STRATEGY AND PLANNING FRAMEWORK FOR THE INTEGRATED PACKAGE OF MATERNAL, NEONATAL AND CHILD HEALTH SERVICES 2009-2015: GENDER/EQUITY EVALUATION REPORT

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EXECUTIVE SUMMARY

The Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services 2009-2015 represents an ambitious vision to improve Maternal, Neonatal and Child Health in Lao PDR, and to drive health sector reform. Over the period covered by the strategy, improvements in MNCH have been seen at a national level, though not at a rate that would meet the MDG targets, nor in a way that is equitable across the population. The evaluation considers the progress of MNCH program implementation with a special focus on gender, inclusion and equity, and a consultant was seconded to the evaluation team by Plan International to specifically focus on gender and inclusion in the Integrated Package.

The Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services 2009-2015 is organized into three main objectives: leadership and management; health systems; and, community engagement. Findings are detailed below, in three sections reflecting the three objectives of the Strategy.

Improving leadership, governance and management capacity for program implementation.

In the current MNCH Strategy, the Convention of Elimination of All Forms of Discrimination Against Women (CEDAW) and Convention on the Rights of the Child (CRC) are cited as "guiding principles". The MoH has established the Sub Committee for the Advancement of Women (Sub CAW), and investments have been made, through technical training, of the Sub CAW by USAID and Plan International. This is an excellent first step toward grounding women’s equity in health care. The evaluation found that implementation of activities and practices aimed at empowering women to improve their health outcomes could have been much stronger across the MNCH package. For example, using the WHO Individuals, Families, Communities (IFC) approach to community health education, incorporating non-harmful birthing practices into facility births, and deploying female SBAs to all health centers.

It is recommended that:

1. The role of the SubCAW be strengthened by appointing senior staff to the committee and increasing the number of committee members to enable their input into planning processes for the various departments in

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1 Maternal mortality has reduced from 796 per 100,000 live births in 1995 to 357 per 100,000 births in 2012. Fertility has shown marked declines from a Total Fertility Rate (TFR) of 6 births per woman in 1990 to 3.2 births per woman in 2012 (UNDP 2014).
the MoH and technically supported by INGO partners with training on gender mainstreaming in health programming, and the analysis of gender issues in health services provision to enable gender mainstreaming into policy and implementation at all levels of the health system.

2. Further technical support is required to build sub-national and national MoH staff capacity to implement the IFC approach, and women and child friendly service delivery.

3. Strive to increase equity of health service provision to remote rural populations by conducting a needs analysis of all health centers nationally, followed by an action plan to address the needs identified. The action plan should be monitored and evaluated for its effectiveness with a clear schedule for follow up.

4. Ensure equity criteria applied in planning exercises for Maternal Neonatal and Child Health at all levels of the system to ensure that those areas with the greatest need and the worst indicators are prioritized in rolling out of Human Resources for Health, program implementation, training and logistics plans.

5. For the new strategy, specific information sessions at Public Health Offices and District Health Offices are developed and rolled out to ensure that staff are aware of the contents of the strategy and what they can do to ensure it is implemented.

6. Greater dissemination of the national standards for Skilled Birth Attendant training and qualification in order to increase the efficiently of decisions about health staff deployment.

**Strengthening efficiency and quality of health service provision**

The development of a “Sufficient and skilled health workforce for the provision of the MNCH integrated package” is a key aim of the current MNCH Strategy. The evaluation found that 1,700 SBAs have been trained in recent years and that there has been attention to equity with regards to ethnicity in that some targeting of ethnic young women in SBA recruitment through scholarship allocation has occurred. Unfortunately deployment of SBAs has not been efficient, with only 30% of health centers nationally having an SBA on staff.

Findings from the desk review and discussions with remote communities triangulated well in that the presence of a female midwife at facility greatly increases women’s access to MNCH services, although there are a few reported examples of sensitive and competent male health workers being able to improve

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2 External review if the SBA Development Plan, (Skinner and Phrasisombath 2012).
4 CARE International in Lao PDR (2012).
these services. Language barriers were also cited as a major disincentive for ethnic women to deliver their babies at facilities.  

In the current strategy, it is stated that: “Standards for an adequate building with functional amenities of all health facilities are established and baby, child, mother and youth friendly services are provided by all health facilities”. The evaluation found that in remote areas, many fixed site health facilities are not adequately provisioned with MNCH related drugs, personnel and equipment.

In terms of encouraging more facility births among ethnic groups, the current strategy recommends that “Medical practices will be reviewed to accommodate women’s concerns and traditions (companion in childbirth, free position at delivery, fire bed, etc.)”. The evaluation found that diverse birthing practices were being incorporated in some sites (with development partner support), but that in sites where no specific project aimed at making facilities more inclusive of ethnically diverse birthing practices, there was no provision for the inclusion of diverse birthing practices at all.

It is recommended that:

1. Investment in training and mentoring of SBA is prioritized, with particular attention paid to the deployment of new graduates to rural and remote health centres, and to their professional supervision.
2. There is a need for gender-disaggregated and geographic data on health personnel, and in particular SBAs, to support planning.
3. Deployment is planned to enable each health facility to have at least one female SBA.
4. Young ethnic women are targeted in SBA recruitment (with scholarships or other conditional support).
5. Promotion of providing equity and respective care irrespective of the ethnicity, language and social status is included in SBA curriculum.
6. SBA training to include training and clinical practice of evidence-based non-harmful birthing positions and practices including those traditionally preferable for women.
7. All facilities are supported by training from the Provincial Health Office (PHO) to include evidence-based non-harmful birthing positions and practices including those traditionally preferable for women.

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5 CARE International in Lao PDR (2012).
6 For example, the disparity in the percentage of women who were attended by a health professional during delivery between urban rural women is significant: with 79.6% of urban women attended by a health professional compared to 12.4% of women living in rural areas without roads (LSIS 2012).
8. MoH supports national scale up of existing good practice in incorporating diverse birthing practices into facility births (an example was seen in Nan District, Luang Prabung Province).

9. All data for maternal, child and newborn intervention is systematically disaggregated by sex to identify any difference in care seeking behavior and practices related to the sex of newborn or child and any differences in referral or outcomes identified and underlying causes and determinants addressed.

Mobilizing individuals, families and communities for maternal, neonatal and child health

The consideration of mobilizing individuals, families and communities for MNCH has significant gender and equity dimensions. In focus group discussions conducted during the evaluation, both women and men reported that men hold decision-making power over whether or not members of the household seek medical care, including MNCH related services. This evidence is supported by research in Laos that shows that in some communities women must defer to the male head of household on matters related to their health seeking behaviors, including decisions about seeking MNCH services and use of contraception. Some development partners have developed approaches working with communities aimed at increasing women’s decision-making power in relation to their health.

It is recommended that:

1. The national strategy for MNCH should include mechanisms for sharing and coordinating existing good practice in empowering individuals, families and communities to engage with the health system and participate in activities which affect their health care.

2. Strategies to improve male involvement in efforts to increase community actions for MNCH at home, in the community and for early care seeking be developed, this is an area in which international NGOs (INGOs) and local non-profit associations (NPAs) in Laos can specifically provide the MOH with support.

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9 See appendix C.

10 CARE International in Lao PDR, (2014)

11 For example, Participatory Learning Action education activities related to MNCH and gender training, see Appendix B for details.

12 Local NGOs and other civil society organisations are referred to as NPAs in Laos, reflecting their legal status.
3. There is greater allocation of financial and technical resources for PHOs to implement, adapt and expand successful, participatory community mobilization models based on the WHO IFC model. This is an area in which INGOs and NPAs can provide specific support.

Recommendations for further strengthening of the gender transformative potential and equity of interventions in the next MNCH strategy (areas not well covered in the current strategy):

1. Prioritize adolescent health especially that of adolescent girls. Work with adolescent girls as the entry point for improving access and demand for appropriate quality services.
2. Disaggregate MNCH data by age (10-14 years, 15-18 years) and sex, geographical coverage, access to services, outcomes to be mapped, measured and progress followed over time.
3. Include specific policy pertaining to the rights of women and children with disabilities to minimum health standards and services and establish supporting monitoring and service response staff within the MoH.
4. Include specific actions and initiatives to reach women and children marginalized because of disability in the next strategy and measure progress.
5. Ensure alignment with the revised National Nutrition Policy and Plan of Action (review currently underway).

13 For example, having all village volunteers report on the number of women and children with disabilities in their village and their health status (nutrition, pregnancy, MNCH indicators) on a regular basis (e.g. every three months).
Acknowledgments

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Plan would also like to thank the staff from Save the Children, Health Poverty Action and CARE for their generous support and assistance during the evaluation. We are also very grateful to the men and women of ethnic communities in Bokeo and Attapeu who gave up their time to talk to the research team.
INTRODUCTION

The Lao People’s Democratic Republic (PDR) Government, under the responsibility of the Ministry of Health (MoH) has a policy of providing preventative and curative health services to the whole country, including remote and ethnic areas. This policy is in line with the Government’s commitment to reaching the Millennium Development Goals (MDGs) by 2015, and includes commitment to achieving clear targets in health. As part of this commitment, in 2009, the MoH developed a national strategy for improving Maternal, Neonatal and Child Health (MNCH) outcomes, which aimed to ‘achieve rapid and equitable scale-up for the delivery of essential, cost-effective, evidence based interventions to improve maternal, neonatal and child health’ (Maternal, Neonatal and Child Health Strategy, 2009: 1). The strategy covered a period from 2009-2015. In January 2015, a team of external consultants were contracted to evaluate the effectiveness of the MNCH Strategy, and this report documents the gender and equity component of the evaluation.

This report is structured in four sections. The first, introductory section details the aims of the gender and equity component of the evaluation and provides background context on MNCH in Lao PDR. The second section describes the methodology for the gender and equity evaluation. In the third section, the findings, analysis and recommendations of the evaluation are reported with a focus on actionable recommendations for the development of the next MNCH Strategy. Finally, the conclusions of the gender and equity component of the evaluation are detailed.

GENDER AND EQUITY IN HEALTH POLICY IN LAO PDR

It is increasingly recognised that gender strongly influences the health outcomes of men, women and children and that gender related barriers can limit the reach and scale up of health interventions. However, global analysis has shown that many health policies, programmes and strategies do not adequately take in account issues of gender and equity at various stages of the policy cycle.\textsuperscript{14}

The MoH In Lao PDR has been working with USAID, Plan International (through Plan USA) and UNFPA to strengthen gender integration within the MoH and is currently building capacity of the Sub Committee for the Advancement of Women (Sub CAW) to promote gender equity in health policy and planning to improve health outcomes. The current evaluation of the MNCH Strategic

\textsuperscript{14} See for example: ‘Promoting women’s empowerment for better health outcomes for women and children’, Strategy Brief for the Inter Ministerial Conference on “South-South Cooperation in Post ICDP and MDGs”, Beijing, China 22-23 October, 2013. Prepared by Partners in Population and Development, an intergovernmental organization promoting South-South cooperation.
framework provides an important opportunity to assess the extent of gender integration within the strategy and will provide important recommendations for the design of the new MCH strategic framework from 2016 onwards.

Broadly, health policies can be categorised as either Gender Blind or Gender Aware (see Table One).

<table>
<thead>
<tr>
<th>Gender Blind</th>
<th>Gender Aware</th>
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<tr>
<td>Policies and programmes do not explicitly articulate how gender issues are being addressed, how gender affects the program outcomes, or how the objectives, content, structures and management of programmes may affect gender outcomes</td>
<td>Policies and programmes which deliberately examine and address the environment in terms of gender and consider how gender influences programme objectives, Gender aware programmes incorporate gender considerations into design and implementation including conducting gender analysis, to develop strategies to address gender barriers and constraints, monitoring gender related outcomes and measuring impact the program has on gender equality.</td>
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<tr>
<td>Ignores (often unintentionally) underlying gender constraints and opportunities</td>
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Lao PDR is a landlocked country, and is categorised among the ‘Least Developed Countries’ (LDC) worldwide. Geographic conditions pose difficulties in the development of social infrastructure, transport and communication links and trade. A highly dispersed and thinly spread population compounds this. Since 1975, national development policies have been introduced gradually and the New Economic Mechanism has introduced reforms aimed at the gradual transformation from a centrally planned economy to a more market oriented one. In 2013, Lao PDR’s population was estimated at 6.8 million, and is projected to grow to 8.3 million in 2025, and 10.6 million in 2050.

Laos is still characterised by a developing health system and, for remote communities, limited access to health services. Pronounced disparities in access to MNCH services exist between different population groups. For instance, in terms of skilled assisted delivery, urban areas show a proportion that is twice the national average and over six times that in remote rural areas. The groups living

USAID, 2012, Integrating Gender into the scale up of Family Planning and Maternal, Neonatal and Child Health programs.
in remote rural areas, the poorest and least educated groups, and the ethnic non-Lao-Tai groups have the lowest rates of facility-based delivery.\footnote{16 Lao Social Indicator Survey 2012}

The Maternal Mortality Ratio (MMR) was estimated at 405 deaths per 100,000 live births in 2005, 357 in 2011/12, and a recent (2012/2013) UN estimation situates it at 220. Consequently, Laos seems to have met its MDG5 target on MMR for 2015, which was set at 260. The contraceptive prevalence rate is approximately 50\% for all methods and needs to be increased to meet the need for family planning, and for women to be able to space their births. While the unmet need for contraception has decreased over the past years, the unmet need is still 20\%. In 2011/2012, the total fertility rate of 4.5 ranged from 2.3 in Vientiane to 6.4 in Huaphan province.

Whilst policies exist to protect the right of all women and children in Lao PDR to have access to quality services for pregnancy, childbirth and after birth, there continues to be barriers to achieving this. In addition, wide spread poverty and poor infrastructure contribute to Lao PDR’s high MMR and newborn mortality. In an attempt to address this situation, the MoH, with assistance of their external development partners, has developed an integrated MNCH package. The vision of the MNCH Strategy is universal and equitable coverage of an essential package of interventions for all mothers and children in Lao PDR, regardless of geographical, socio-economic and ethnic differences, in a health system based on primary health care. The Lao PDR government is, and remains, committed to create primary care networks in which all players of the health sector and communities contribute to their full potential to the national goal of reducing maternal, neonatal and child mortality and maternal and child malnutrition.

Six strategic indicators with targets, largely based on MDGs 1, 4 and 5 were developed to guide the MNCH Strategy. The declared targets for 2015 are to:

1. Reduce MMR to 260 per 100,000 live births
2. Reduce under-five mortality rate to 55 per 1000 live births
3. Reduce IMR to 45 per 1000 live births
4. Reduce NMR to 24 per 1000 live births
5. Reduce prevalence of malnourished under-five children by one quarter between 2005 and 2015
6. Reduce anaemia in women of reproductive age from 37\% to 25\%

The MNCH Strategy has three main objectives, through which the above targets were planned to be achieved:

1. Improving leadership, governance and management capacity for programme implementation
2. Strengthening efficiency and quality of health service provision
3. Mobilizing individuals, families and communities for maternal, neonatal and child health

THE MNCH STRATEGY: SPECIFIC ASPECTS RELATED TO GENDER AND EQUITY

Gender and equity are cross-cutting issues that are related to every stage of the MNCH policy cycle, and to each of the three objectives outlined in the MNCH Strategy: leadership, governance and management; health service provision; and mobilizing individuals, families and communities for MNCH. Below, the specific aspects of each objective that pertain to gender and equity are detailed, providing a framework for the presentation of the results, (which will be presented after the discussion of the methodology).

With regard to Objective 1, ‘Improving leadership, governance and management capacity for programme implementation’, there are three key considerations related to gender and equity. First, to what extent has the MoH enabled gender and equity issues to be mainstreamed into the planning processes of the various departments that contribute to the supply of MNCH services and resources? Second, to what extent has the national leadership, governance and management of the MoH ensured gender mainstreaming in health programming? Finally, to what extent has the MoH ensured equitable provision of health services by correctly interpreting the ongoing MNCH needs of the country?

With regard to Objective 2, ‘Strengthening efficiency and quality of health service provision’ the following considerations relate to gender and equity, four key considerations need to be considered. First, has the quality of the education and training of MNCH service providers evolved to better meet the needs of women and children? Second, does the MNCH workforce provide (culturally) sensitive, respectful care? Third, are MNCH services accessible to vulnerable population groups? Finally, are the health facilities that provide MNCH services to remote and vulnerable populations adequately provisioned and maintained?

With regard to Objective 3, ‘Mobilizing individuals, families and communities for maternal, neonatal and child health’, the following consideration relates to gender and equity: to what extent has the strategy contributed to communities taking responsibility for the health of their mothers and children? Empowering communities to take responsibility for the health of their mothers and children encompasses a range of activities and programs aimed at increasing gender equity in order to support women to make informed choices about their health care and that of their children, and be empowered to act on their choices. Gender roles and relations have a significant impact on women’s health, and working toward greater gender equity to support improvements in women’s and
children’s health outcomes requires comprehensive, participatory community engagement.

This report documents the evaluation of the effectiveness of the MNCH Strategy in promoting the changes in the health system required to achieve these objectives. The results section will present findings from the desk review and field visits conducted for this evaluation and be structured according to the three objectives of the Strategy, focusing only on those aspects of the Strategy that relate to gender and equity.

**METHODOLOGY**

The gender and equity component of the MNCH Strategy evaluation included four key components: a desk review of literature documenting gender and health issues in remote ethnic communities in Lao PDR; review of the findings from the MoH internal assessment of the MNCH strategy; field visits to Bokeo, Luang Prabang and Attapeu provinces and some of their districts and villages, representing northern and southern provinces; and in-depth interviews with development partners involved in implementation of specific aspects of the strategy at central level.

The desk review of existing research aimed to review and capture existing good practice in achieving improved MNCH outcomes in remote rural communities in Lao PDR. A range of development partners working on health issues with remote and vulnerable population groups were contacted with a request to provide research reports detailing MNCH interventions and their results. These documents were reviewed with the aim to draw out lessons learned, focusing specifically on practices that have potential for scale-up and implementation in the next MNCH Strategy period. In addition, the results from the recent comprehensive internal review of the MNCH Strategy (2009-2015) were reviewed to triangulate data gathered in both the document review and fieldwork phases of the evaluation.

The field-visit component of the evaluation involved visits to Bokeo, Luang Prabang and Attapeu. These sites were selected because they represent a range of assistance levels from development partners, thereby demonstrating the impact of development partner assistance on implementation of the strategy in remote and rural communities. In Bokeo, Plan International has been working for four years supporting MNCH outcomes by supporting the Provincial Health Office (PHO) and the District Health Offices (DHO) in fixed site delivery of maternal and child health services as well as integrated package of maternal and child health through mobile clinic out-reach services. In Nan District, Luang Prabang Province, Save the Children have been implementing a comprehensive Primary Health Care Approach for seven years. In Attapeu, the World Bank have
been supporting health improvement since 2005 through a project that involves very little direct implementation support at provincial or district level with assistance provided through the MoH at national level. Selecting a range of sites with different approaches and levels of donor support enabled the evaluation of the effectiveness of the different approaches on improving MNCH outcomes.

In each site, field visits included a number of activities: In-depth interviews with PHO managers; in-depth interviews with DHO managerial and clinical staff, interviews with clinical staff at Health Centers and inspection of health facilities at District and Village levels. In Bokeo and in Attapeu, separate focus group discussions were conducted with men and women to incorporate the gendered perspectives of service rights holders into the evaluation. Unfortunately there was no opportunity to conduct focus group discussions in Lauang Prabung, however, secondary data on the perspectives of service rights holders in that site was available and was incorporated into the desktop review. In all cases, fieldwork data was triangulated with secondary data.

In-depth interviews were also conducted at central level with key informants from development partners implementing aspects of the MNCH Strategy. These interviews enabled the evaluation of the process of implementing the Strategy and highlighted challenges faced by development partners in achieving improvements in MNCH indicators.

The primary limitations for the methodology adopted for the evaluation were time constraints and resources. Had more time and resources been available it would have been good to undertake more field visits and to conduct a wider community consultation process, thereby incorporating more data into the evaluation on community perspectives on MNCH in rural and remote areas. While this would likely have resulted in a stronger data set on which to base the recommendations for the evaluation, the presence of a substantial amount of secondary data on community perspectives provides ample evidence of community perspectives on MNCH service perception and utilization.

RESULTS, ANALYSIS AND RECOMMENDATIONS

The Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services 2009-2015 represents an ambitious vision to improve Maternal, Neonatal and Child Health in Lao PDR, and to drive health sector reform. Over the period covered by the strategy, national improvements in MNCH have been seen, though not at a rate that would meet the MDG targets, nor in a way that is equitable across the population (See Tables 1 and 2, below).

Table 1: Percentage of deliveries assisted by any health professional (source: LSIS
Table 2: Percent distribution of women who had anti natal care visits (source: LSIS 2012).

The data displayed in Tables 1 and 2 clearly indicates significant gaps in the utilization of MNCH services between rural and urban, rich and poor women. Below, the factors contributing to the disparity of service utilization between rural and urban population groups will be examined, structured according to the three components of the MNCH Strategy: leadership and management; health systems; and, community engagement.
Improving leadership, governance and management capacity for program implementation.

RESULTS:

In the current MNCH Strategy, the Convention of Elimination of All Forms of Discrimination Against Women (CEDAW) and Convention on the Rights of the Child (CRC) are cited as “guiding principles”. The MoH has established the Sub Committee for the Advancement of Women (Sub CAW), and investments in supporting the Sub CAW have been made, through technical training by USAID and Plan International. This is an excellent first step toward grounding women’s equity in health care. The three key areas in which the MoH Sub CAW could provide leadership and guidance in advancing women’s access to MNCH services are: activities and practices aimed at empowering women to engage with health services, including demand and accountability to improve their health outcomes; the incorporation of non-harmful birthing practices into facility births; and the deployment of female SBA to all health facilities.

The evaluation found that implementation of activities and practices aimed at empowering women to improve their health outcomes could have been much stronger across the MNCH package. For example, the community health education/mobilization models employed vary across the nation. In sites where development partners are committed to applying the IFC approach and support MoH staff to implement the model, the quality of implementation is good and there is evidence of community health education, participation and mobilization to improve health outcomes. In sites without development partner assistance, most community education/mobilization is conducted during outreach activities by MoH staff and is based on a top-down, didactic model. Clinical staff at health centers interviewed during the evaluation expressed a desire to increase their skills in community education and mobilization for health service utilization but noted that they did not have the necessary facilitation skills nor access to appropriate support materials to conduct IFC-based community education/mobilization.

The MNCH Strategy calls for the incorporation of non-harmful birthing practices into facility births. In focus group discussions conducted with rural women for this evaluation, women expressed a preference for a vertical birthing position (supported squatting) and the incorporation of non-medical support people in the birth room (for example the presence of the husband or another family member). This data is supported by research conducted by development
partners into traditional birth practices in remote and rural communities in Laos (Albone, 2011). 17

Despite the clear preference for the inclusion of non-medical birth support as well as SBA, and the incorporation of traditional birthing positions into facility births, the vast majority of facility birthing units (at village, district, provincial and central levels) do not allow non-medical support people into the birth suite, and women are required to give birth in the supine position with their feet secured in stirrups. MoH management staff in both Provincial and District levels stated that SBA training included only the supine, stirrup bed delivery position. Staff were not trained to manage delivery in other positions and because of this, were not confident to allow other delivery positions in facility-based deliveries. The other constraint to allowing a variety of delivery positions that was observed during the evaluation was that of facility design and equipment supply: all health facilities are equipped with a stirrup bed for deliveries, and the limited floor space, and at times lack of cleanliness, in many facilities means that there is not enough room to allow for other birth positions in the delivery rooms.

Deployment of female SBA to all health facilities is a key factor in increasing the number of women choosing facility births, (as evidenced by the fieldwork conducted for this evaluation), a finding supported by qualitative research conducted by CARE International documenting the barriers to accessing maternal, child and reproductive health services for remote ethnic groups. 18 It is well documented that men in remote rural communities hold considerable power over women’s health-seeking behaviors, and that the majority of rural ethnic men do not approve of their wives receiving obstetric treatment from a male service provider. 19 In light of this evidence of rural men and women’s preference for female health staff for MNCH services, the deployment of female SBA could potentially be a significant factor in increasing women’s access to MNCH services.

Registration of SBA graduates and records documenting where they have been deployed was an issue raised as needing attention during the evaluation. The UNFPA provides significant and commendable support to SBA training schools across the country, but are not yet able to monitor the deployment of SBA graduates because records of deployment were not available. The target

17 Albone (2011) ‘Study on barriers to accessing maternal, child and reproductive health services in remote groups in Laos’ available from CARE Laos.
18 See for example Albone (2011) “Study on the barriers to accessing maternal, child and reproductive health services for remote ethnic groups and vulnerable urban women”. CARE Lao PDR.
19 There is some evidence of sensitive male health workers managing deliveries, but for the majority of men from rural ethnic communities this is seen as undesirable, and would therefore be likely to discourage facility birth if a female SBA was not available at the health facility. See for example Albone (2011) “Study on the barriers to accessing maternal, child and reproductive health services for remote ethnic groups and vulnerable urban women”. CARE Lao PDR, Malam, L. (2015) Gender baseline: Women Organized for Rural Development, Phongsaly and Sekong, available from CARE Lao PDR.
number of SBA graduates for 2015 was 1500, this has been exceeded by 200. This target number was calculated based on a formula for the number of SBA at each level of facility, and theoretically would have resulted in one SBA at each village health facility and a greater number at district, provincial and central level facilities, yet, currently, 60% of village-level facilities do not have the required level of staffing of at least three health workers including at least one SBA (MNCH Strategy Internal Assessment, 2015).

In depth interviews with Provincial and District level MoH managers, as well as clinical staff at health centers found that there was confusion around crucial aspects of the MNCH package, such as which staff are qualified as SBA (highly important knowledge in ensuring staffing levels of at least one SBA at each health center). In some sites, Provincial and District managers were not clear on the differences between SBA and Traditional Birth Attendants (TBAs): when asked how many of the health centers in the Province had a SBA they reported 100% deployment, however, after a discussion clarifying the qualifications required for SBA, the staff agreed that the percentage of Health Centers with an SBA was actually around 30%. Clinical staff interviewed at the health centers in Attapeu Province were of the opinion that staff who had attended 2 week training in birth assistance at the Provincial Hospital were qualified to manage facility births at the Health Center, moreover, they stated that staff who had witnessed other staff managing a birth (but had never actually received training themselves) were also competent enough to manage facility births without any supervision. This example highlights the need for greater dissemination of the policy and national standards for Skilled Birth Attendant training and qualification.

In interviews with Provincial and District MoH managers, it was found that awareness of the MNCH Strategy was low. In Bokeo and Attapeu, the Provincial Deputy Director and Provincial Director respectively, stated that they had not seen the MNCH Strategy document, and were not aware of its contents. Interviews with District-level facility managers in Bokeo revealed that they, too, had no awareness of the strategy. Moreover, district level managers reported that there were serious problems in the supply of crucial resources that they require in order to deliver MNCH services, including money to fund free MNCH services (money is needed for consumables, and also to pay women the per diem and travel allowance they are untitled to under the scheme), money to pay for health staff salaries, and a deficit in the human resources needed to deploy SBA to all health centers.

ANALYSIS:

One way of addressing gaps in cross-department coordination for the MNCH package, particularly focusing on gender and equity, could be to strengthening the role of the sub CAW. The sub CAW in the MoH has the potential to drive gender aware policy and program implementation, thereby addressing some of
the issues of divergent programming approaches in delivering MNCH services. Achieving this would involve strengthening both the capacity of the members of the committee to undertake gender and equity driven analysis of health programming and implementation and increasing the number of personnel on the committee; plus ensuring that the personnel selected have the drive and political power to action the committee’s recommendations. Some examples of gender aware health programming and practice that could potentially be championed by the sub CAW as part of gender mainstreaming in the MNCH package are: using the WHO IFC approach to community health education/mobilization, incorporating non-harmful birthing practices into facility births, and deploying female SBAs to all health centers.

The WHO Model of IFC developed in 2003 as part of the Making Pregnancy Safer Initiative. The health promotion approach as articulated in the Ottawa Charter, defines IFC as “a process of enabling people and groups to increase control over, and to improve, their health and quality of life”. The IFC strategy is based on global evidence which shows that the availability of quality services will not produce the desired health outcomes if there is no possibility for women, men, families, and communities to be healthy, to make healthy decisions, and to be able to act on these healthy decisions. This is particularly important in an environment where civil society is very weak and few mechanisms for people’s participation in decision-making are afforded to local communities (see Appendix A for more details).

Vertical birthing positions, such as those preferred by many rural women in Laos, have been found to be medically preferable to the supine position (WHO, 1996). These findings have been applied in numerous developing countries to enable greater empowerment of women during the birthing process, while ensuring their safety and that of their babies by increasing the amount of medical expertise available to them during delivery (by delivering at medical facilities as opposed to home births). Enabling the incorporation of traditional birth positions into facility births and practices such as having a family member in the birth room for support would give a clear message that women’s knowledge and cultural practices were respected, and could potentially be a very empowering and positive experience, thereby encouraging further engagement with the health system in the future.

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Recommendations pertaining to leadership, governance and management of MNCH services:

The three examples above of potential pathways for gender-aware health programming could be included in the next strategy and implemented following the recommendations below:

1. The role of the SubCAW be strengthened to enable their input into planning processes for the various departments in the MoH and the committee technically supported by INGO partners with training on gender mainstreaming in health programming, and the analysis of gender issues in health services provision to enable gender mainstreaming into policy and implementation at all levels of the health system.

2. Further technical support is required to build sub-national staff capacity to implement the IFC approach, and women and child friendly service delivery.

3. Ensure equity criteria applied in planning exercises for MNCH at all levels of the system to ensure that those areas with the greatest need and the poorest indicators are prioritized in rolling out of HRH, program implementation, training and logistics plans.

4. For the new strategy, specific information sessions at Public Health Offices and District Health Offices are developed and rolled out to ensure that staff are aware of the contents of the strategy and what they can do to ensure it is implemented.

5. Greater dissemination of the policy and national standards for Skilled Birth Attendant training and qualification.

Strengthening efficiency and quality of health service provision

RESULTS:

The first specific objective in this section of the MNCH Strategy, to strengthen the delivery of MNCH services by encouraging women to deliver their babies at fixed site health centers, is a reasonable aim, but weaknesses in the standard of facilities and staff expertise at many remote rural facilities (and some District level facilities), means that more attention needs to be placed on developing a functioning health platform before encouraging greater utilization of services.

The design of birthing rooms across the country, with stirrup beds that require women to give birth in a prone position is not in line with current international standards and is antithetical to many rural women's traditional birthing practices (WHO 1996). For rural (and indeed urban) women to give birth in the prone position with their legs secured in the air is highly uncomfortable, both physically and culturally. This result is supported by the findings of the evaluation of the midwifery component of the SBA development plan (Skinner
and Phrasisombath, 2012: 48), where they state that:

“The observations of the health centers [in remote villages where non-Lao Lum women live] did not reveal any attempts to make the physical environment more culturally acceptable, nor to incorporate any of the non-harmful cultural practices.”

While the standard design of birthing rooms across the country does not incorporate traditional birthing practices, the evaluation did find that in some sites with development partner support, traditional birthing practices have been incorporated into facility-based deliveries. For example, in Nan District in Luang Prabung, ongoing supportive supervision and mentoring of midwives has enabled them to successfully incorporate a range of birthing positions into the MNCH practices at facilities. Where midwives are skilled and well supported to assist women to give birth in positions which are comfortable to them the outcome is a much more empowered and comfortable and culturally acceptable birthing experience, and this can serve to strengthen women’s commitment to engaging with MNCH services in the future, as well as encouraging others in their community to do so (see figure 1, below).

Outreach is extremely important in reaching communities where access to health centers is not possible. In many sites around the country, development partners support outreach activities. Integrated approaches to outreach provide opportunities for SBA and other health staff to offer a range of MNCH services, though as yet MNCH has not been fully integrated with the national childhood vaccination program. Evidence from successful programs running in Sayaboury (11 Districts) and Luang Prabung (5 Districts), supported by Save the Children, shows that outreach activities must be seen as part of a comprehensive community-to-health service interface approach if best practice results are to be achieved. The case study detailed in Appendix B describes the approach adopted in the Save the Children Model of Community Health promotion.

The second specific objective related to strengthening efficiency and quality of health service provision is: to develop sufficient and skilled health workforce for the provision of MNCH integrated services. This specific objective has been met in some regards, but further work is needed to reach the MDG targets of reducing Child Mortality and Improving Mortality Health, particularly among remote ethnic populations.

The evaluation found that many fixed site health facilities are not adequately provisioned with MNCH related drugs, personnel and equipment (MNCH internal review, 2015). The comprehensive, internal MoH national MNCH review found that only 30% of facilities nationally have the required staff levels, including SBA. Encouraging women to deliver at facilities where the facility, staffing and standard of care is inadequate will not necessarily improve MNCH
outcomes, and is likely to discourage others in the community from delivering at the site in the future is one or more community members have a negative birthing experience while at a health facility.

Since 2008, a highly successful midwifery-training program has been implemented in Lao PDR (supported by UNFPA). In their evaluation of SBA training programs in Lao PDR, Skinner and Phrasisombath, (2012) argued the quantity of midwives produced had been emphasized over quality of training in recent years, citing skills gaps such as lack of clinical experiences among graduate midwives, and lack of basic skills in midwives deployed to Health Centers. Skinner and Phrasisombath’s finding was supported by the fieldwork conducted for this evaluation, which found that newly graduated midwives tended to lack confidence when questioned on protocols for managing common clinical problems they are likely to encounter as SBA.
The gender of the cohort of SBA being trained is highly significant. During the evaluation some key informants indicated that not all SBA trained in the cohort of 1700 graduates were female. Some male MoH staff were enrolled and trained as SBA even though they were later posted or returned to administrative or other positions. The issue of the selection of inappropriate students for midwifery training was raised in the evaluation of the midwifery component of the SBA development plan published in December 2014, which stated that:

“...there were students recruited into the post-basic programs who were not working in the clinical area and returned to those areas following the midwifery program...Getting a midwifery qualification meant a rise in status and pay, whether or not there was employment in the maternal workforce...The midwifery school managers commented that there were a significant number of students recruited who were not motivated to be midwives and that they were very hard to teach” (Skinner and Phrasisombath 2014, pp 35-36).

The more recent internal assessment of the MNCH Strategy conducted by the MCH Center also found that some of the graduates from the SBA training were not deployed to SBA duties, and that there was a “mismatch in gender and required skills.”

Significant gains in improving MNCH outcomes for some population groups who are located close to facilities and are ethnically alike most service providers (i.e. Lao Lum) have been achieved. However, inequities exist when comparing
the MNCH outcomes of non-Lao Lum and Lao Lum ethnicities. Many reasons for these inequalities exist, (including difficulty in accessing appropriately staffed facilities), but one key barrier that has been reported in a number of key informant interviews is that of discrimination by service providers against people from ‘other’ ethnic groups (Albone 2011). During the interviews with the ethnic women in the villages, they strongly suggested that ensuring that all health facility staff are respectful, skilled, and kind to service rights holders could potentially have a significant impact in increasing the number of ‘ethnic group’ women seeking MNCH services (Figure 2, below, shows standard service and drugs charges on display at a health center in Non District. This is an excellent example of a simple practice that positions ethnic group women. Men and children as service rights holders).

Figure 2: Standard drug charges displayed at a Health Center in Nan District.

ANALYSIS:

Where traditional cultural practices are positive and helpful to the birthing process, incorporating and valuing women’s knowledge into medical protocols would demonstrate that women’s cultural practices are recognized and valued by the medical establishment and would be very empowering for women. Currently, women come to the birthing room at the health center or hospital and into an environment that is highly medicalized. If some aspects of traditional birth practices could be incorporated into facility design (for example, birthing

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22 For example, the disparity in the percentage of women who were attended by a health professional during delivery between urban rural women is significant: with 79.6% of urban women attended by a health professional compared to 12.4% of women living in rural areas without roads (LSIS 2012). Living in a rural area without a road is a proxy indicator of being a member of an ethnic group. See also the data from the initial years in the Save the Children supported districts and provinces, presented in Appendix B.
'stools', ropes that women can hold suspended from the ceiling, comfortable beds), the birthing experience could be much more empowering and positive.

Standardized design of birthing suits with pre delivery, delivery and post delivery rooms is necessary to ensure that all facilities are indeed healthy, safe spaces for women and children. Many health centers have no running water in the delivery room, no budget for antiseptic soap for hand washing, no antiseptic liquids with which to clean surfaces—nor do they have established cleaning protocols which are followed and which ensure that women, babies and children and, indeed health workers, are not put at greater health risk due to potential infections by delivering at the health facility. Before encouraging women to come for fixed-site facility birth it is important to ensure that facilities are safe and welcoming spaces in which to deliver babies.

Cost-effective, yet well designed alternatives to the current standard of stirrup beds can be readily developed and deployed, making the design of birthing rooms across the country more medically appropriate and in line with current international best practice standards, which aim to make the birthing space more welcoming for women and less medicalized, without compromising on standards of hygiene or medical care.

In the context of Lao PDR, many women, and especially rural ethnic women, would be discouraged to attend facility birth if only a male SBA was available (Albone 2011). Given the many other barriers ethnic women face to accessing MNCH services, it would be wise to try to eliminate the barriers that are easily addressed, such as the gender of the SBA. In this context, affirmative action toward women enrollments in SBA training is necessary to ensure that ethnic women feel that they are freely able to access MNCH services without cultural and gender-related barriers limiting their access.

It is important to make working in remote rural sites a more attractive option for trained SBAs. One possible recommendation would be to aim to have two, rather than one SBA at each village facility, that way they could support and relieve each other. Further investigation as to the reasons why SBA have not been deployed to is need to address this significant gap in personnel provision (some informants have referred to the staff deployment quota system that prevents deployment of SBA and other health personnel to areas where they are needed—this needs urgent review).

Some informants have argued that the way to address active discrimination against ‘ethnic groups’ (for example being refused treatment by health workers and told they are smelly and dirty) in the health sector is to train young ethnic women to be SBA and serve in their own communities. This is an excellent initiative and one that also seeks to address inequalities in access to educational opportunities faced by women of non-Lao Lum ethnicity. In addition to
providing scholarships for non-Lao Lum ethnic women, it is important to build a significant component on ‘respectful treatment of all potential service rights holders’ into all SBA and other health staff training. It is also important to include elements in the training that seeks to improve the self-esteem among the trainees, especially the non-Lao Lum women, and inculcate a passion and esteem about their future profession.

Skilled, compassionate SBA can potentially have significant impact in improving women’s and children’s health outcomes, as evidenced by indicators achieved in Nan District, Luang Prabung Provence. The staff in Nan District receive high quality supportive supervision and training, and as a result experience high levels of job satisfaction and morale. Positive staff morale is reflected in the standard of service provided to women and children and in the maintenance of the facility. SBA in the District-level dedicated MCH center (located at the District hospital) delivered comprehensive MNCH services, with a visit to a facility offering opportunities for staff to discuss contraception, offer nutritional advice, conduct immunization checks and post-natal checks for mothers. High staff morale and motivation was also reflected in the level of cleanliness of the various facilities visited. In health facilities observed in Nan District the standard of cleanliness in Nan District facilities was a great contrast to those observed in other areas where staff morale seemed to be much lower.

Gender equity in the health workforce has not yet been reached, and a greater effort could be directed toward encouraging the promotion of women in the health workforce, as has been done in Nan District in Luang Prabung, where affirmative action toward female staff has resulted in a number of women being promoted to senior positions within the MNCH workforce. In such sites, this action has resulted in an increased level of status for women’s contribution to MNCH services, particularly midwifery.

Recommendations pertaining to quality health service provision:

1. Investment in training and mentoring of SBA is prioritized, with particular attention paid to the deployment of new graduates to rural and remote health centers, and to their professional supervision.
2. HR deployment is planned to enable each health facility to have at least one female SBA.
3. Young ethnic women are targeted in SBA recruitment (with scholarship/other conditional support).
4. Promotion of providing equity and respective care irrespective of the ethnicity, language and social status is included in SBA curriculum.
5. There is a need for gender-disaggregated data for human resources for Health SBAs and their geographical posting as SBA gender has an impact at facility level, Women seeking more MNCH related services from a female SBA especially delivery and post natal care.
6. SBA training to include training and clinical practice of evidence-based non-harmful birthing positions and practices including those traditionally preferable for women.

7. All facilities are supported by training from the Provincial Health Office (PHO) to include evidence-based non-harmful birthing positions and practices including those traditionally preferable for women.

8. MoH supports national scale up of existing good practice in incorporating diverse birthing practices into facility births (an example was seen in Nan District, Luang Prabung Province).

9. All data for maternal, child and newborn intervention is systematically disaggregated by sex to identify any difference in care seeking behavior and practices related to the sex of newborn or child and any differences in referral or outcomes identified and underlying causes and determinants addressed.

Mobilizing individuals, families and communities for maternal, neonatal and child health.

RESULTS:
The 2009-2015 strategy mentioned empowering citizens to demand appropriate health interventions and quality of care. This is a very positive commitment, but more progress is needed in the next strategy phase as progress to date has been slow, with most health education currently being conducted being based on the BCC model, rather than the WHO IFC model. Practical support from development partners, including dissemination of the policy sub-nationally and support with developing annual work-plans that align with the policy are recommended. Annex 1 of the MNCH Strategy documents details the MNCH package implementation plan, with responsible agencies/individuals designated for each strategic objective and expected result. For strategic objectives one and two agencies and individuals were clearly designated for all expected results and activities, yet for strategic objective three almost every result and activity area has no agency or individual designated to be responsible for implementation.

The desk review of research conducted investigating the impact of gender roles and relations on MNCH revealed that gender inequality at both community and household levels has significant impacts on MNCH. At the household level, men hold the power to give or to deny permission to women and children to seek medical care (WHO 2014). There are a range of traditional practices whereby

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23 With the exception on those Provinces and Districts being supported by development partners who specifically implement the IFC model.

men control the health outcomes for pregnant women, for example: pregnant women are considered “dirty” in certain ethnic groups and asked to deliver babies in the forest, in some communities and families, in many families men decide of ANC care is considered necessary (and only see it as necessary if there are symptoms of pathology), and control over women’s bodies regarding the use of contraception rests, in many cases, with their husbands (Albone 2011).

Focus group discussions conducted during this evaluation revealed that inequitable household divisions of labor can force women to return to heavy manual labor very shortly after giving birth, (in some cases within a week, but in many cases around one month). This is a problem particularly evident in rural areas, but it is also a trend that impacts on urban poor. Poverty and lack of food security and access to clean water sources within close proximity to the home contribute significantly to this trend. These constraints seriously inhibit women’s ability to exclusively breastfeed their babies, resulting in the introduction of harmful solid foods from as early as one week to one month in many cases in rural areas. These findings are supported by comprehensive primary research conducted in rural Lao, such as the report on Barriers to Accessing Maternal, Child and Reproductive Health Service for Remote Ethnic Groups and Vulnerable Urban Women, (Albone 2011: 16), which states that:

"Women generally felt that men worked far less hard and in many cases did little to relieve the woman’s burden. There was no spontaneous mention of workloads and pregnancy and in general men appeared to be quite proud that their women were strong. Men acknowledged that women worked longer hours than men.”

The desk review found that in sites where significant development partner support is offered, participatory approaches aimed at empowering individuals, families and communities have been effective in empowering IFC to demand appropriate health interventions and appropriate quality of care, and to increase women’s decision-making power in relation to their health have been highly successful. 25 Examples of these best practices models of community engagement are presented in Appendix C.

ANALYSIS:


Reviewing activities under strategic objective 3 in the current (2009-2015) Strategy makes it evident that the activities are geared more towards involving individuals, families, and communities in provision of medical services to households or individuals as an extension of the health sector rather than making them participants of long term social change towards a better overall maternal and child health status. However, as recent strong evidence suggests (Participatory planning, action and monitoring cycles, WHO) any strategy focusing on engaging and empowering IFC needs to go beyond bio-medical model of health in which IFC are considered “patients” who need treatment or intervention from “experts” but look towards working in partnership with communities. Literature from worldwide is currently available as to how to operationalize this.26 Strategy should have space for health workers to engage in community mobilization and work. It also has to have adequate space in the activities to be customized at the level of village to suit different ethnicities, cultures, and traditions.

Community and individual activities aimed at increasing women’s empowerment and gender equity at community and household levels will improve women’s ability to influence key decisions in the household including health expenditure and health seeking behaviors for family members. There are many excellent examples of development partner-supported projects and programs aimed at promoting gender equity among men and women, boys and girls from non-Lao Lum groups (see the case studies detailed in Appendix C).

Recommendations pertaining to Community Mobilization and Engagement:

1. National strategy on MCH should include mechanisms for sharing and coordinating existing good practice27 in empowering Individual Families and Communities to improve MNCH, which can then be taken forward by the development partners and MoH staff.

2. Strategies to improve male involvement in efforts to increase community actions for MNCH at home, in the community and for early care seeking be developed, this is an area in which INGOs and NPAs in Laos can specifically provide the MOH with support.


27 See for example the case studies documented in Appendix B.
3. There is greater allocation of financial and technical resources for sub-national center staff to implement, adapt and expand successful, participatory community mobilization models based on the WHO IFC model. This is an area in which INGOs and NPAs can provide specific support.

**Additional recommendations for further strengthening of the gender transformative potential and equity of interventions in the next MNCH strategy (areas not well covered in the current strategy):**

1. Prioritize Adolescent health especially that of adolescent girls. Use adolescent girls as the entry point for improving access and demand for appropriate quality services.
2. Disaggregate MNCH data by age (10-14 15-18) and sex to scale, geographical coverage, access to services, outcomes to be mapped, measured and progress followed over time. This should be linked to partners supporting early marriage interventions.
3. Include specific policy pertaining to the rights of women and children with disabilities to minimum health standards and services and establish supporting monitoring and service response staff within the MoH.
4. Include specific actions and initiatives\(^28\) to reach women and children marginalized because of disability in the next strategy and measure progress.
5. Identify areas of overlap with Food and Nutrition Action Plan of Lao PDR and establish synergy with the health sector actions outlined there, in order to maximize impact of both MCH and nutrition intervention

**CONCLUSION**

The two key challenges of making MNCH strategy equitably implemented are the supply of quality health services and the engagement of communities with the health system. In terms of supply of quality health services, the MNCH strategy seeks to channel the MNCH program interventions through an existing health system, which struggles to support universal basic health services. The capacity at the different levels and in various elements of the health system varies widely depending on two key dynamics: first, the level of facility (central level hospital, provincial hospital, district hospital or village-level health center), and second, the level and type of development partner assistance in supporting MoH staff in program implementation, supply of health equipment and

\(^{28}\) For example, having all village volunteers report on the number of women and children with disabilities in their village and their health status (nutrition, pregnancy, MNCH indicators) on a regular basis (eg. every three months).
consumables and support for infrastructure development. Generally, health services are better funded and supported at Central and Provincial level, with highly significant decreases in support (both funding and personnel deployment, training and supportive supervision) when District and Village level services are evaluated. More support for the health system aimed at strengthening capacity of staff to provide high quality basic health care at district and village levels could contribute significantly to engaging communities to seek health care from health facilities, including MNCH services.

The MoH has been limited in its ability to correctly analyze and continuously interpret the on-going MNCH needs in the country, as evidenced by the disparities in service provision and utilization between rural and urban areas. As discussed above, limiting factors include underdeveloped inter-departmental collaboration mechanisms, and the difficulties posed by underdeveloped record keeping with regard to registration and deployment of health staff. District and Village level MoH staff are often so under-resourced (both in terms of material commodities and in terms of provision of professional development and supportive supervision) that they are unable to provide feedback to Provincial and Central level MoH mangers on MNCH resource needs. Limitations in budget and management capacity in the MoH mean that even in cases where resource needs are communicated, they are sometimes unable to be met. Given these challenges, it is difficult to say that national leadership, governance and management has evolved significantly due to the Strategy.

While development partners have demonstrated significant ability to correctly analyze and interpret the ongoing MNCH needs of the sites in which they work, their reach often limited to the province/district in which they are working. Each agency that was reviewed for the evaluation designed their programs based on the MNCH Strategy document, but the nature of each of the programs differs in its focus, therefore the type of support received and the outcomes of the support varies from one program to another. It is possible to say that in relation to development partner’s programming that the MNCH Strategy has been highly influential.

In terms of the gender/inclusiveness aspects of MNCH service provision, there has been excellent progress in terms of increasing the numbers of trained SBA since 2008, after a period of almost 20 years with no SBA training programs in the country. The challenge for the next period of development toward strengthening the efficiency and quality of health service provision is to incorporate more training on culturally sensitive and respectful care into health personnel training programs, including SBA training, and to provide ongoing training and supportive supervision to SBA graduates.

There are many excellent programs being implemented by MoH personnel and supported by development partners, to engage communities with the health
system. In a number of sites, there is evidence of increased knowledge around MNCH and the need for ANC, delivery at health centers, post-natal care and child nutrition. Programs based on the IFC approach and guided by the MNCH Strategy have been very successful in empowering women to access MNCH services, and mechanisms should be developed for cross-collaboration among implementing agencies so that best practice examples of programs and activities can be scaled up.

For future targeted interventions (for example, MNCH, Child Nutrition, Free MCH) to have a good chance of success in terms of reaching the most vulnerable populations there are a number of improvements that need to be made in each of the three strategic areas of the MNCH strategy, many of which also relate to the general capacity and efficiency of the health system more broadly. First, strengthen the leadership, governance and management of the health system so that inputs into the health system at all levels of service (central, provincial, district and village) can be monitored and delivered effectively. Second, ensure that staff who are appropriately trained and skilled in the delivery of MNCH services are deployed to all health centers and that they receive ongoing supportive supervision. Finally, drawing upon the expertise of the successful INGO-supported programs that utilize the IFC model of community mobilization for health improvements, seek to scale up the IFC model across all provinces.
Appendix A: WHO Individuals, Families and Communities Model

**Individuals, Families and Communities – A model for demand creation and community empowerment**

Strategic Objective 3 of the GOL MNCH Package is based on the WHO Model of Individuals, Families and Communities developed in 2003 as part of the Making Pregnancy Safer Initiative. The health promotion approach as articulated in the Ottawa Charter, defines IFC as “a process of enabling people and groups to increase control over, and to improve, their health and quality of life”. The IFC strategy is based on global evidence which shows that the availability of quality services will not produce the desired health outcomes if there is no possibility for women, men, families, and communities to be healthy, to make healthy decisions, and to be able to act on these healthy decisions. This is particularly important in an environment where civil society is very weak and few mechanisms for people’s participation in decision-making are afforded to local communities. IFC:

- Describes a solution-focused approach where communities are involved in analysis of their own situation and can feed into district level health planning.
- Presents a strong rights-based agenda, including awareness raising and protection of rights
- Describes itself as a comprehensive approach aimed at empowerment. In particular it represents a shift away from the individual (usually women) towards social groups and social relationships, allowing a closer examination of the role gender and other socio-cultural norms (play in health decision making.
- Recognizes that IEC and Behaviour Change (BCC) interventions alone, which tend to focus on (achieving desired behaviour, do not necessarily advance the goal of empowering individuals and (communities.
- Focuses on appropriate relationships between the community and the formal health care (delivery system
- Broadens the dimensions of quality of care to include intercultural and interpersonal skills and a (supportive and caring environment
- Acknowledges that MNCH Interventions need to be addressed within the broader programs of (poverty alleviation, gender equality and education of girls and women
- Broadens the approach to health promotion to be addressed by multi-sectoral authorities and (community based civil society interest groups (Laos has a tradition of employing strong didactic training methodologies. The Ministry of Health leadership together with development partners will need to recognize that the implementation of the IFC approach requires a paradigm shift away from solely IEC/BCC
approaches which promote a set of desired behaviours to an education approach which is oriented to create knowledge rather than deliver knowledge. Successful implementation of IFC requires the MoH to support a critical and reflective process within the health delivery system which will empower the health sector to work with communities, including community involvement in defining and monitoring the quality of care.


Appendix B: Case studies of good practice in participatory engagement of IFC for improved MNCH outcomes.

CARE Lao PDR: Maternal, Neonatal and Reproductive Health Strategy 2011-2020

Working with Individuals, families and communities is considered to be the critical link in ensuring the recommended continuum of care throughout pregnancy, childbirth and the post partum period. Furthermore, it recognised that where the availability of quality services will not produce the desired health outcomes where there is no possibility to be healthy, to make decisions and to be able to act on those decisions.

Current thinking on behaviour change for health reflects the shift from communities as ‘targets of change’ to ‘agents of change’. Communities can play a strong role supporting a woman’s right to improved reproductive health. Engagement and empowerment of individuals, families and communities require approaches that go beyond telling people what they should know and what they should do. It involves building capacities for self-care, increasing awareness on rights, needs and problems, building linkages within communities and with health delivery systems and involving communities in monitoring the quality of health services. A strength of the WHO IFC approach is that it provides important opportunities for greater accountability to communities. CARE is committed to supporting an enabling environment to increase community participation in health decision-making. CARE Laos will foster a shift in thinking by health service providers and development partners to support the successful implementation of IFC. At the same time, CARE will work to ensure that people’s basic needs are met and rights are upheld. CARE’s long term program for both impact groups provides the synergy and supportive environment for both such changes to occur concurrently.

Key activities to operationalize CARE’s strategy to mobilize communities to
improve MNCH outcomes include:

- Build capacity of MOH and development partners at all levels to understand and engage with IFC approaches through workshops, cross visits and coordination mechanisms for IFC established under the MNCH package
- Pilot interventions to support the IFC model in 2 geographical areas (for comparison of effectiveness in two areas with different quality of health service provision and with different ethnic groups), document, replicate and take to scale
- Develop district and community capacity to conduct community maternal death audits and analyze underlying determinants of poor health care
- Support communities to set up appropriate mechanisms to address maternal and child health and nutrition, to develop plans for community action for safe delivery and post partum care, and identify and support champions among village health care providers and village leaders
- Work with health service providers to conduct participatory community assessment to inform district planning provide an entry point for greater linkages between providers and community
- Ensure IFC interventions extend to young, unmarried, vulnerable women and men
- Work with men and influential people to create a new vision of men’s role in support of (a woman’s right to safe pregnancy, delivery and post partum care

Alison Rusinow, CARE Lao PDR’s Deputy Director, was interviewed for this evaluation and noted some of the important, yet difficult to measure, shifts in gender roles and relations that had contributed to women’s ability to make decisions about their health care and follow through on their health choices for themselves and their children:

- CARE’s program on negotiation skills gets people to discuss sexual and reproductive health publically, which is something that was not possible before the program. This has had a positive impact on women’s ability to discuss sexual and reproductive health within their households.
- Significant changes in women’s and children’s health status came from program interventions aimed at reducing women’s workloads, giving them more time to look after themselves and their children: breastfeeding, cooking nutritious food, and spending time with their children.
- Ethnic language communication around health education has helped to increase engagement by IFC with health improvement activities and practices.
- One seemingly obvious, but important logistical issue, is that outreach
planning MUST involve announcing/notifying the people in the village of outreach activity with enough time for people to prepare themselves to participate before visiting the village. In many villages, the normal practice is that the outreach visit is announced in Lao language on the morning of the visit.

- In each village CARE has a female MNCH focal point who is trained in some MNCH services such as what to do with a retained placenta and cord care.
- In many sites, men and women now eat together, whereas in the past men ate before women, with women only coming to eat once men were finished. This is a subtle, but significant symbol of shifting relations between men and women. Greater gender equity is an important step in empowering women to be able to make informed decisions about their health and to act on their decisions.

**Plan Laos: health interventions in Bokeo Provence**

Plan improves the health and nutrition status of women of reproductive age and children under 5 through supporting the increased availability and use of health and nutrition services. Plan designs long-term interventions including:

- Training and professional development for health staff from villages and health centres, including up-skilling birth attendants.
- Strengthening the capacity of government officials and village trainers to conduct village level nutrition training.
- Providing community based health and nutrition education.
- Establishing women’s groups and other community empowerment mechanisms.
- Equipping rural health centres and district health facilities.

Plan Bokeo’s MNCH Officer, Dr Amphone Keooudom was interviewed for the evaluation, and described the details of Plan’s successful community engagement work in Bokeo:

- Outreach activities, including health education, are conducted in local ethnic languages
- Health education is conducted with whole village participation; it is planned well in advance and villagers are informed well before time of the planned activity
- It was important to have very good relationships with Village Heads to enable whole village participation in activities and to ensure that health messages are supported and reinforced after the project workers have left the village
- Outreach activities use a range of tools and materials to engage people’s participation and to appeal to different learning styles: LCD presentations,
flipcharts and drama shows are used to communicate health messages.

- Plan conducts quarterly monitoring in changes in MNCH outcomes and has seen good results in terms of increases in service utilization of ANC, facility delivery, PNC and EPI.

- Plan has established parenting groups in a number of sites, which operate in gender segregated, open discussion format focused on broad-based health education. Participants discuss and present their ideas on past and current health issues and collectively seek solutions to challenges that individuals and families in their community face in terms of accessing quality health care and services.

- In the past 3 years, Plan has supported 25 ethnic young women to train as SBA through a scholarship program, and has successfully managed to have these young women deployed appropriately so that every health center in the district as covered by Plan’s program in Bokeo is staffed with an SBA who speaks the local ethnic language. This addresses language and culture barriers to MNCH service utilization.
Appendix C: Save the Children’s Primary Health Care Outreach Model

Community Health work is done by a number of levels:

1. Village volunteers
2. Female health volunteers
3. Outreach / mobile clinics by health staff
4. Health days at Health Centers
5. Supervision of volunteers by district health staff

1. Village volunteers

The incentive for working as a Village Volunteer (VV) is the opportunity to participate in capacity building opportunities and receive a small per diem for transport costs and food during training events. The initial training for VVs takes 6 days; thereafter they attend 2 days refresher training per year (each year, the refresher training focuses on different topics). After training, the VVs report to Village Head and explain the work to be done in the village each month. Village Volunteers receive annual supervision by District Health team and also participate in mobile clinic outreach sessions in their community, and are required to complete a monthly report form and send it to the health center nurse or District Health Office each month. More recently the VVs are using their personal mobile phones to report activities to health dispensary staff. They are selected on the basis of their gender (preference for female volunteers), age (between 20-45), willingness to work and motivated to be active and keen in the community, and are preferably literate. They are expected to work approximately 5 hours per week and are supplied with basic equipment including a weighing scale; basic kit and health education materials.

Role of volunteers:

1. Give health education using the messages in your book at village meetings or when you visit families – please use a new message each time.
2. Visit families and encourage them to attend immunization sessions at the dispensary or when the mobile team visits the village.
3. Encourage all pregnant women to attend for antenatal care at the hospital, dispensary or with the TBAs, and deliver at a health facility.
4. Encourage families to drink clean boiled water, use latrines and sleep under mosquito nets.
5. Encourage families to keep the village clean and pen animals.
6. Encourage families to use family planning services at the hospital and health center.
7. Treat simple illnesses in the village and refer serious cases to the health
center or hospital as soon as possible.

2. Female health volunteers (TBA)

The focus for TBA is on maternal and child health, and their key role is to refer women to health center or hospital, but for back-up they are trained in basic delivery and newborn resuscitation. In addition they promote breastfeeding and other key MCH behaviors. The incentive for working in this voluntary role is the opportunity to participate in training events and receive a small per diem for transport costs and food during training events. Initial training takes one week, followed by refresher training of 2 days per year. TBAs receive annual supervision from District Health and they work together with Village Health Volunteers (who are mostly male).

3. Outreach/mobile clinics

To every village > 5km from district hospital, conducted twice a year, and staffed 100% by District Health department and Health Centre staff.

Clinics consist of:

Health Promotion done in the evenings

Clinical service done from early morning

- Immunisation
- Growth monitoring of children
- Ante-natal & post-natal care
- Family planning
- Child health
- Basic rapid testing: anemia, malaria
- Pharmacy
- General population (eg older people)
- Each mobile clinic manages a revolving drug fund

4. Health days at Health Centers

The health day at health centers is conducted every three months during the district monitoring and supervision team visit. The monitoring visit takes 2 days. On the first day the district team supervise health center activities using a standard monitoring checklist. In the afternoon they meet with the health center staff to provide feedback, discuss challenges and record decisions and follow up actions.

In the evening of the first day the team conducts a health education evening with the communities in the surrounding villages. This consists of showing health
education videos on various topics and distributing health education materials. Sometimes there will be a small, facilitated discussion following video viewing. If a large group attends this is not possible.

On the 2nd day the district health staff invite community members from surrounding villages to have a health check up at the health center. The district staff work with the dispensary staff and provide on site coaching.

5. *Supervision of volunteers by district health staff*

The supervision of village volunteers is done once per year and is conducted by the health center staff for the villages in their coverage area. They receive a budget from the district to visit each village and monitor the work of the village volunteer using a standard checklist. The checklist includes feedback from village leaders and community members. The health center staff also update village data during this activity especially for women and children under five years old.