items	Percentage	e of SDP w	vith stock	Average	quantity in	hand
	in hand at the time of survey					
	Province	District	HC	Province	District	HC
Speculum-bivalve-large	100	93	12	9.33	2.29	0.14
Speculum-bivalve-medium	100	100	20	9.67	3.36	0.28
Speculum-bivalve-small	33	64	10	4.00	1.57	0.16
Sterilization drum	100	86	22	4.00	2.07	0.28
Sterile hand set	67	86	16	6.00	0.00	0.24
Probe set	67	64	0	3.67	0.00	0.00
Cotton probe sterile	67	57	36	4.00	0.00	0.46
Basin for used instruments	100	93	32	2.33	1.29	0.68
Beaker 1000 ml	0	7	0	0.00	0.14	0.00
Thermometer, oral/anal	33	64	50	0.67	0.36	0.00
Shade examination couch	67	86	38	2.67	1.14	0.86
Sponge holding forceps	0	7	0	0.00	0.07	0.00
Uterine sounds	33	21	12	1.67	0.29	0.14
Tenaculum	67	86	4	3.00	2.21	0.04
Scissors	100	100	46	4.67	2.79	0.72
Examination lamp	100	43	2	2.00	0.50	0.02
Shade windows	0	21	2	1.67	0.43	0.02
Shade examination	0	7	4	1.00	0.07	0.04
Insert IUD room	33	100	0	0.67	0.86	0.00

Table 2.2.3 shows the percentage of available FP equipment with stock in hand at the time of study. All provincial hospitals had the following equipment: speculumbivalve-large, speculum-bivalve-medium, sterilization drum, basin for used instruments, scissors and examination lamp. In contrast, beakers 1000 ml, sponge holding forceps, shade windows and shade examination were out of stock.

Almost all items of FP equipment were in stock, but not in sufficient quantities at district hospitals. HCs of all three provinces had a shortage of FP equipment. Those HCs which had FP equipment also appeared to be in poor condition.

Availability of maternal and neonatal health kits

Maternal and neonatal health kits include 14 items, ranging from: equipment for emergency procedures (such as resuscitation equipment, vacuum extraction delivery kit, manual vacuum aspiration kit, operating instruments for caesarian section and embryotomy/craniotomy kit); equipment for deliveries (pregnancy diagnostic kit, delivery kit for use at home, professional midwife kit, delivery set, suture set, kit for suture of vaginal and cervical tears); to management equipment (eclampsia management kit, post partum hemorrhage and retained placenta management and blood transfusion kit).

Provincial hospitals lacked some of the most basic equipment, such as delivery kit to use at home, professional midwife kit, eclampsia management kit, blood transfusion kit, operating instruments for caesarean section and embryotomy/craniotomy kit (Table 2.2.4). The situation on the availability and condition of basic equipment was not much different at district hospitals. None of the hospitals had any equipment for eclampsia management and blood transfusion.

Items	Percentag	e of supplies	s in hand	Average quantity in hand		hand
	Province	District	HC	Province	District	HC
Pregnancy diagnostic kit	66.7	78.6	26.0	1.33	1.14	0.28
Delivery kit for using at home	0.0	7.1	6.0	0.00	0.07	0.06
Professional midwife kit	0.0	7.1	4.0	0.00	0.07	0.18
Delivery set	33.3	71.4	2.0	0.67	1.21	0.02
Suture set	33.3	50.0	2.0	0.67	0.79	0.02
Resuscitation equipment	66.7	7.1	0.0	0.67	0.07	0.00
Vacuum extraction delivery	66.7	7.1	0.0	1.00	0.07	0.00
Kit for suture of vaginal	66.7	7.1	0.0	1.00	0.21	0.00
Eclampsia management kit	0.0	0.0	0.0	0.00	0.00	0.00
PPH and retained placenta						
management	33.3	7.1	0.0	0.67	0.07	0.00
Blood transfusion kit	0.0	0.0	0.0	0.00	0.00	0.00
Manual vacuum aspiration kit	66.7	50.0	2.0	0.67	0.71	0.04
Operation instruments for						
caesarean	0.0	7.1	2.0	0.00	0.07	0.02
Embryotomy/craniotomy kit	0.0	7.1	0.0	0.00	0.07	0.00

Table 2.2.4: Availability of maternal and neonatal health kits and average quantity in hand

Commodity management

The majority of the SDPs, particularly provincial hospitals (67 percent) and district hospitals (57 percent), had a system for keeping records of FP commodities received and dispersed (Figure 2.2.2). The comprehensive logistics system was not maintained at more than 50 percent of district hospitals and 80 percent of HCs. On the whole, only 28 percent of SDPs have an inventory system available, and the teams found that only 24 percent of SDPs had the up-to-date inventory system. This suggests that there is need to act urgently to establish a comprehensive logistics system at all levels.



The teams also observed that supplies were not stored according to expiry date, and SDPs in general did not have sufficient storage facilities to store RH supplies, including contraceptives, drugs for STDs, toxoids and vaccines, emergency obstetric drugs and other medicines. Table 2.2.5 shows the percentage of SDPs distribution, according to expiry date and sufficient storage facilities. Data indicate that about two-thirds of the provincial and district hospitals followed the expiry date system and had sufficient storage facilities. But conditions were not good at the HC level.

Table 2.2.5: Percentage of SDPs with commodities stored according to	expiry
date, and with storage facility	

SDPs	According to expiry date	Have storage facilities
Province	66.7	66.7
District	78.6	78.6
HC	46.0	38.0
All	53.7	47.8

Figure 2.2.3 indicates that 67 percent of the provincial hospitals and 79 percent of the district hospitals stored commodities (FP-injectable) according to expiry date, and had storage facilities that were not exposed to rain or sun, and not subject to excessive heat.



For STD drugs, only 12 percent of all SDPs stored commodities according to the expiry date, and only 10 percent had storage facilities (Table 2.2.6).

Table 2.2.6: Percentage of SDPs with STE	drugs stored according to expiry date, and
with storage facility	

SDPs	According to expiry date	Have storage facilities
Province District HC All	- 7.1 14.0 11.9	7.1 12.0 10.4

The survey data (Figure 2.2.4) show that only 18 percent of SDPs stored TT-vaccines according to expiry date, and had storage facilities. This result suggests that storage facilities are inadequate at all levels and must be addressed very urgently.



Also, essential drugs were found to be stored in unsatisfactory conditions. More than 80 percent of SDPs, including hospitals, did not store according to expiry date, and had no proper storage facilities. Only 9 percent of SDPs did not store drugs that had passed the expiry date, and also had storage facilities (Figure 2.2.5). Provincial hospital data were not collected.



The study findings point to the fact that improvements in logistics management systems should focus on improving all aspects, such as distribution, warehousing and storage. A comprehensive logistics management system needs to be developed, tested and implemented.

Supervision

The teams found that all three provincial hospitals and the majority of district hospitals had been supervised once in the past 12 months from the higher level (Figure 2.2.6). When analyzed according to subject areas, it was found that 67 percent of SDPs had been supervised for family planning services (an average of twice in 12 months). In contrast, no records were found about whether there was any supervision in the areas of EOC, RTI/STI and ARH. HC data were not collected.



Supervision is a vital part of effective project management, and should be undertaken as an integral part of project implementation. Table 2.2.7 shows the percentage of SDPs that have been supervised for general purposes. Less than half (47 percent) of the SDPs had any supervision (i.e. an average of once per year). This result indicates that the general integration of the projects has not been implemented properly.

SDPs	Any supervision	Average number in past 12 months
Province District	66.7 42.9	1.3 0.9
HC All	47.1	1.0

Table 2.2.7: Percentage of SDPs that have been supervised for general purposes in the past 12 months

The study teams also asked the staff of the SDPs who were working on the day of the visit whether they had been supervised for IEC activities in the past 12 months. Less than 25 percent of SDPs had been supervised in the area of IEC, an average of less than once per year per SDP (Table 2.2.8).

Table 2.2.8: Percentage of SDPs	hat have been supervised for IEC activities in the
past 12 months	

SDPs	Any supervision	Average number in past12 months
Province District HC All	33.3 21.4 23.5	0.3 0.4 0.4

2.3. Staffing and Staff Competency

Staff of SDPs

At all SDPs visited, the study teams gathered information about the total number of permanent staff, compared with those who were on duty at the time of visit, and the total number of contract staff, compared with those who were on duty at the time of visit. The information refers to only MCH/FP sections of the provincial and district hospitals.

Table 2.3.1 shows the average number of staff assigned to work for MCH/FP section per hospital. There were, on average, 1 medical doctor, 8 medical assistants, 7 nurses and 1 midwife who were assigned to work at the provincial hospitals. At the time of visit, the study team found that only 4 out of 8 medical assistants, 3 out of 7 nurses and almost all midwifes were on duty.

	Perm	anent	Contract		
Type of staff	Full time	On duty at	Full time on	On duty at	
	assigned	time of visit	contract	time of visit	
Medical doctor	1.0	0.7	0.0	0.0	
Medical assistant	8.3	4.0	0.3	0.3	
Nurse	6.7	3.3	0.0	0.0	
Midwife	1.3	0.7	0.7	0.3	
Other	0.0	0.0	0.3	0.3	

 Table 2.3.1:
 Average number of staff assigned to work for MCH/FP section at provincial hospitals

The average number of staff on duty was found to be higher at district hospitals, compared to provincial hospitals. On average, there were 2 medical doctors, 10 medical assistants, 18 nurses and 3 midwives working for MCH/FP at the time of visit (Table 2.3.2).

 Table 2.3.2:
 Average number of staff assigned to work for MCH/FP section at district hospitals

	Permanent		Cont	Contract	
Type of staff	Full time assigned	On duty at time of	Full time on contract	On duty at time of	
		survey		survey	
Medical doctor	2.0	1.0	0.0	0.0	
Medical assistant	9.7	8.7	0.3	0.3	
Nurse	18.0	11.3	1.3	0.7	
Midwife	3.0	2.0	0.0	0.0	
Other	0.7	0.3	0.0	0.0	

Figure 2.3.1 indicates that some staff working for MCH/FP had not had received training on RH/FP. At the district hospitals, 77 percent of medical doctors of the district hospitals and 33 percent of medical doctors of the provincial hospitals needed training on RH/FP. Also, the figure suggests that more than 33 percent of the midwives both at provincial and district hospitals needed training on RH/FP. Training was also needed for nurses and medical assistants.



The elements of obstetric care that are essential at first referral level to reduce maternal morbidity and mortality can be classified as follows:

- 1. Surgical obstetrics
- 2. Anesthesia
- 3. Medical treatment
- 4. Blood replacement
- 5. Manual procedures and monitoring labor
- 6. Management of women at high risk
- 7. Family planning support
- 8. Neonatal special care

The subject of obstetric care, implemented under the safe motherhood project, is a new one for MCH/FP in Lao PDR. At the time of the survey, all staff in these three provinces had not received training on EOC, except 14 percent of medical assistants of the district hospitals (Figure 2.3.2).



Figures 2.3.3 also indicates that training in the areas of RTI/STI is equally needed for almost all staff who, so far, had not received any training in these areas.



Adolescence is traditionally regarded as a period relatively free of health problems. However, it is a crucial period in which malnutrition and diseases can have a devastating effect, both in the short and long term. This is particularly true in relation to RH. For example, pregnancy complications, or sexually transmitted diseases, can permanently affect future reproductive capacity, as well as the wellbeing of the whole family.

Figure 2.3.4 indicates training needs for specific areas. None of the SDPs was without trained staff on RH/FP at provincial level, and only 7 percent of district hospitals were lacking training on RH/FP. On the whole, from these findings it can be concluded that training in various areas such as EOC, RTI/STI and ARH should receive priority, if the programme is to make an important contribution to improve women's health in Lao PDR.



Village health volunteers (VHVs)

VHVs are the front line workers, and they work as volunteers. Each village has one VHV who has direct contact with women of the community. VHVs visit women's houses and inform and educate them about RH, and particularly about FP methods. The volunteers also distribute oral pills and condoms to those who are interested. They also encourage women to seek other RH services at the nearest HC. VHVs report their findings to officers in-charge of the HC in the area.

In this study, a total of 90 VHVs were interviewed, located in 14 districts within 3 provinces. Of these 90 VHVs, 42 were traditional birth attendants (TBAs) before becoming VHV (Table 2.3.3). Among the 3 provinces, only 16 percent of VHVs were TBAs in Saravane, while about half in Sekong and more than two-thirds in Attapeu undertook this role.

Province	No. of VHVs	No. of those TBAs before VHVs	Percentage of VHVs who were TBAs
Saravane	25	4	16
Sekong	33	16	49
Attapeu	32	22	69
All	90	42	47

Table 2.3.3: Number of TBAs/VHVs in each province, and whether they have been a TBA before becoming a VHV

Table 2.3.4 presents the age distribution of VHVs according to their background characteristics, such as age, marital status, number of living children, education status and gender.

The mean age of these VHVs was 40 years. The percentages that never married were: 20 percent in Saravane, 3 percent in Sekong and 15 percent in Attapeu. In terms of literacy, 16 percent of the VHVs were illiterate.

Background characteristics	Saravane	Sekong	Attapeu	Total
Age				
15-19	4.0	15.2	3.1	10.0
20-24	8.0	12.1	3.1	7.8
25-29	20.0	15.2	3.1	12.2
30-34	12.0	9.1	9.4	12.2
35+	56.0	48.5	84.4	57.8
Mean	36	39	43	40
Sex				
Male	24.0	39.4	81.3	50.0
Female	76.0	60.6	18.7	50.0
Marital status				
Married	76.0	78.8	84.4	80.0
Living together	0.0	3.0	0.0	1.1
Widowed/divorced/separated	4.0	3.0	12.5	6.7
Never married	20.0	15.2	3.1	13.2
Number of living children				
0	8.0	3.0	9.4	6.7
1	12.0	18.2	15.6	15.6
2	16.0	15.2	9.4	13.3
3+	56.0	48.5	59.4	54.4
No response	8.0	15.2	6.3	10.0
Education status				
Illiterate	24.0	3.0	21.9	15.6
Primary	64.0	90.9	53.1	70.0
Secondary+	12.0	6.1	25.0	14.4
Total	100.0	100.0	100.0	100.0
Number of cases	25	33	32	90

Table 2.3.4: Percentage distribution of VHVs by background characteristics

Table 2.3.5 shows the number of VHVs according to the type of work they do, and whether they received training in that area. Data indicate that the majority of the VHVs perceived that their work involved providing information in the areas of RH/FP, ANC, safe delivery, PNC, prevention of STD, ARH and visiting health facilities. VHVs perceived their work as follows: 70 percent as providing information on RH/FP (63 out of 90 VHVs) and ANC (64 out of 90 VHVs), and 67 percent as providing information on safe delivery and prevention of STDs (34 out of 90 VHVs).

In terms of receiving training, about 70 percent of VHVs (64 out of 90 VHVs) reported that they had received training on RH/FP, but those who received training in other areas were less than 50 percent. About half said that they received training on providing information on ANC, one-third reported receiving training on safe delivery, STDs and ARH.

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Table 735	Twne of RH	work in the	community	and any	i training	received
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			2		0	

Type of work	No. of VHVs	Received any training
Provide information on RH/FP	63	64
Provide information on ANC	64	43
Provide information on safe delivery	60	34
Provide information on PNC	45	22
Provide information on prevention of STD	60	33
Provide information on ARH	51	23
Encourage to visit health facility	49	21

Table 2.3.6 presents the age of VHVs with knowledge of FP methods. Data indicates that the large majority of VHVs know about oral pills (80 percent) followed by IUDs (66 percent), male condom (63 percent) and injectable (62 percent). There are about 8 percent of VHVs who know of at least one FP method, and 6 percent knew at least two FP methods.

Table 2.3.6: VHVs with knowledge of FP method

FP method	No. of VHVs with knowledge	Percent knowing the method
At least one FP method	7	8
At least two FP methods	5	6
Pill	72	80
IUD	59	66
Injection	56	62
Implants	22	24
Men condom	57	63
Female condom	3	3
LAM	5	6
Rhythm	13	14

Table 2.3.7 presents the level of knowledge of possible side effects of FP methods. It indicates that 35.6 percent have no knowledge of possible side effects of FP methods, 64 percent know at least one possible side effect, and 53 percent who know at least two possible side effects of FP methods.

Know of possible side	Number of VHVs with	Age of VHVs with
effects of FP	knowledge	knowledge
Know no side effects of		
FP methods	32	35.6
Know at least one side		
effects of FP methods	58	64.4
Know at least two side		
effects of FP methods	48	53.3

Table 2.3.7: VHVs with knowledge of possible side effects of FP methods

Table 2.3.8 presents VHVs' knowledge on complications during pregnancy, delivery and after delivery. It indicates that 52 percent had knowledge of at least one sign of complications during pregnancy. Those who knew at least two signs were 34 percent, while there were 26 percent who knew of at least three signs of complications.

Table 2.3.8: VHVs with knowledge of complications during pregnancy, delivery and after delivery

Complications	No. of VHVs with	Percent knowing the
~	Kilowiedge	complication
Complications during		
pregnancy		
1 sign	47	52.2
2 signs	31	34.4
3 signs	23	25.5
Complications during		
delivery and after delivery		
1 sign	46	51.1
2 signs	17	18.8
3 signs	33	36.6
4 signs	12	13.3

The majority of VHVs recognized important ways of HIV/AIDS transmissions, such as unsafe blood and needle sharing. Table 2.3.9 indicates more than 66 percent of VHVs (65/90) knew the major sources of transmission.

Ways of HIV/AIDS	Number of VHVs					
transmission	Saravane	Sekong	Attapeu	All		
Unsafe blood	21	22	22	65		
Needle sharing	20	23	22	65		
Others	0	2	1	3		
Don't know	2	1	3	6		

Table 2.3.9: Ways of HIV/AIDS transmission known by VHVs

Table 2.3.10 presents the number of VHVs by selected province who knew how to prevent HIV/AIDS. The most frequently cited preventive methods were: "Condom use" (80/90), "Avoiding multiple partners" (65/90), "Clean needles" (49/90), and "Sterilized equipment" (38/90). Those who did not know how to prevent were 8 VHVs (3 each from Saravane province and Attapeu province, and 2 from Sekong province). In Saravane, Sekong and Attapeu, 100 percent, 67 percent and 75 percent of VHVs, respectively, knew of at least two ways of preventing HIV/AIDS. On the whole, 79 percent of VHVs knew of at least two ways of preventing HIV/AIDS.

Ways of HIV/AIDS prevention	Number of VHVs					
	Saravane	Sekong	Attapeu	All		
Condom use	22	31	27	80		
Abstinence	12	17	7	36		
Avoiding multiple partners	18	24	23	65		
Clean needles	13	15	21	49		
Sterilizing equipment	14	7	17	38		
Other	0	1	0	1		
Don't know	3	2	3	8		
Know at least two ways to						
prevent HIV/AIDS	25	22	24	71		
Percent who know at least two						
ways to prevent HIV/AIDS	100.0	66.7	75.0	78.9		

Table 2.3.10: Ways of HIV/AIDS prevention known by VHVs

2.4. Reproductive Health Knowledge, Accessibility and Use among Community Members

This section of the BSA report presents information about potential beneficiaries of RH services. The study collected information on married women of reproductive age 15-49 (MWRAs) and their husbands aged 15-59. MWRAs and their husbands were interviewed separately. The information from the interviews will help service providers and programme managers to understand what benefits have been received from the existing services, as well as how to better serve them to improve their reproductive health status in the progarmme areas.

Information and issues in this section include background information about MWRAs and their husbands, their knowledge and methods of family planning, their awareness of information sources and FP services, and their knowledge of possible side-effects or complications due to the use of their contraceptive methods. Specific information about awareness of problems that might arise during pregnancy, delivery and after delivery is also presented, as perceived by MWRAs and their husbands. There is also information on assistance sought during pregnancy, delivery and after delivery, knowledge about HIV/AIDS and knowledge about risks involved in trafficking, alcohol use and drug abuse among MWRAs and their husbands.

Background information

Tables 2.4.1 presents the percentage distribution of the MWRAs and their husbands according to their background information such as age-group, marital status, the number of pregnancies, the number of living children, whether they have ever attended school and their literacy level.

More than half (57 percent) of MWRAs and two-fifths (43 percent) of husbands are under 35 years of age. The majority of MWRAs (93 percent) and their husbands (92 percent) are currently married. Only 5 percent of MWRAs and 4 percent of men said that they are not married, but living together. Only about 2 percent of MWRAs (about two percent) are divorced, separated or widowed. Over half of MWRAs (52 percent) reported that they have been pregnant more than five times, while only one-third of MWRAs have five or more surviving children, indicating that not all pregnancies result in surviving children.

More than 50 percent of MWRAs and 75 percent of their husbands or partners reported that they have attended school. In terms of literacy, about half of MWRAs and 80 percent of their husband or partners can read and write. This indicates that a strategy to provide information to MWRAs should be different from that geared towards their husbands or men.

Background Characteristics	MWRA	Husband
Age-group		
15-19	3.6	0.9
20-24	14.9	8.4
25-29	19.7	16.1
30-34	18.8	17.6
35-39	17.2	17.6
40-44	13.4	14.4
45-49	12.3	12.8
50+	-	12.2
Mean age (years)	33	37
Marital status		
Currently Married	92.7	92.2
Living together	5.0	4.1
Divorced/separated	1.2	0.1
Widowed	1.1	0.1

Table 2.4.1.	Percentage	distribution	of MWRAs	s and h	nusbands,	according to	background
	Characterist	ics					

4.7	5.0
8.5	8.4
11.7	11.2
11.2	11.1
12.2	12.5
10.4	10.6
41.1	41.2
6.9	7.3
12.1	11.7
16.5	15.8
16.3	16.4
15.5	15.9
12.3	11.9
20.3	21.0
55.0	78.4
45.0	21.6
50.6	75.6
4.5	2.8
44.8	21.6
100.0	100.0
1499	1447
	4.7 8.5 11.7 11.2 12.2 10.4 41.1 6.9 12.1 16.5 16.3 15.5 12.3 20.3 55.0 45.0 50.6 4.5 44.8 100.0 1499

Note: Total may not add up to 100 due to rounding.

Knowledge and the use of family planning

In this section, questions on FP particularly on knowledge of contraceptive methods were asked, followed by questions on the use of contraceptive methods. In the interview, the first questions were about knowledge of FP methods, followed by questions on the use. This order of questions does not follow the general principle, and the effects of this are unknown. Therefore, readers should interpret the data with caution.

curren	t use of contracep	otive methods		
	M	WRA	H	Husband
Knowledge & FP methods	Knowledge	Current Use	Knowledge	Current Use
Knowledge/use				
Yes	44.8	15.9	45.1	4.0
None	55.2	84.1	54.7	96.2
Total	100.0	100.0	100.0	100.0
FP method				
Pill	92.4	33.6	86.6	0.0
IUD	57.1	7.6	54.5	0.0
Injectable	82.4	42.9	69.4	0.0
Implants	12.4	10.1	15.4	0.0
Male condom	47.4	2.9	67.3	67.2

Table 2.4.2. Percentage distribution of MRWAs and husbands by knowledge and current use of contraceptive methods

Female condom	3.3	0.0	1.5	0.0
Diaphragm	0.0	0.0	0.0	0.0
Foam or jelly	0.6	0.0	0.6	0.0
LAM	0.3	0.0	1.4	0.0
Rhythm	2.2	0.1	4.3	0.0
Withdrawal	3.9	0.4	11.1	32.8
Emergency	0.1	1.7	0.6	0.0
contraception				
Do not know	0.0	0.8	0.0	0.0
Total	100.0*	100.0	100.0*	100.0
Number of cases	1499	1499	1447	1447

* Note: Total may not add up to 100 due to multiple responses.

Table 2.4.2 shows the percentage distribution of MWRAs and their husbands who had knowledge of FP methods to prevent pregnancy. Responses were spontaneous. Data presented in Table 2.4.2 indicate that more than half of MWRAs and husbands did not know about any FP method. Among both MWRAs and husbands who knew of any FP method, 92 percent of MWRAs and 87 percent of husbands knew about oral pills as a method of FP. The second highest known method of FP was injectable, followed by IUDs, male condoms and implants. More husbands knew about male condoms (67 percent) and withdrawal (11 percent) than MWRAs (47 percent and 4 percent, respectively).

Only 16 percent of MWRAs and 4 percent of husbands were using a FP method. Among the FP methods used by MWRAs were: injectables (43 percent), pills (34 percent), implants (10 percent), IUDs (8 percent) and male condoms (3 percent). There were about one percent of MWRAs who did not know what method they were using. The FP methods used by husbands were: male condoms (67 percent) and withdrawal (33 percent). However, since interviewers did not ask about all FP methods but only about condoms and withdrawal, data on husbands can not be relied upon. It may nonetheless call for more advocacy and promotion of awareness on FP methods among couples to increase contraceptive use.

Sources of information and services

Table 2.4.3 shows the percentage of MWRAs and their husbands who are aware of the sources of RH information and services. It has been reported that approximately 54 percent of MWRAs get information from health facilities, and 31 percent from VHVs. Comparatively, 51 percent of husbands get information from health facilities and 32 percent from VHVs. About 18 percent of MWRAs and of husbands get information from trained TBAs.

specific	MWRA	tion und ser	Hus	band
FP method	Information	Service	Information	Service
Don't know	9.4	84.1	8.8	96.1
Health facility	53.8	0.0	51.4	0.0
Hospital	0.0	9.7	0.0	2.1
Health center	0.0	3.9	0.0	1.0

Table 2.4.3. Percentage distribution of MWRAs and husbands about awareness of specific sources for information and services

VHV	30.5	0.6	32.3	0.2
Trained TBA	17.7	0.0	17.9	0.0
Pharmacy	0.0	0.4	0.0	0.4
Private clinic	0.0	1.1	0.0	0.0
Radio	10.9	0.0	14.2	0.0
TV	5.6	0.0	6.0	0.0
Print materials	5.7	0.0	7.6	0.0
Others	18.7	0.2	17.7	0.1
Number of cases	1499	1499	1447	1447

With regard to services, 84 percent of the MWRAs and 96 percent of husbands were not aware of places where services are available. These findings suggest that the community needs to be informed of places of RH services. Health workers should be proactive in informing about the places of services, especially the place for birth delivery. In order to raise the level of contraceptive use in the community, it is important to have advocacy information and education campaigns in the community and to let the community know about information and education on health care and basic RH care including the location of SDPs and the different types of services.

Knowledge of side-effects or complications of FP use

This section provides information about side-effects or complications of current users of FP methods. Data on Table 2.4.4 present the percentage of MWRAs and those who are currently using a FP method, who know of the possible side-effects of contraceptives. It can be seen that 73 percent of MWRAs reported they did not know of any side-effects of contraceptives. However, this percentage is much lower among those who are currently using a contraceptive method. On the other hand, those reporting specific side-effects are higher among the current users, reflecting the fact that they have been informed of or have practical experiences from the use of FP. The pattern and level of knowledge of side-effects among husbands are not much different from those of MWRAs. About three-fourths of all respondents and half of current users among husbands did not know the side-effects of FP use. However, 36 percent of MWRA users and about 44 percent of husband users knew the side-effects of FP use from loss of appetite/weight loss. More than 30 percent of MWRA users faced irregular menstruation/amenorrhea as a side-effect, while only 16 percent of husband users noticed knew spots appearing on their skin.

MWRA		Husband	
Among all	Among users	Among all	Among users
72.5	46.2	74.3	49.1
21.0	35.7	19.5	43.6
8.3	15.5	8.4	9.1
1.7	4.2	3.2	0.0
3.6	9.2	4.8	16.4
1.0	1.7	1.2	0.0
	MW Among all 72.5 21.0 8.3 1.7 3.6 1.0	MWRA Among all Among users 72.5 46.2 21.0 35.7 8.3 15.5 1.7 4.2 3.6 9.2 1.0 1.7	MWRA Husb Among all Among users Among all 72.5 46.2 74.3 21.0 35.7 19.5 8.3 15.5 8.4 1.7 4.2 3.2 3.6 9.2 4.8 1.0 1.7 1.2

Table 2.4.4. Percentage distribution of MWRAs and husbands who know of sideeffects or complications of FP use

Number of cases	1499	238	1447	55
Others	3.1	7.6	1.4	1.8
amenorrhea				
Irregular menstruation/	15.1	30.3	8.3	9.1

Nearly 14 percent of MWRAs reported that they had paid for FP services. Of those who paid, more than one half (55 percent) paid between 1,000 and less than 5,000 kip. The amount of money paid for FP ranges from kip 100 to 140,000 kip. On average, one person paid 21,895 kips. Only 2 percent of respondents expressed that it was an expensive amount.

Awareness of problems during pregnancy and birth delivery/after delivery

Table 2.4.5 displays the problems faced during pregnancy and delivery/after delivery such as bleeding, severe abdominal pain, convulsion, high fever, headaches, swelling of feet/oedema, anemia/loss of energy/tiredness, excessive/foul smelling, loss of fetal movement, persistent vomiting and others. It shows that nearly half of MWRAs and their husbands did not know the complications that might be faced by mothers during pregnancy, delivery, and after delivery. The most commonly known problem was anemia/loss of energy/tiredness by 30 percent among MWRAs and 64 percent among husbands, followed by headaches and experiencing difficulties during delivery. Obstructed labour is known to almost one-third of MWRAs and husbands as a potential problem during delivery.

	<u>N</u>	AWRA	H	Husband
Problems	Pregnancy	Delivery/after	Pregnancy	Delivery/after
Don't know	49.5	43.1	53.8	58.5
Bleeding	10.9	17.8	11.7	18.9
Severe abdominal pain	13.7	0.0	13.7	0.0
Convulsion	4.1	4.8	4.4	5.1
High fever	16.0	16.0	15.8	15.1
Headaches	29.0	0.0	26.7	0.0
Swelling of feet/edema	7.6	0.0	6.4	0.0
Anemia/loss of	30.0	0.0	64.4	0.0
energy/tiredness				
Excessive/foul smelling	3.1	0.0	2.6	0.0
Loss of fetal movement	3.7	0.0	3.5	5 0.0
Persistent vomiting	9.6	0.0	7.5	0.0
Infection	0.0	3.5	0.0	4.2
Obstructed labor	0.0	29.8	0.0	28.9
Others	5.4	5.4	3.8	3.5
Number of cases	1499	1499	1447	/ 1447

Table 2.4.5. Percentage distribution of MWRAs and husbands who are aware of problems during pregnancy and delivery/after delivery

Note: Total may not add up to 100 percent due to multiple responses.

Assistance needed during pregnancy

Of the MWRAs who had been pregnant, approximately 62 percent did not have any problem during pregnancy and delivery/after delivery, while 80 percent of respondents had health problems (answers could be more than one). Among those who had problem, 24 percent had sought for help or assistance.

Figure 2.4.1 : Percentage distribution of MWRAs who have problems and sought help during pregnancy and delivery/after delivery

Sought help when needed		24.4	-	-	-	-
Health problem	=	_	_	_	80.5	
No problem		=	=	<mark>61.6</mark>		
	0	20	40 Percen	60 t	80	100

Note: Total percentage will add up to more than 100 as answers could be more than one

The study found that deliveries at home numbered 51 percent, while an additional 40 percent delivered at home with the assistance of TBA (Figure 2.4.2). Only 2 percent delivered at an HC.

Figure 2.4.2 : Distribution of place of delivery by those who had been pregnant or delivered



The study also asked respondents about receiving antenatal and postpartum care. Figure 2.4.3 indicates that 36 percent of MWRAs received ANC and 33 percent received postpartum care. Hence, a lot of emphasis needs to be made to educate women and their family members to have access to ANC and PNC services to improve the health of mothers.

Figure 2.4.3: Percentage of MWRAs who received ANC and PNC



Knowledge of STIs and HIV/AIDS

Table 2.4.6 presents the percentages of MWRAs and husbands who have heard about or know at least two ways of preventing STIs, know how HIV/AIDS is transmitted, or know of places to get information/service on STIs. More than half of MWRAs (59 percent) and husbands (52 percent) reported that they had not heard of STIs. However, most of the husbands knew at least two ways of preventing STIs and HIV/AIDS. However, only 31.7 percent of MWRAs knew how to prevent STIs. About 58 percent of both MWRAs and husbands knew how to prevent HIV/AIDS.

About half of both MWRAs and husbands did not know where to get information and services on STIs. While 33 percent of husbands and 31 percent of MWRAs knew that information and services can be accessed through hospitals, only one-fourth or an even lower proportion knew that HCs, VHVs and trained TBAs are sources for information and services.

	MWRA	Husband
Heard of STI		
Not heard STI	58.7	51.8
Know at least ways to prevent STI	31.7	53.7
Total	100.0	100.0
Heard of HIV/AIDS		
Not heard of HIV/AIDS	41.4	33.7
Heard of HIV/AIDS but don't know how	0.8	1.2
transmitted		
Know how to prevent HIV/AIDS	58.2	58.8
Total	100.0	100.0
Location to get information/services on STI*		
Don't know	44.2	53.6
Hospital	30.6	33.4
HC	25.6	26.7
VHV	15.5	17.1
Trained TBA	11.5	11.2
Private clinic	0.4	0.8
School teacher	2.4	3.2
Youth center	0.8	1.2
Others	5.0	5.5
Number of cases	1499	1447

Table 5.4.6. Percentage of MWRAs and husbands who know how to prevent STIs, know how HIV/AIDS is transmitted and where to get information/services

Note: Percentages may not add up to 100 because of multiple responses

Awareness of risks involved in trafficking, alcohol use and drug abuse

Table 2.4.7 presents the percentage of awareness of the types of risks and problems involved in trafficking among MWRAs and husbands. Over 40 percent of both MWRAs and husbands did not know the risks involved with trafficking. About one-third of both respondent groups knew that trafficking could result in economic hardship, while only a small percentage were aware that it might result in sexual exploitation, hard working conditions, illegal status and possibility of abuse by others. However, about one-tenth felt that they might loose support from their families. The programme should make MWRAs and other community members aware of possible consequences of trafficking, and give support to anti-trafficking.

Problems	MWRA	Husband
Don't know	46.4	43.7
Economic hardship	32.2	34.9
Sexual exploitation	2.5	2.3
Lack of family support	11.3	12.6
Hard working conditions	3.3	3.7
Illegal status	0.4	0.9
Prone to be abused	0.6	0.5
Others	10.5	9.7
Number of case	1499	1447

Table 2.4.7 : Percentage distribution of MWRAs and husbands aware of risks involved in trafficking

Table 2.4.8 shows the percentage of MWRAs and husbands who are aware of risks due to alcohol use and drug abuse. Three-fourths of MWRAs and husbands reported that they might face family disputes as a result of alcohol use. At the same time, about 50 percent also felt that this could create economic problems in the family, and close to 40 percent thought that alcohol use could result in violence.

Drobloms		Hughand	
	alcohol use and drug abuse		

Table 2.4.8 : Percentage distribution of MWRAs and husbands aware of risks involved in

Problems	MWF	Husband		
	Alcohol	Drug	Alcohol	Drug
Don't know	13.5	32.9	10.2	26.1
Accidents	33.1	25.0	40.3	28.1
Unsafe sex	9.0	9.2	11.9	12.1
Family disputes	75.8	49.4	76.5	52.9
Violence	37.2	32.0	39.8	35.7
Economic problems	46.6	38.8	47.7	42.0
Educational problems	8.0	14.0	10.8	16.1
Dependency	0.0	3.3	0.0	3.7
Others	11.4	2.9	10.9	4.1
Number of case	1499	1499	1447	1447

With drug abuse, nearly half (49.4 percent) of MWRAs and more than half (52.9 percent) of husbands were aware of the risks of having family disputes. About one-third of them felt that family violence could occur, and one-fourth felt that there was a possible risk of accidents from drug abuse.

3. Summary of Findings and Recommendations

Under the sponsorship of the UNFPA, the National Statistical Center (NSC) and Maternal and Child Health Center (MCHC) have conducted the Baseline Situation Analysis (BSA) in three southern provinces (Saravane, Sekong and Attapeu). The survey covered 8 districts, 3 provincial hospitals, 14 district hospitals, 64 health centers (HCs), 158 villages and 1580 households, in which 1499 married women at reproductive age between 15-49 (MWRAs) and men (husbands) aged 15-59 years as well as 90 village health volunteers (VHVs) were interviewed. The field work was conducted at the beginning of November 2002. The BSA was designed to provide up-to-date information on reproductive health (RH) services such as: availability of services, conditions of facilities, service utilization, availability of supplies and equipments including IEC/BCC; staff knowledge relating to particular services or types of family planning methods; and background information, RH knowledge, accessibility and use of RH services by MWRAs and their husbands. The main findings are described below.

3.1 Summary of findings

Objectively Verifiable Indicators (OVIs) for CP III

- 1. Zero percent of provincial and district hospitals provided core package of RH counseling services.
- 2. Four percent of primary health centers (i.e. HCs) provided basic RH services and counseling.
- 3. Eighty-seven percent of SDPs provided at least three modern family planning (FP) methods and counseling.
- 4. Between 8 percent and 72 percent of the SDPs had IEC materials available for distribution.
- 5. On the day of visit, there was no stockout of any contraceptive methods at the 3 provincial hospitals and the 14 district hospitals with exception of IUD at some district hospitals. Primary health centers (i.e. HCs) had lack of stocks of injectable (24 percent), OC-microval (24 percent), OC-microgynon (18 percent) and condoms (42 percent).
- 6. Training on RH/FP was generally not adequate.

Functioning of SDPs

Availability of services

- All basic RH services were offered at the provincial hospitals but for the district and village levels, there was a decreasing number of service types offered.
- Of the 11 elements of core RH services, only 3 services (FP, ANC, distribution of IFA tablets) were provided at 100 percent at the district hospitals and in HCs.
- Only 58 percent of HCs were providing normal delivery.
- No provincial and district hospitals were providing all elements of core RH services together.

- Only 4 percent of 50 HCs provided 9 elements of basic RH services together.
- The best source of FP methods remained the provincial hospitals, and access to FP methods was more difficult at district and village levels.
- 100 percent of provincial and district hospitals were providing services of oral pills (both microval and microgynon) and injectables, while only about 80 percent of HCs were providing oral pills of both types and less than 75 percent of HCs were providing injectables. The clients of provincial hospitals liked to use IUDs and condoms more than the clients of district hospitals.
- Not all district hospitals and HCs offered IUDs.
- It was difficult to get services of permanent FP methods, but female sterilization could still be obtained from some provincial hospitals. It seemed impossible to get a male sterilization.

Counseling service

- All provincial hospitals provided FP counseling, while only 92 percent of district hospitals and 30 percent of HCs provided counseling services to FP clients.
- There was a wide variation in the availability of basic facilities. In many district hospitals, basic facilities were generally not available.
- No district hospitals under study had laboratory facilities. HCs also lacked some basic facilities.
- Working toilets for clients were not available in the majority of SDPs including provincial hospitals.

Condition of facilities at SDPs

- Most SDPs did not offer audio privacy in counseling services.
- Adequate light and adequate water were available only at the provincial hospitals, and most of the provincial and district hospitals were unclean.

Visible signs and IEC/BCC materials

- All provincial hospitals had a visible sign, both outside and inside, to help direct FP clients to the FP clinics, while fewer district hospitals and health centers displayed signs to show FP clients for FP services.
- More IEC materials were available at the provincial hospitals than at the district hospitals. Provincial hospitals had more IEC/BCC materials on FP than for any other subjects.
- IEC/BCC materials were found less frequently at district hospitals and HCs. Between 8 percent and 72 percent of the SDPs had IEC materials available.

Service utilization at SDPs

• The highest number of clients visited in last six months per SDP was for FP services. District hospitals were visited more often by youth than provincial hospitals for services ranging from FP, ANC, counseling and treatment of RTI/STI and minor ailments.

Availability of Supplies and Equipment

Availability of contraceptive methods

- Contraceptive methods are generally available at the provincial and district hospitals but some districts don't offer IUDs for the client (no record).
- At the sub-district level, stockouts of injectable, OC-microval, OC-microgynon and condom were observed respectively at 24 percent, 24 percent, 18 percent, and 42 percent of the HCs.

Availability of FP kits

- Not all FP kits were distributed to the right SDPs.
- All FP kits (IUD insertion and removal kits, mini-laporatomy and tubaligation kit) needed for the work in the SDPs were found to be available at all provincial and district hospitals. Some supplies were also available at the district hospitals, although they were not supposed to have them.
- IUD kits were needed at the provincial and district hospitals but not at the HCs. This indicates that the distribution system needs to be improved so that right supplies are distributed to the right SDPs.

Availability of FP equipment

- FP equipment and facilities were almost always available at the provincial hospitals except beakers, sponge holding forceps, shade windows and shade examination.
- At the district level, almost all items of FP equipment were also available but not in sufficient quantity.
- HCs did not have sufficient equipment, and were facing serious shortages.
- Though most SDPs had basic FP equipment, they were old and in poor condition.

Maternal and neonatal health kits

• Both provincial and district hospitals lacked some of the most basic maternal and neonatal health kit and equipment, such as delivery kit for use at home,

professional midwife kit, eclampsia management kit, blood transfusion kit, operating instruments for caesarian section and embryotomy/craniotomy kit. None of 14 district hospitals in fact had equipment for eclampsia management and blood transfusion.

Management of commodities and supplies

- The majority of the SDPs, particularly province hospitals (67 percent) and district hospitals (57 percent), had a system for keeping record for FP commodities received and distributed.
- More than 50 percent of district hospitals and 80 percent of HCs had no logistics system.
- Only 28 percent of SDPs had an inventory system available and only 24 percent had the inventory system up to date.

Supervision

- Supervision of all SDPs was generally poor. All 3 provincial hospitals and the majority of district hospitals had been supervised at least once in 12 months from the higher level. The subject area most supervised was family planning, for an average of twice in 12 months.
- On a general level, only 47 percent of SPDs had any supervision with an average of once per year.

Staffing and Staff Competency

Staff of SDPs

- At the time of the visit, about half of the staff at the provincial hospitals were working. The proportion, on average, of the number of staff on duty at the time of the visit was much higher at the district hospitals. On average, there were: 1 medical doctor, 4 medical assistants, 3 nurses and 1 midwives working for the MCH/FP at the time of the visit.
- The majority of staff working for MCH/FP had not received training on all elements of the core package of RH/FP. Seventy-seven percent of the medical doctors working at district hospitals and one-third of the medical doctors at provincial hospitals needed to be trained on RH/FP. In addition, more than one-third of the midwives both at provincial and district hospitals also needed training on RH/FP. Training was also needed for nurses and medical assistants. All staff need to be trained on various aspects of RH/FP, especially STI/RTI and adolescent reproductive health.

Village health volunteers (VHVs)

- In this study, a total of 90 VHVs were interviewed, scattered in 14 districts within three provinces. Of the 90 VHVs, 42 persons were traditional birth attendants (TBAs) before being selected as VHVs. The mean age of these VHVs was 40 years. VHVs that had never married were: 20 percent in Saravane, 3 percent in Sekong and 15 percent in Attapeu. In terms of level of literacy, 24 percent of VHVs in Saravane, 3 percent in Sekong and 22 percent in Attapeu were illiterate.
- Data indicates that the large majority of VHVs knows about oral pills (80 percent) followed by IUDs (66 percent), male condom (63 percent) and injectables (62 percent).
- There are about 8 percent of VHVs who knew of at least one FP method, and 6 percent who knew of at least two methods.
- Sixty-four percent of VHVs knew at least one possible side effect of FP methods, and 53 percent knew at least two possible side effects.
- The majority of VHVs recognized the ways of HIV/AIDS transmission, such as unsafe blood and needle sharing. More than two thirds of VHVs (65 out of 90 VHVs) knew the major sources of transmission.

Reproductive Health Knowledge, Accessibility and Use among Community Members

Background information

- Fifty-seven percent of the MWRAs and 43 percent of their husbands were under 35 years of age. About half of the MWRAs (52 percent) reported to have been pregnant more than five times, while only one-third of the MWRAs had five or more surviving children.
- More than half of the MWRAs and three-fourths of their husbands had reported to have attended school. Fifty-one percent of the MWRAs could read and write, while 76 percent of their partners had those skills.

Knowledge and use of family planning

- More than half of the MWRAs and their husbands did not know any FP method. Of those who knew, about 92 percent of the MWRAs and 87 percent of their husbands knew oral pills, followed by injectables (82 percent of MWRAs and 69 percent of husbands) and IUDs (57 percent of the MWRAs and 54 percent of husbands).
- It was reported by the MWRAs that only 16 percent of them were using a family planning method with injectables (43 percent), pills (34 percent), implants (10 percent) or IUDs (8 percent).

Sources of Information and Services

• It was reported that 54 percent of the MWRAs get information from health facilities, 31 percent from VHVs and about 18 percent from trained TBAs. Comparatively, 51 percent of husbands got information from health facilities, 32 percent from VHVs and 18 percent from trained TBAs. However, 84 percent of the MWRAs and 96 percent of husbands did not know where to get services.

Knowledge of side-effects or complication of FP use

- According to the survey result, it was noted that about three quarters of all MWRAs and husbands and about half of current users did not know of side effects and complications of family planning methods.
- Thirty-six percent of the MWRA users of contraceptives and 44 percent of husband users knew about the loss of appetite or weight as a side-effect of family planning.
- Over 30 percent of MWRA users knew about irregular menstruation/amenorrhea as a side-effect, and only 16 percent of husband users knew of spots appearing on the skin.
- Approximately 14 percent of MWRAs reported that they had paid for FP services.
- Of those who paid, 55 percent paid an amount between 1,000 and 5,000 kip. However, the average amount of payment was 21,895 kip.
- Only very few of them (2 percent) expressed that the service was expensive.

Awareness of problems during pregnancy and delivery/after delivery

- About half of the MWRAs and their husbands did not know about the problems that mothers might face during pregnancy (50 percent and 54 percent, respectively) and during delivery and after delivery (43 percent and 59 percent, respectively).
- Common problems known to them were anemia/loss of energy/tiredness (30 percent among MRWAs and 64 percent among husbands).
- Obstructed labor is known to about one-third of MWRAs and husbands as a potential problem during delivery.
- Approximately 62 percent did not have any problems during pregnancy and delivery/after delivery.
- 24 percent of MWRAs sought help, 51 percent delivered at home, and 40 percent with the assistance of a TBA. Only 2 percent was delivered at an HC. In addition, 36 percent of the MWRAs received ANC care and 33 percent received postpartum care.

Knowledge of STIs and HIV/AIDS

- Fifty-nine percent of the MWRAs and 52 percent of husbands reported that they had not heard of STIs.
- Most husbands had heard at least two ways of how to prevent STIs and HIV/AIDS (54 percent) and only 32 percent of MWRAs knew how to prevent STIs. They also knew how to prevent HIV/AIDS as well as husbands.
- Overall, about half of MWRAs and husbands did not know where to get information and services on STIs. While about one-third of MWRAs and husbands knew that information and services could be accessed through hospitals, only one-fourth of them knew that they could get information and services from HCs, and much less from VHVs and trained TBAs.

Awareness of risks involved in trafficking, alcohol use and drug abuse

- Over 40 percent of both MWRAs and husbands did not know risks that would result from trafficking. About one-third of both respondent groups knew that trafficking could result in economic hardship, while only a small percentage of them were aware that trafficking could result in sexual exploitation, hard working conditions, illegal status and prone to abuse. However, about 10 percent felt that they might loose family support.
- Three-fourths of MWRAs and husbands reported that they might face family disputes as a result of alcohol use. About half also felt that this could lead to economic problems in the family and about one-third to violence.
- Nearly half of the MWRAs and more than half of their husbands (53 percent) were aware of the risks of having family disputes from drug abuse. About one-third felt that drug abuse might cause family violence and one-fourth felt that there was a possible risk of accidents from drug abuse.

3.2 Recommendations

Functioning of SDPs

- 1. The programme should ensure that core and basic RH services are available at all SDPs including HCs as per the standard guidelines.
- 2. If the quality of care for the clients is to increase in Lao PDR, the programme needs to focus on service facilities and environment from the provincial level to HC level.
- 3. SDPs, including provincial hospitals, must improve their management urgently to maintain a high standard of cleanliness.

Availability of Supplies and Equipment

4. There is a need to act urgently to establish a comprehensive logistics system at all levels in order to improve the supply situation at all levels of SDPs.

- 5. Storage facilities are inadequate at all levels, and therefore there is an urgent need for the government to address this problem.
- 6. Improvement in logistics management systems should focus on strengthening all aspects such as distribution, warehousing and storage and, in addition, a comprehensive logistics management system needs to be developed, tested and implemented.

Staff and Staff Competency

7. Staff involved in the RH programme do not have adequate training in various elements of RH. Training in various areas of RH/FP should receive priority if the programme is to make an important contribution to improve the health of women in Lao PDR.

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List of sample provinces, districts and villages

Province	District	Village
Saravane	Таоі	Loi
		Kappa
		Kokbok
		Thonghang
		Lavy
	Saravane	Channeua
		Xongkalong
		Phonthong
		Kengkavao
		Dongkotay
		Kokpor
		Phonpheng
		Thameuangse
		Paksanoth
		Xaokady
		Naphengnay
		Naphengnoi
		Pakpui
		Vangson
		Boungxui
		Maknaognay
		Maknaonoy
		Napady
	Vapee	Nawa
		Muang
		Southi
		Lan
		Sinuanxay
		Nonggnong
		Nonnongbua
		Nalaong
		Bangkhanam
Total	3	32

Province	District	Village
Sekong	Lamam	Phon
_		Nonnongwa
		Honglay
		Huakeo
		Nongping
		Teeu
		Beng
		Toksaming
		Tadnoy
		Navakengluang
		Nagnong
		Pakpoom
		Kengyang
		Xongkhongnay
		Xongkhonnov
		Pakkavong
		Heungtav
		Heungneau
		Heaunkang
		Chanamtay
		Kaxangkang
		Paoh
		Namheingmay
		Nmahiengkao
		Pan
		Vanxang
	Thateng	Nongnok
	Thatong	Senneau
		Sentav
		Kohhuanhou
		Kohlakang
		Kani
		Leek
		Iaxamonay
		Jaxamkao
		Keepiounla
		Iakood
		Jakamonay
		Café
		Palay
		Gnokhong
		Jakamsit
		Jakammay
		Noneyamphan
		Kokhai
		Havilang
		Sathi
		Saull
		Kandone

		Kamkok
		Peupgnay
		Lavang
		Valang
		Valing
		Kokphounggneau
		Kokphoungkao
		Kokphoungmay
		Takeomay
		Toumgnoh
		Bongneau
		Bongtay
		Meunkang
		Paleirtay
Total	2	62

Province	District	Village
Attapeu	Samakheexay	Sisomphone
-	-	Oudomxay
		Somsanook
		Champao
		Khamxang
		Donexay
		Boungxay
		Gangkham
		Lanaokao
		Xayphosy
		Lanaomay
		Lanaokang
		Thaphim
		Kagnee
		Naxaythong
		Konghang
		Bengphoukham
		Khoumkham
		Sork
		Meunhaumeaung
		Sok
		Mixay
		Halanggnay
		Kasom
	Phouvong	Phouhome
		Taoum
		Vienxay
		Vongxay
		Jeingheing
		Lamong
		Phouvieng
		Vonglakhorn
		Naxeauk
		Huaukood
		Kang
		Palay
		Bounxanphanh
		Vangyang
		Vonvilaykao
		Vongvilaymay
	Sanamxay	Muang
		Dongpakhen
		Tapaktay
		Thauanneau
		Thaeauntay
		Nongmouang
		Khokkong
		Donedou

		Bok
		Mayneau
		Maytay
		Thainneau
		Thaintay
		Hadgnao
		Sanagneau
		Sanongtay
		Donetapad
		Doneseau
		Kui
		Khang
		Auingkham
		Oudomxay
		Donesoung
		Chomphon
Total	3	64

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Mr Lothkeo	Mr Bounthan	Mr Doomkham

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Mr. Somdy	
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References

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