Nutrition Policy Brief

Study of the determinants of malnutrition in Lao PDR

Qualitative evidence from Phongsaly, Houaphanh, Bokeo & Saravane Provinces

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More evidence is needed to gain better knowledge and understand which factors are hindering the provision, demand, and use of nutrition services, as well as recognise what actions can contribute to the reduction of malnutrition in Lao PDR.

> This brief highlights findings from a "Qualitative assessment on the determinants of malnutrition in Lao PDR – Focus on Phongsaly, Houaphanh, Bokeo and Saravane Provinces," a report prepared in August 2022 by the Socio-Economic Policy Research Institute (SPRI) part of the Lao Academy of Social and Economic Science (LASES) in collaboration with the Development Research Institute (DRI) part of the Ministry of Planning and Investment (MPI).

1 What's at stake?

Despite impressive gains in economic growth over the past decades and improvements in nutrition, Lao PDR has one of the highest rates of chronic malnutrition in Southeast Asia.[1] In addition, available evidence indicates high disparities in malnutrition among the provinces in Lao PDR. Undernutrition threatens lives and national socio-economic development; it is associated with cognitive impairment and reduced school enrolment, which poses a challenge to attaining education targets and impacts development and overall economic growth.[2]

Malnutrition leads to enormous economic and human costs in Lao PDR. Nearly 2 million Lao citizens, mainly women and children, suffer from some form of malnutrition – and, therefore, cannot achieve their full development potential, which has adverse effects on the overall human capital of the country. An estimated 481 million USD or 2.66% of GDP is lost due to malnutrition annually.[3] Therefore, prioritising efforts in the most affected provinces can make a difference in improving the nutritional situation of the country with positive effects on health outcomes and the national economy.

2 Research Approach

This qualitative assessment investigates the determinants of malnutrition in four selected provinces assisted by the EU/UNICEF in Lao PDR: Phongsaly, Houaphanh, Bokeo and Saravane Provinces.

The lessons presented here are based on a literature review and insights from 140 key informant interviews and focus group discussions that took place from December 2021 to February 2022. The participants in these interviews and discussions included pregnant and lactating women/caretakers and adolescents, village authorities and village health volunteers, local and public health officers, and district- and provincial-level officials from the government.

1 Ministry of Health, 2016a
2 Ibid.
3 NIPN, 2021.

3 Key Findings

Factors hindering the delivery of nutrition services

The literature review and interviews found that Lao PDR faces several challenges in delivering nutrition services at the community level. These include but are not limited to:

- **Inadequate health staff's competency in providing nutrition services at all levels:** Health staff have limited capacity to provide basic primary health care. A workforce survey of 120 health centres showed that 44% of health centre staff had never received in-service training in areas such as ANC and PNC, essential newborn care, nutrition, and growth monitoring.[4] Health centre staff lack appropriate nutrition training and have minimal nutrition knowledge. For example, health workers would give the same advice if a child was mild, moderately, or severely malnourished and tend not to recognise stunted children, especially in areas where stunting is common.[5,6]

  The challenge of the limited capacity of the health workforce could be attributed to the fact that the Lao education system does not train nutrition cadres or professionals. Also, the pre-service training curriculum of health professionals offers little scope for nutrition courses.[7] Therefore, students who want to study nutrition must study in a neighbouring country such as Thailand, which has comprehensive nutrition education programmes.
- **Limited access to remote rural areas without road access – some only seasonal accessibility.** Many villages are located remotely with limited road access, and some villages are not accessible during the rainy season. Due to the location of some villages, health centre staff cannot carry out MCH outreach services, even though these should be carried out quarterly. In some cases, health centre staff cannot conduct growth monitoring during outreach, as they cannot carry equipment such as weighing scales, height boards, medicines, and supplies to the communities on their motorbikes. This affects the growth monitoring of infants and children.[8]
- **Language barriers - health staff do not speak the local dialect.** In some communities, health staff cannot speak the local dialect, which hampers effective communication between them and community members. An example from the Lao PDR Health Center Workforce Survey 2016 showed that 85% of health centre workers spoke the most common language in the community (typically Lao), and only 31% spoke the second most common language.[9]
- **Insufficient nutrition education and awareness-raising activities in communities**. A limitation of providing nutrition education in the villages is that health staff lacked updated behavioural change communication materials for their sessions. Health centre staff reported that they do not offer nutrition education or counselling during outreach, as they have nothing to attract villagers' attention such as posters, brochures, flipcharts, or other communication materials and raise awareness on nutrition and food intake.[10,11]

[4] World Bank, 2016b
[5] Ibid.
[6] World Bank, 2016a
[7] NIPN, 2020
[8] World Bank, 2016a
[9] World Bank, 2016b
[10] World Bank, 2016a
[11] NIPN, 2020

Factors hindering demand for nutrition services

The assessment identified the following factors hindering the demand for nutrition services in communities include but are not limited to:

- **Limited education and lack of nutrition knowledge in the communities.** Some women do not seek nutrition advice and counselling due to little poor health-seeking behaviour. This is partly attributable to personal preferences, social norms, and practices. For example, some women in the communities do not attend ANC or give birth at a clinic if they do not experience any discomfort during pregnancy.
- **Ethno-linguistic barriers – some communities do not understand the Lao language.** While non-Lao-Tai ethnic groups in rural areas generally show a higher burden of child stunting, linguistic barriers still prevent them from benefiting fully from nutrition services. Non-Lao-Tai ethnic groups often do not receive adequate information and care from health and nutrition education/counselling due to linguistic barriers. Most health centre staff are of Lao-Tai origin and often do not speak other ethnic languages.[12]
- **The practice of food taboos and food restrictions during and after pregnancy.** Due to traditional beliefs, women are commonly limited to a particular diet during and after pregnancy. As a result, some women are not allowed to eat nutritious foods during and soon after birth, severely affecting their health and lactation. In addition, many such traditional practices impact child growth and development.

  Also, women in some ethnic groups do not give birth at a clinic due to the cultural belief that pregnancy and childbirth are natural events and do not require medical attention. In some communities, it is believed that preparing for delivery is a bad omen for the birth; others believe that colostrum is unhealthy for the newborn baby. In addition, mothers often report that they are encouraged to restrict food intake during pregnancy so they can have smaller babies for easier deliveries and that food restrictions often continue through the delivery and breastfeeding period. All these restrictions could affect the well-being of the mother and the child. [13]
- **Financial barriers.** For the rural poor, many of whom live in remote areas, distance to health facilities is a significant barrier, as some households cannot afford transportation to the hospital. For example, a study from Kham District in Xiengkhouang Province showed that 71.3% of women did not use the ANC facility because they lived far away and could not afford transportation.[14]

  Poor access to quality nutrition services is a persistent problem and affects women and poor households. Findings in LSIS 2 found that 97.3% of pregnant women in the wealthiest quintile have access to ANC, only 52% of pregnant women from the poorest quintile received ANC from a trained health professional, and over 36% of pregnant women living in rural areas without roads had not received any ANC services. In addition, 6% of pregnant women living in urban areas had no access to ANC compared to 19.5% of pregnant women living in rural areas with road access. 34% of pregnant women in rural households were assisted by a skilled birth attendant when giving birth, compared to the national average of 64%.[15]

  Financial and time constraints make women return to work soon after giving birth, impacting breastfeeding and complementary feeding. Often the child will be at home with grandparents or other family members and will not be exclusively breastfed for the first six months.[16]

[12] World Bank, 2016a

[13] World Bank, 2016a

[14] Yang Ye et al, 2010

[15] Lao Statistic Bureau, 2017

[16] World Food Programme, 2016

4 Recommendations

The following recommendations are made to address the determinants of malnutrition and factors hindering nutrition services delivery and demand at the community level:

- **Invest in human resources for health.** There is a great need to invest in human resources in the health sector to strengthen their skills and confidence in providing health and nutrition services. The capacity of trainers should be strengthened – both at central and sub-national levels – to roll out nutrition counselling training at all levels with regular supervision and monitoring of health staff and counselling skills. More staff should also be allocated to health centres to provide the best assistance and nutrition advice to all communities in the catchment area. Staff should also reflect on the ethnicity of the catchment area and be able to speak the local dialect, thereby reducing language barriers with ethnic minorities living in the area.
- **Increase financial resources for nutrition.** A sufficient budget must be provided for nutrition services, especially to meet the minimum requirement in remote rural areas. This way, health centre staff can reach and deliver nutrition services as required to communities far from the health centre. In addition, allocating a sufficient budget will make it possible for staff to undertake nutrition counselling, cooking demonstrations and social behavioural change activities in the communities.
- **Strengthen social behavioural change communication on nutrition.** There is the need to raise awareness of optimal nutrition through campaigns targeting mothers and other caretakers in the household directly with a focus on appropriate feeding practices for infants and young children and consumption of diverse, nutritious, and locally available foods. In addition, more emphasis should be put on awareness-raising campaigns specifically targeting adolescent girls to prevent early marriage and early pregnancy, as evidence shows that early pregnancy increases the risks of children being stunted.
- **Develop social behavioural change communication materials in multi-ethnic languages.** There is a need to develop and translate communication materials to local dialects. This will enhance communication and contribute to improved knowledge and understanding of nutrition, especially among ethnic communities who do not understand the Lao language.
- **Strengthen routine management information system (MIS).** A computerised and user-friendly routine monitoring system should be made available for the health centre staff to collect, analyse, and produce good-quality data and evidence regularly to track progress and support the requirements of the national health management information system (HMIS).
- **Strengthen the multi-sectoral approach in the implementation of nutrition activities.** Collaboration among the stakeholders involved in nutrition activities will lead to better results. Cross-sectoral collaboration should be strengthened, such as between nutrition and agriculture or nutrition and education and others.

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