

Annex 1: USAID Laos MCHN NOFO 72048621RFA00001 Lao PDR Health Background

Maternal health

Despite progress in addressing maternal mortality in the last two decades, Lao PDR still has the highest maternal mortality rate of all Association of Southeast Asian Nations (ASEAN) countries at 151 per 100,000 births.¹ On average, the interventions for maternal health reach less than half of the intended population of pregnant women nationally, and reach just over a quarter of pregnant women in the poorest groups.² The main causes of maternal death are postpartum hemorrhage, eclampsia and sepsis.³

Antenatal care (ANC): ANC services provide an important opportunity to reach pregnant women and their families, including husbands, monitor and support the pregnancy, prepare for delivery, promote maternal and infant nutrition and newborn health, and counsel for healthy spacing and timing of pregnancy. More than a third (38 percent) seek ANC services late into their pregnancy, after the fourth month. Nearly one in six pregnant women do not receive any ANC services (17 percent).⁴

There are large differences among women and access to ANC services. For example, 93 percent of women living in urban settings receive at least one ANC compared to 55 percent of women living in rural areas with no road. Receiving ANC services varies by provinces. Only half of pregnant women living in Phongsaly (53.1 percent) receive at least one ANC service compared to 81.4 percent of women living in Xaysomboune. ANC also varies by ethno-linguistic groups. Chinese Tibetan (45.7 percent) and Hmong-Mien (32.7 percent) are most at risk of not receiving ANC compared to 7.9 percent among the Lao-Tai ethnic group. Women in the poorest wealth quintile are about 40 times more likely to not receive ANC (43 percent) compared to the richest wealth quintile (1.6 percent).⁵

Proportion of birth attended by skilled birth attendant (SBA): Ensuring deliveries with an SBA is critical to decreasing maternal morbidity and mortality. Lao PDR made it a priority to increase access to SBAs during delivery through the promotion of midwives deployed at the health center level. Through this initiative, the proportion of births attended by a skilled provider increased dramatically in the last 15 years: from 40.1 percent in 2012 to 64.4 percent in 2017.⁶ However, to date, four out of ten women do not deliver with an SBA (46 percent).⁷ As with many of the maternal health indicators, the proportion of births attended by an SBA is much lower among women living in remote rural areas (34 percent) than women living in urban areas

¹ "Improving health and nutrition outcomes for mothers and children in vulnerable populations," UNICEF.

² Ibid.

³ "National Strategy and Action Plan for Integrating Services on Reproductive, Maternal, Newborn, and Child Health 2016-2025," MOH, <http://www.laoshealth.org/assets/national-rmch-strategy-2016-2025.pdf>.

⁴ Lao Social Indicator Survey II 2017, Survey Findings Report," Lao Statistics Bureau and UNICEF, <https://dhsprogram.com/pubs/pdf/FR356/FR356.pdf>.

⁵ Ibid.

⁶ "Births attended by skilled health staff (% of total) – Lao PDR," The World Bank, <https://data.worldbank.org/indicator/SH.STA.BRTC.ZS?locations=LA>.

⁷ Ibid.

(89.7 percent); and those in the lower income quintile (32.6 percent) compared to women in the highest wealth quintile (96.8 percent) and educational groups. Deliveries with SBAs also vary by provinces with Xayaburi being the highest (81.5 percent) compared to Phongasaly, the lowest, with 37.3 percent. The proportion of births attended by SBA varies by ethno-linguistic groups with more than three-quarters of Lao-Thai delivering with an SBA (78 percent) compared to less than half of Chinese Tibetan (42.5 percent) and Hmong Mien (45.7 percent).⁸

Postnatal Care (PNC) for the mother and newborn: PNC is a critical period after birth when it's possible to identify health problems and deliver lifesaving interventions for both the mother and newborn. Global evidence shows that about a third of neonatal deaths occur within the first day after birth, and close to three quarters occur within the first week of life.^{9 10}

PNC services for the mother and newborn in Lao PDR are very limited. Less than seven percent of women who delivered receive a PNC visit^{11 12} after giving birth, and only 12 percent of newborns receive a PNC visit within two days of being born. There are very small differences in PNC among women living in rural versus urban settings, or among provinces, or among wealth quintiles or ethno-linguistic groups.¹³

Maternal undernutrition: Poor maternal nutrition is related to socio-cultural norms, including gender inequalities, local dietary practices, education levels and poverty. Poor maternal nutrition also results from adolescent pregnancies.

Women have limited access to a diverse and nutritious diet in Lao PDR. Recent survey data in five provinces show that only 36 percent of non-pregnant women who had given birth in the last two years of the survey had minimally diverse diets, and less than half (44 percent) of all currently pregnant women had minimally diverse diets.¹⁴ Minimum dietary diversity for women (MDD-W) was much higher in urban areas (76 percent) than rural areas with or without roads (33 percent and 20 percent respectively), and this correlated with both educational level and wealth quintile. MDD-W was the lowest (29 percent) among the Mon-Khmer.¹⁵

⁸ "Lao Social Indicator Survey II 2017, Survey Findings Report."

⁹ M. J. Sankar et al., "When Do Newborns Die? A systematic review of timing of overall and cause-specific neonatal deaths in developing countries," *Journal of Perinatology*, vol 36, suppl 1 (May 2016): S1-S11, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4848744/>.

¹⁰ Joy Lawn, et al., "Every Newborn: Progress, priorities, and potential beyond survival," *The Lancet*, vol 384, no 9938 (12 July 2014): 189-205, <https://pubmed.ncbi.nlm.nih.gov/24853593/>.

¹¹ PNC visits refer to a separate visit by any health provider to check on the health of the mother and provide preventive care services. PNC visits do not include health checks following birth while in a facility. 47.2% of mothers received a PNC health check before being released from the health facility.

¹² "Lao Social Indicator Survey II 2017, Survey Findings Report."

¹³ Ibid.

¹⁴ "Fill the Nutrient Gap Lao PDR: Summary Report," World Food Programme (September 2017): 47, <https://www.wfp.org/publications/2017-fill-nutrient-gap-lao-pdr>.

¹⁵ Ibid.

Maternal anemia remains a significant health problem in Lao PDR. More than a third of women aged 15-49 years suffer from anemia (39.8 percent).¹⁶ Nutritional deficiencies, including iron-deficiency, chronic infections, malaria, hookworm, and other helminths infections, are all causes of maternal anemia. Anemia during pregnancy is associated with increased risks of adverse maternal health outcomes including postpartum hemorrhaging, preeclampsia and blood transfusion.¹⁷ Anemia during pregnancy contributes to adverse newborn health including low-birth weight due to intrauterine growth retardation, pre-term birth, perinatal mortality, and neonatal mortality.¹⁸

Pregnancy and childbirth are associated with diverse traditional cultural social practices.¹⁹ Traditional food practices and women's limited agency all contribute to restrict what pregnant and lactating women consume. Food restrictions during pregnancy are practiced across the country and vary by ethnolinguistic groups, level of education, and wealth quintile. The practice of "eating down" during pregnancy to avoid a difficult delivery and a large baby is common.²⁰ The major barriers that limit women's consumption of diverse foods are food taboos during the postpartum period. These food taboos vary by region and ethnolinguistic groups, but one restriction that appears to be common across most groups is for women to avoid meat and only eat rice, salt, and ginger for up to one month after delivery.²¹ Other postpartum taboos include not eating meat that is white in color, not eating fruit or vegetables, and not eating foods that are fermented, oily, sour, raw or spicy. However, these practices vary by ethnolinguistic groups. Some can be beneficial to women's health, such as the tradition for Akha men in Phongsaly province to prepare a special meat soup for their breastfeeding wives. Others, such as the Hmong-Mien, have been reported as practicing some of the most restrictive post-partum nutrition taboos.²²

Poor maternal nutrition has intergenerational consequences as maternal undernutrition is a root cause of inadequate fetal growth, which can contribute to child undernutrition.²³ Thus, it is of vital importance to tackle maternal malnutrition to improve women's well-being and child health outcomes.

¹⁶ "Lao Social Indicator Survey II 2017, Survey Findings Report."

¹⁷ Melissa Young et al., "Maternal hemoglobin concentrations across pregnancy and maternal and child health: a systematic review and meta-analysis," *Ann N Y Acad Sci*, vol 1450, no 1 (Aug 2019): 47-68, <https://pubmed.ncbi.nlm.nih.gov/30994929/>.

¹⁸ Md Mizanur Rahman et al., "Maternal anemia and risk of adverse birth and health outcomes in low- and middle-income countries: systematic review and meta-analysis," *Am J Clin Nutr*, vol 103, no 2 (Feb 2016): 495-504, <https://pubmed.ncbi.nlm.nih.gov/26739036/>.

¹⁹ Vanphanom Sychareun et al., "Cultural Beliefs and Traditional Rituals about Child Birth Practices in Lao PDR," The Asian-Pacific Resource & Research Centre for Women (2011), <https://www.unfpa.org/sites/default/files/pub-pdf/Socio-cultural%20maternal%20health%20report%20laos.pdf>.

²⁰ USAID Nurture (September 2016 - September 2021), USAID, https://www.usaid.gov/sites/default/files/documents/1861/USAID_Nurture_JAN_2019.pdf.

²¹ "Fill the Nutrient Gap Lao PDR: Summary Report."

²² Ibid.

²³ Robert Black et al., "Maternal and child undernutrition and overweight in low-income and middle-income countries," *The Lancet*, vol 322, issue 9890 (Aug 2013): 427-51, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60937-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60937-X/fulltext).

Women's health in the context of disabilities

People with disabilities are at increased risk of poor health outcomes as they face many barriers that limit access and quality of services they receive. These barriers, such as poverty, limited physical and mobility, social norms, and attitudes of providers have a compounding effect that limit demand and utilization of health services. Women with disabilities who live in remote areas are also at increased risk of sexual assault when traveling alone to seek health or other services.²⁴

There is a growing recognition that services for people living with disabilities go beyond catering for people affected by unexploded ordnance (UXO)-related accidents, and that primary care services for RMNCHAN need to be tailored and responsive to the needs of people living with disabilities, including providing these services for people with psychosocial and developmental disabilities.

Adolescent health

Young people, those below the age of 25, are critically important for Lao PDR as they constitute more than half the population (59 percent). For the country to boost its potential benefits from the demographic dividend, adolescent programming across sectors, including health and nutrition, needs to be strengthened.

Adolescent girls in Lao PDR require focused attention as these girls are at high risk of poor health outcomes due to societal norms regarding early marriage and teenage pregnancy. Improving adolescent girls' health and nutrition outcomes contributes to breaking the intergenerational cycle of deprivation. Lao PDR has the highest rates of early marriage and the highest adolescent birth rate in the ASEAN region.²⁵

The situation regarding child marriage has not shown great improvement over the last decade. A third (33 percent) of girls aged 20 to 24 are married before the age of 18 and one in four girls aged 15-19 are married.²⁶ To date, there has been limited capacity and commitment from the public and private sectors in Lao PDR to reduce early or forced marriages and provide quality adolescent health services.

Lao PDR's adolescent fertility rate, 83 births per 1,000 female adolescents aged 15-19,²⁷ is among the highest in the ASEAN region. Adolescent birth rates vary across groups by a factor of five times between provinces (26 per 1,000 adolescent girls in Vientiane Capital to 138 per 1,000 in Xaysomboune), and by a factor of 21.8 times between those with little or no education (176 per 1,000) and those that completed secondary education (eight per 1,000).²⁸

²⁴ "Lao PDR Gender Analysis", USAID Okard (Mar 2018).

²⁵ "Lao Social Indicator Survey II 2017, Survey Findings Report."

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid.

The latest Lao Social Indicator Survey (LSIS) data show that 18.4 percent of young women (20-24 years old) have given birth before the age of 18. Of these adolescent births, ten percent were to girls before the age of 15. More than forty percent (43 percent) of adolescents with little or no education have gone through early childbearing compared to six percent of adolescents with secondary education. When comparing wealth quintile, 37 percent of adolescent births before age 18 occur among the poorest wealth quintile compared to four percent in the richest quintile.²⁹ The adolescent birth rate is the highest among the Hmong-Mein (192 per 1,000) and among adolescents from the poorest wealth quintile (156 per 1,000).³⁰

Progress in reducing adolescent birth rates has been slow. Among adolescent girls with primary or lower secondary level of education, progress has even reversed in the five years between LSIS 2011 and LSIS 2017.

Adolescent pregnancy has a significant impact on maternal and neonatal mortality as well as child stunting. Children born to teenage mothers have a higher likelihood of being malnourished. In Lao PDR, children born of mothers younger than 20 years of age are 1.7 times more likely to die before their fifth birthday compared to those born of mothers aged 20-34.³¹

Adolescent pregnancy has a significant impact on girls' wellbeing, including increased risk of dropping out of school as well as increased risk of morbidity and mortality. While lack of education and poverty appear to be associated with early sexual debut and marriage, culture also plays a role. Nationwide, five percent of female youth and three percent of male youth engage in sex before age 15.³² Risk-taking sexual behaviors, including low condom use and multiple sexual partners, are prevalent among young people, particularly among adolescents from certain minority ethnic groups.³³ The practice of early sex is most common among the poorest households and among Hmong-Mien girls and Chinese-Tibetan boys.³⁴ Child marriage can also be part of traditional culture in some ethnic groups, such as the Hmong, where there is a practice of kidnapping young girls as young as 12 or 13 years old to be married off.³⁵

In rural settings, and particularly in villages with no road access, a lack of sexual and reproductive health knowledge and poor access to condoms and other forms of contraception contribute to both unplanned pregnancy and to sexually transmitted infections. Limited access to adolescent and youth-friendly reproductive health information and counselling, limited

²⁹ Ibid.

³⁰ "The Situation of Children and Women: Lao PDR," UNICEF (Dec 2019), [https://www.unicef.org/laos/media/4516/file/The%20Situation%20of%20Children%20and%20Women%20of%20Lao%20PDR%20\(2020\).pdf](https://www.unicef.org/laos/media/4516/file/The%20Situation%20of%20Children%20and%20Women%20of%20Lao%20PDR%20(2020).pdf).

³¹ Ibid.

³² "The Situation of Children and Women: Lao PDR."

³³ "Adolescent and Youth Situation Analysis Lao PDR," Lao People Revolutionary Youth Union and UNFPA (2014), https://lao.unfpa.org/sites/default/files/pub-pdf/Final_Eng_AYSA%20Report.pdf.

³⁴ "The Situation of Children and Women in Lao PDR."

³⁵ "Global Monitoring – Status of Action against Sexual Exploitation of Children: Lao PDR," ECPAT International (2017), https://www.ecpat.org/wp-content/uploads/2017/05/A4A-Laos_2017_Final.pdf.

information and services for married and unmarried young people, the attitudes of health workers, social stigma, and a perceived lack of confidentiality are all factors that discourage adolescents (15-19 years old, married or unmarried) from seeking health services and the information they need.³⁶

Gender-based violence (GBV)

There is growing recognition in Lao PDR that violence against women (VAW) is a serious public health problem,³⁷ yet in Lao PDR, VAW is culturally tolerated. Per the latest LSIS in 2017, 29.5 percent of women and 16.2 percent of men aged 15-49 believe that a husband is justified in beating his wife in various circumstances.³⁸ Physical and sexual violence against children remains a significant issue. A violence against children survey found that 15 percent of females and 16.9 percent of males had experienced at least one form of physical violence before the age of 18, and that one in ten had experienced sexual abuse. Only 5.2 percent of girls knew where to get help if sexually abused. Of girls who reported experiencing sexual abuse, none received any help or services.³⁹

Child health

Lao PDR has made significant progress in improving child health and survival; however, neonatal and child mortality rates today remain the highest in the ASEAN region. Neonatal mortality is estimated at 18 per 1,000 live births.⁴⁰ Neonatal death varies by location, province, wealth quintile, and ethno-linguistic groups status. For example, the risk of dying before the first month of life is twice as high for a newborn in a remote rural area (24 neonatal deaths per 1,000 live births) compared to the risk for a newborn in an urban area (14 neonatal deaths per 1,000 live births). Neonatal mortality has declined at a slower pace (40 percent between 2000-2018) compared to the child mortality rate (56 percent during the same time period). As the under-five mortality rate declined from 61.8 per 1,000 live births in 2012 to 46 per 1,000 live births in 2019,⁴¹ deaths became increasingly concentrated in the neonatal period (48 percent of child mortality is attributed to neonatal mortality). This high level of neonatal mortality relative to under-five mortality calls for a sharpened focus on care of the newborn.⁴² Eighty percent of all newborn deaths result from three preventable and treatable conditions: complications due to prematurity; intrapartum-related deaths including birth asphyxia; and neonatal infections.

³⁶ “Adolescent and Youth Situation Analysis Lao PDR.”

³⁷ “Lao National Survey on Women’s Health and Life Experiences 2014: A Study on Violence Against Women, National Commission for the Advancement of Women and UNFPA (2015), https://asiapacific.unwomen.org/-/media/field%20office%20eseasia/docs/publications/2016/03/final_eng_vawreport-lowres.pdf?la=en&vs=5859.

³⁸ “Lao Social Indicator Survey II 2017, Survey Findings Report.”

³⁹ “The Situation of Children and Women in Lao PDR.”

⁴⁰ “Adolescent and Youth Situation Analysis Lao PDR.”

⁴¹ “Key Demographic Indicators: Lao People’s Democratic Republic,” UNICEF, <https://data.unicef.org/country/lao/>.

⁴² “Ending Preventable Newborn Deaths and Stillbirths by 2030,” WHO and UNICEF (2020), <https://www.unicef.org/reports/ending-preventable-newborn-deaths-stillbirths-quality-health-coverage-2020-2025>.

Under-five mortality is decreasing, from 51 per 1,000 live births in 2016 to 45 per 1,000 live births in 2019.⁴³ The largest share of deaths among under-fives is due to neonatal causes (48 percent) followed by acute respiratory infection (19 percent) and diarrheal diseases (16 percent), with malnutrition as the underlying cause contributing to half of child mortality (52 percent).⁴⁴

Many challenges impact the wellbeing of children under five years old. Vaccination coverage is low, with less than half of children (48 percent) being fully vaccinated. Vaccination coverage varies widely by provinces. For example, in Xaysomboune province less than ten percent of the children are vaccinated, whereas in Bolikhamxay province nearly 75 percent of the children are vaccinated. Vaccination coverage varies among ethno-linguistic groups, by wealth quintile, and by level of education.⁴⁵

While an estimated 6.5 percent of children under five years old suffered from an episode of diarrhea, care was sought for only half of those children. When care was sought, only six out of ten children received any type of rehydration therapy (59.9 percent) and less than two out of ten children received zinc (15 percent). Only 12.5 percent of children received oral rehydration solution (ORS) and Zinc when ill with diarrhea.⁴⁶ As with other child health indicators, care seeking behaviors and treatment for child illnesses varies by location (rural/urban, province), wealth quintile, ethno-linguistic group, and education of the mother.⁴⁷

Child undernutrition levels in Lao PDR remain some of the highest in the ASEAN region and in the world, despite both rapid economic growth and a decline in poverty. About a third of children under five years old are stunted (33 percent). But stunting prevalence rises to 50 percent in disadvantaged regions and communities, such as Sekong provinces and the Hmong Mien ethnic groups. Acute malnutrition (weight-for-height or wasting) in some provinces is very high. In Xayaburi and Attapeu, 19 percent and 15 percent of children less than five years old, respectively, suffer from acute malnutrition.⁴⁸ Child undernutrition rates vary by location, province, level of education, ethno-linguistic group, and wealth quintile.⁴⁹

Suboptimal infant and young child feeding practices are important causes of child malnutrition.⁵⁰ Less than half of children under six months old were exclusively breastfed (44.9 percent). Only half of newborns were breastfed within one hour of birth (50 percent), and one out of four newborns (24.7 percent) received liquids or items other than breastmilk during the

⁴³ “Key Demographic Indicators: Lao People’s Democratic Republic.”

⁴⁴ Laura E Caulfield et al., “Undernutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria, and measles,” *Am J Clin Nutr*, vol 80, issue 1 (Jul 2004), 193-198, <https://academic.oup.com/ajcn/article/80/1/193/4690278>.

⁴⁵ “Lao Social Indicator Survey II 2017, Survey Findings Report.”

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

⁵⁰ “Nutrition in Lao PDR: Causes, Determinants, and Bottlenecks,” The World Bank (2016), <https://elibrary.worldbank.org/doi/pdf/10.1596/24953>.

first three days of life. Pre-lacteal feeds, sometimes as early as the first day, commonly consist of water, pre-masticated sticky rice, formula, or diluted condensed milk.⁵¹ Complementary feeding practices are very poor. Only 66 percent of children aged six to 23 months continue to be breastfed once complementary foods are introduced. Only 26.2 percent of children aged six to 23 months had a minimum acceptable diet, including appropriate diversity and frequency of complementary foods.⁵² Geographical variations in breastfeeding practices are likely associated with different practices among ethnolinguistic groups, with the Hmong Mien and Chinese Tibetan groups in the northern region practicing exclusive breastfeeding at a much higher rate than the Lao-Tai and Mon-Khmer groups in the south.⁵³

Many local beliefs influence young child feeding practices. Many mothers believe that colostrum is dirty milk, hot, sour, or otherwise not good for babies and therefore discard it, sometimes up to six days after birth.⁵⁴ Some mothers also believe that breastmilk is not sufficient and babies need other foods such as pre-masticated rice, water, or other kinds of powdered milk. When babies cry, many mothers believe it is due to the child being hungry. Frequency and diversity are influenced by beliefs that children know when to eat and how much they should eat.⁵⁵

Other practical barriers include women's need to go back to work (including agricultural labor) and being unable to breastfeed regularly while away or working. In this case, infants are left to the care of grand-others or caregivers who feed the children pre-masticated rice, condensed milk, and water.⁵⁶ Older female members of the household are important influencers on young child feeding practices. Local and ethnic traditions are also strongly associated with infant young child feeding practices and the choice of complementary foods.⁵⁷ The mother's level of education is strongly associated with appropriate initiation of complementary feeding.

On the nutrition services supply side, health care providers' skills in providing counseling on maternal and young child nutrition, hygiene, and sanitation promotion are often limited. Many primary health care workers capture child growth information for statistical purposes rather than for counseling pregnant women and lactating women on infant young child feeding practices and health promotion.⁵⁸

Sanitation behaviors are also associated with nutrition outcomes. The probability of childhood stunting in a village decreases when there is a decrease in rates of open defecation in that village. Children living in households with access to safe water have a lower probability of being

⁵¹ "Fill the Nutrient Gap Lao PDR: Summary Report."

⁵² "Lao Social Indicator Survey II 2017, Survey Findings Report."

⁵³ "Fill the Nutrient Gap Lao PDR: Summary Report."

⁵⁴ "USAID Nurture: A Literature Review: Maternal, Infant and Young Child Nutrition and WASH Practices in Lao PDR," Save the Children and RDA (Sep 2016), https://pdf.usaid.gov/pdf_docs/PA00MJZ9.pdf.

⁵⁵ Ibid.

⁵⁶ "Fill the Nutrient Gap Lao PDR: Summary Report."

⁵⁷ Ibid.

⁵⁸ "Nutrition in Lao PDR: Causes, Determinants, and Bottlenecks."

malnourished. Improving hygiene behaviors and access to water, sanitation, and hygiene supplies are important to reduce child stunting.⁵⁹

Tackling undernutrition requires a holistic, multi-sectoral approach. Causes of undernutrition are interdependent and complex. Socio-cultural norms, gender inequities, behaviors and cultural/religious beliefs, poverty, limited education, and limited access to nutritious foods are all determinants of child undernutrition.⁶⁰ Solely developing nutrition promotion activities targeting mothers is insufficient as older women, husbands, community members, and traditional socio-cultural practices influence maternal and child nutrition.⁶¹ Social and behavior change activities need to be broadly directed at adolescent girls, pregnant and lactating women, child caregivers (including grand-mothers), influential family members (particularly husbands), and community influencers.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Ibid.