Formative Research and Gender Analysis

USAID NURTURE

June 2017
USAID Nurture Project

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On behalf of the research team, I would like to extend sincere appreciation to the Government staff who made it possible to conduct the research.

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Dr. (Ms) Niramonh Chanlivong
June 2017
## Acronyms

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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>CHA</td>
<td>Clean Household Approach</td>
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<td>CLTS</td>
<td>Community-led Total Sanitation</td>
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<tr>
<td>CIEH</td>
<td>Center for Information and Education for Health</td>
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<tr>
<td>CMD</td>
<td>Common Mental Disorders</td>
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<tr>
<td>DHO</td>
<td>District Health Office</td>
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<td>DHHP</td>
<td>Department of Hygiene and Health Promotion</td>
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<tr>
<td>ERB</td>
<td>Ethical Review Board</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GMP</td>
<td>Growth Monitoring and Promotion</td>
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<td>ICYF</td>
<td>Infant and Young Child Feeding</td>
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<tr>
<td>IDI</td>
<td>In-depth Interview</td>
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<td>IGWG</td>
<td>Inter-Agency Gender Working Group</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MICYN</td>
<td>Maternal, Infant and Young Child Nutrition</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>ODF</td>
<td>Open Defecation Free</td>
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<td>SBCC</td>
<td>Social and Behavior Change Communication</td>
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<td>SC</td>
<td>Save the Children</td>
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<td>SCI</td>
<td>Save the Children International</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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Executive Summary

Introduction

USAID Nurture Project: The U.S. Agency for International Development “Nurture” (USAID Nurture) project, led by Save the Children (SC) is aimed at contributing to a reduction in young child stunting. Over a three-year period, USAID Nurture will be implemented in all villages of six districts of two provinces — Savannakhet and Khammouane — in the central region of Lao PDR. The approach focuses on: improving maternal, infant and young child nutrition (MIYCN) and water, sanitation and hygiene (WASH) behaviors in households with pregnant women and children under two years; increasing access and use of quality nutrition and health services and WASH facilities and products; and strengthening the enabling environment, through strengthening multi-sectoral coordination and planning, particularly at provincial and district levels. This integrated delivery model supports the Lao PDR Government in its implementation of the National Nutrition Strategy to 2025, and the National Plan of Action 2016-2020 and the forthcoming National SBCC Strategic Action Plan.

Study Purpose: To learn with communities, families and women about the barriers and facilitators to optimal adolescent nutrition, maternal nutrition, infant and young child feeding (IYCF), WASH, and health care seeking behaviors as well the feasibility of improving nutrition-enhancing behaviors. In addition, the study explored gender dynamics related to these nutrition and WASH behaviors and the potential effect of project activities. The findings will guide the project’s Social and Behavior Change Communication (SBCC) strategy.

Methodology: An experienced research team gathered data between November 28 and December 23, 2016. Provincial and district health officials accompanied the research team to oversee the arrangements in each village. Ministry of Health experts and USAID Nurture guided the study to ensure adherence within the framework of national policies and priorities. This study adhered to ethical standards under approval from the Lao PDR National Ethical Committee for Health Research and Save the Children’s Ethical Review Board (ERB).

Researchers conducted 60 in-depth interviews (IDI) and 12 focus group discussions (FGD) using semi-structured guides with in and out of school adolescent girls, pregnant women, mothers, other caregivers including fathers and grandmothers, and village leaders. In addition, researchers observed 12 home environments using structured observation checklists. The team purposively sampled four villages: lowland and midland areas and, in each area, near and far to a health center.

Key Findings and Implications

Adolescent Nutrition
Girls learn about nutrition, especially which food groups to eat, and WASH, primarily handwashing, from school, TV and through health outreach activities. However, they lack an in-depth understanding of nutrition or its implications on growing up. Girls and their families believe that menstruation signals adulthood and that girls are no longer growing or developing; girls sacrifice food for younger siblings “who are still growing”.

Girls eat the same food as their families, although girls in school may eat less as they skip meals, either because they are too rushed or not hungry in the mornings to eat breakfast and/or because they try to diet in order to be thin. Girls in school also get money once a week or more often to buy treats at school, such as noodle soup, desserts and fruit. As a result, girls in school may have less diverse diets than their families, and consume inadequate quantity to meet the needs of growing adolescents. Out of school girls, who follow families’ eating patterns, may have slightly more diverse
diets (except the dry season when this should be explored), but also eat an insufficient quantity of all types of food other than fruit and vegetables to meet their needs for continued growth.

Delaying pregnancy is key to improving maternal and infant nutritional outcomes, so the study also explored girls’ related expectations and opportunities around marriage and childbirth. Girls have goals for themselves, but only girls in school feel excited about their futures. They want to finish school, get a job and marry after age 18, often much later. Girls out of school have similar goals but are resigned to fate; some girls in midland areas intend to migrate to cities to earn income before marriage. All girls recognize that marriage will be more successful if both people are financially stable and know each other well before getting married.

Girls value school as a necessary step to reaching their dreams. Girls out of school, who cannot continue to high school, often marry soon after leaving school and children follow. Families do not usually oppose an early marriage because they and girls believe that once out of school marriage offers ‘protection’ from premarital pregnancy.

Program Implications and Considerations: Girls and their families would benefit from understanding that adolescents are still growing and developing, and need additional nutrient-dense food each day. Girls rely on their families to grow, collect and prepare food. Motivations to support family engagement in finding and allocating more food to girls include value of adolescent girls for contribution to family resources as well as excitement for future grandchildren. Girls in school also need encouragement and support from families to avoid skipping meals in order to eat an adequate amount of food each day, even if it is only carrying rice (which families have) to school to eat at mid-morning break.

Girls want peer group learning, with the periodic inclusion of parents. Topics for nutrition include food quantity and diversity to achieve adequate weight and diet quality. To further improve intake of foods, girls—as well as families and communities—need structured opportunities to challenge gender norms that underlie girls’ sacrifice of food for others, and desire to be thin to promote a healthy body image (especially girls in school).

To delay childbearing, strengthening the confidence and efficacy of girls just out of school and then at the time of marriage would help girls to remember and work to achieve their life goals, including preparing for communication with their husbands. New adolescent couples need greater access to family planning; although available in villages and known to girls, their stories suggest that once married they tend to follow what their husbands and parents say; and need preparation and support to have their voices heard. In the longer-term, girls would benefit from vocational training or business opportunities to support longer-term efforts to delay the age of marriage.

Maternal and Child Nutrition
Pregnant women and families report that pregnant women get special care and consideration including extra food, especially sour fruits to combat morning sickness, help with housework, and support to go for antenatal care. Families also reduce the pregnant woman’s workload, but in midland villages this is often only from field work in the last months of pregnancy. When the pregnant woman is a daughter-in-law living with the husband’s family, some family members resent her for extra work. As a result, most pregnant women try to do as much work as possible but still want their husbands to do more without always having to ask.

Men recognize changes in their wives when pregnant, including wanting to eat more and mood swings, and accept that women can scold them freely during this time. Most know the benefits of helping with heavy work and some ‘light’ work like carrying water and firewood, but some are reluctant to do so due to fear of what their friends say.
Many pregnant women are concerned that they cannot follow health worker recommendations to avoid food restrictions. These findings suggest that pregnant women could eat a nutrient-rich, diverse diet with available food source, at least most of the year. However, few are able to do so due to a widespread lack of understanding and support for pregnant women to gain adequate weight.

Many of the pregnant women report that they eat more, especially after the fifth month, compared to before pregnancy. They respond to their cravings and believe that the baby is asking for more food. Many prepare extra food for themselves, and sometimes get food from family members, including husbands who collect sour fruits and parents or brothers who buy noodle soup or meat from markets. For the most part, despite food restrictions which varied between villages, women report being able to find a sufficient variety of food, including fruit, vegetables and animal source protein, but do not get enough to satisfy hunger.

Lactating mothers are restricted from eating a variety of foods, including spices, in the first months after childbirth to protect children from getting a stomach ache. The types of food restricted and the length of time imposed varied by village, but generally restrictions were strictest until five months. Some restrictions, such as on spicy foods, continue throughout breastfeeding. Whether true or not, a child’s crying is often blamed on mothers not following food taboos.

Program Implications and Considerations: Health care workers’ recommendations to ignore food taboos are not feasible. However, most pregnant women say that they eat more food and more variety, and would agree to do so if a health worker advises this, but they do not differentiate between types of food. Women are already eating more sour fruit and boiled vegetables, rather than the additional protein and calorie-dense foods needed.

It is likely that pregnant women’s food needs could be met through local resources including rice, home gardens and what they can collect in the rivers and fields most of the year. There are times of the year, especially the dry and lean season, when fewer vegetables and fruits are available and it is more difficult to find frogs and fish. For these times of year, as well as other days (i.e., when going for ANC, which interferes with the daily collection of food) knowledge and skills to preserve and store nutritious food for pregnant women are needed.

The findings show that pregnant women and other caregivers trust health workers, and generally want to follow their advice. Focusing nutritional counseling during ANC visits to promote collecting and eating more – with specific, tailored recommendations – of what families already have, with greater family support, would improve pregnant women’s diets. As much as possible, since husbands accompany pregnant women to ANC, counseling with the couple is key. Ideally the mother or mother-in-law should be engaged as well because, especially for first-time pregnant women, she guides or even makes the decisions. Village leaders are respected and well positioned to encourage greater family support, and recognize efforts. Several people during interviews proudly noted times in the past when their village leader recognized achievements.

Currently there is no awareness that lactating mothers need additional calories each day. Again the calorie gap seems possible to meet through local resources, most of the year. As families trust health workers, during ANC and during outreach visits, health workers could add the recommendation to eat more family food, such as an extra meal each day.

Especially for first-time pregnant women and mothers, who live with extended family, additional family support with their workload is needed. Findings show that this will be more realistic in lowland villages compared to midland villages, but nevertheless, community engagement and
sanctioning for this is needed in all communities. Few families can make these changes without agreement from the whole community out of concern for what others will say. Simultaneously, greater father involvement is needed and desired by both pregnant and lactating women. Fathers also expressed great interest in being good fathers, and some say that they help already. Engaging fathers would enable families and communities to begin to shift the concept from ‘helping’ to jointly sharing household and childcare. As pregnancy is a unique time when women can ask for support from their husbands, this opens the door to additional negotiations.

**Infant and Young Child Care and Feeding**

Mothers and fathers want their children to grow up healthy and strong; some mothers watch their child’s growth and weigh with home scales (used for crabs) during the first months. However, few believe that they can do anything because a child’s growth is restricted by genetics and their situations. None understand the window of the first 1,000 days for life-long impact.

Mothers categorize child care as ‘easy’ and ‘difficult’ and feel that it is difficult until the child is about five months old. It gets increasingly easier as the child gets older; ease is linked to how much time and attention they give the child and how this affects being able to complete other work, as well as worry about illnesses. As children learn to walk, some mothers and fathers mentioned concerns about safety and hygiene in the village.

**Breastfeeding:** Most mothers and other caregivers know to begin early initiation of breastfeeding soon after delivery; mothers learn from health staff during ANC or outreach. Some mothers practice early initiation because they gave birth in a district hospital or because they felt breastmilk come in.

Most families, however, give water and rice – often Cerelac or generic rice powder (usually called ‘rice’) – until breastmilk comes in two to three days after birth. The mothers worry about not being able to breastfeed and try several strategies to get their milk to let down, but none mention letting the baby suckle. Fathers and grandmothers have strong beliefs that mothers need to recover from childbirth before breastfeeding the baby. A few noted that their family discards colostrum.

Knowledge about exclusive breastfeeding recommendations is also high, and generally positive among mothers and grandmothers. However, families give a breastmilk substitute and premasticated rice, along with breastmilk from early months. The desire to satisfy crying babies and women’s work demands drive early supplementation. Families believe that crying during the early months is due to hunger and that only rice satisfies hunger and makes the child fatter. This may be in part due to inadequate length of breastfeeds; mothers often have to breastfeed the child while doing many other household chores, resulting in less than adequate intake of breastmilk. In addition, mothers return to work outside the home several months after childbirth. During the time away the other caregiver, often the grandmother, needs to give something to the child. The selection of breastmilk substitutes is based on what is available and marketed in the village shop, whether brand name or generic, and what they see other families buy.

Social and gender norms limit mother’s options for changing workloads in order to exclusively breastfeed. Even mothers whose families would agree to let her spend more time breastfeeding, feel strong social pressure to work in the fields. Community perception of mothers who care for a child and do not go to the fields is that she is ‘lazy’. Possible strategies to sustain breastfeeding require family support. Mothers say that they can arrange to return home more frequently to breastfeed if the family agrees, between rice planting and harvesting seasons. During rice cultivation, some grandmothers may be willing to take the child to the field to be near the mother.

Mothers and fathers have mixed information on the recommended length of breastfeeding, but most mothers prefer to wean a child by 12 to 15 months so that they can work more easily around
the home and to stop all food restrictions and eat usual family food again. Mothers also stop breastfeeding if pregnant again when they believe the milk ‘sours’.

**Complementary Feeding:** By six months when complementary food is ideally introduced, children are already eating premasticated rice and bites of other food, such as banana and fish or meat when available, in addition to breastmilk. As a child gets closer to one year, and teeth come in, premastication stops and children increasingly take foods themselves. By the age of one year, many children feed themselves – mostly rice and finger foods – with assistance to prepare bites. Children begin to eat some family foods after this and by the age of two years are eating the full range of family foods with spices. At the same time, children are frequently given sweets and biscuits from one year or earlier, and some children also get milk (sweetened condensed or Lactasoy). As a result, children lack adequate diversity and quantity of food to meet their nutrient and energy needs. Few children get animal source foods needed for linear growth until after one year of age or vegetables until even later.

During and after illness, mothers say that they focus on continued breastfeeding and feeding; few know to give additional breastmilk, or foods for children over six months. Mothers describe actively feeding sick children.

Child feeding practices are driven by child-led feeding norms. Caregivers follow a child’s lead in deciding when and what to feed; whatever the family believes a child is asking for the family will give to the child. For example, infant cries are interpreted as hunger so families buy breastmilk substitutes. Toddlers who spit out food are seen to be full, so mothers stop feeding. Many mothers know how to effectively encourage children to eat more, but do this when the child is sick, which is a time when she can stay home and is freed from other tasks and can pay attention. A child who asks for sweets triggers a scramble to get money and buy what he wants. While the mother is expected to keep the child from crying, most families feel that it is family business. Child feeding practices are also driven by labor and time-constraints of mothers. Gender norms require mothers to do multiple tasks simultaneously; child feeding is only one of many priorities.

**Program Implications and Considerations:** Mothers and fathers want their children to grow up healthy and strong. They need confidence that their actions make a difference during the first 1,000 days as well as small, doable actions to feel that they could do something. Mothers and other caregivers seem to give the most attention to children in the first months when children are cute and especially vulnerable, or when sick. As the child grows and requires less attention care is perceived to get easier.

To facilitate early initiation of breastfeeding, agreement with the whole family is needed. After home births, the grandmother and other elders care for the baby while the mother recovers from the pain of childbirth and bathes and cleans herself; they usually give water and/or ‘rice’ when the infant cries before trying to suckle. The family should hear the pregnant woman express willingness to put the baby back on her breast as soon as possible during recovery, and agree to give the baby time to suckle before resorting to substitutes.

To achieve exclusive breastfeeding, families need support and recognition to redistribute mother’s work demands inside and outside of the home to give mothers both the time and permission to focus on breastfeeding. Longer breastfeeds, to empty both breasts, would give infants the full nutritional benefits of breastmilk and keep them from crying out of hunger, which triggers supplementation with ‘rice’. Mothers are willing to return home more frequently to breastfeed more and longer, if her family agrees, in times when they do not travel to rice fields. During rice cultivation, some grandmothers may be willing to take the child to the field to be near the mother.
Continued breastfeeding until two years would require both a reduced workload so that mothers have time to breastfeed, not only to pacify the child, as well as social support and sanctioning; mothers who breastfeed up to two years are seen as spoiling their child.

The role of village shopkeepers, who actively promote breastmilk substitutes as well as processed snack (junk) foods, should be considered during program design. If profitable, they could help to shift emphasis onto healthy snacks and other alternatives with program support with marketing and community dialogue and action.

Child-led feeding needs to be reduced in order to improve the quantity of food that children eat each day, and at each meal. While some level of responsiveness to infants and young children’s hunger cues are important, families take this to the extreme and do whatever they believe a child wants. This results in children eating not enough food, not enough of the right kinds of food especially until after one year of age, and too much processed foods with little to no nutrient-value. Parents also acknowledge that the practice teaches children to cry to get what they want. While families gain confidence and tools in their knowledge and skills as parents over the longer-term, positioning good child care and feeding practices as what the child wants could facilitate immediate changes. Some mothers already have strong skills and practices in active feeding; extending these practices beyond the immediate sick period into recovery would improve child feeding.

Findings also reveal that family support to reduce mother’s workloads would help to improve complementary feeding practices. Feeding is only one of many simultaneous responsibilities of mothers, but not the highest priority for her labor and energy. Some mothers would be willing to focus on child feeding if it were more fun, for example, together with friends or as a mini-competition with other mothers.

To improve consumption of animal source foods, necessary for children’s linear growth, further exploration on locally available foods that could be preserved and prepared for easy addition to children’s meals is needed. For example, powder made from crickets and other insects – building on experiences of the European Union -- could be used as a dip for sticky rice balls. Families also need to be engaged to identify the easiest ways to separate (without spices) and mash family foods for children from 6 months.

**Health Service Care-Seeking**

Although ANC is valued, the recommended timing of the first ANC visit and frequency of ANC is not well known or accepted. In this study, most pregnant women and their families wait to start ANC until after the baby moves. This is when they believe the child becomes human, and needs to be checked. Women expect their husbands to take them for ANC and associate this with care and love; many say they would not go if their husbands could not take them, but would try to persuade husbands through parents or parents-in-law.

Safe delivery is a major concern for families, who conduct protection ceremonies and enforce food and napping restrictions on the pregnant woman for a safe delivery. Most families seek facility-based delivery only for emergencies. A combination of distance, costs and preference for culturally acceptable and family-accompanied childbirth results in seeking care at district hospitals only after prolonged labor and/or ‘severe’ pain. Although fathers take credit for making the decision to travel to the hospital, mothers’ expressed fear of the hospital and shyness to deliver there, coupled with a preference for family support may play a role in delaying action.

Some families, especially those in villages far from a health center, talk with health worker during immunization outreach. All mothers and grandmothers want more frequent visits and advance notice to be sure someone in the family can bring the child to see the health worker.
Infants and young children who are sick with diarrhea, fever and colds are usually cared for at home before families seek treatment. Mothers often stay home to care for sick infants, and describe good child feeding practices during illness including continued breastmilk and food. When a child is very sick or will not eat, the family buys medicine from the district hospital, including vitamins or micronutrient powder. If the child does not recover, they will take the child to the district hospital or Health Center. Fathers, along with a few mothers, say that families use a mixture of traditional and modern medicine for treatment; spiritual healers (“traditional magic”) are sometimes their first line for treatment.

**Program Implications and Considerations:** To counter the belief that ANC is needed only after the baby moves around five months or later, or that women would not be accepted early in pregnancy, communication on the timing of the first ANC visit and the frequency of ANC visits is needed. Fathers-to-be must be reached with this communication as they make decisions about timing, often prompted by their own parents. The benefits of early ANC, including hearing the baby’s heartbeat and tailored information and activities especially for fathers-to-be, will help fathers overcome concerns about costs.

To encourage families to seek assisted delivery for all births, not only emergencies, fathers and parents /parents-in-law need to discuss and plan in advance how to manage extended family members. At the same time, pregnant women, their families and the whole community want to know about the improved quality of services and hear from families who had positive experiences with facility-based delivery. Community discussion and agreement that women can deliver in facilities will take some of the pressure off of families whose relatives want to help with the birth.

Given the central role of fathers and grandmothers in all care-seeking decisions, program activities should reach and engage them, in addition to pregnant women and mothers. Fathers and grandmothers trust and listen to village leaders and health workers. Thus, adding recommendations for these decision-makers into all contacts, or take-home pictorial recommendations, will support women when they want to seek care.

Treatment seeking for more serious illness may be delayed because of some families’ preferences to see the spiritual healer first, and/or buy vitamins from the market or district hospital. Feeding during illness for a sick child is generally good because mothers are permitted to stay home with the child.

**Water, Sanitation and Hygiene (WASH)**
Knowledge of key hygiene and sanitation recommendations is widespread. Some households boil water for drinking with roots from the forest when they have time and wood to boil, while others prefer to drink ‘raw’ untreated spring water which they say tastes and quenches thirst better. Households usually store their drinking water on a platform between the house and the kitchen in a clay jar, sometimes covered. Most use a plastic dipper or cup to get water, creating multiple opportunities for contamination with hands, even when water is treated. Two villages had received education and water filters from previous projects but no water filters were still functional.

It is common practice to rinse hands with water (and no soap) before and after eating meals using a bucket of water the mother brings inside the home. Sometimes people say that they also wash hands after defecating and when a child's hands are visibly dirty, but again not usually with soap. Due to cost and time considerations, households save soap for bathing. Mothers say it takes longer to wash a child’s hands with soap and would require changing where and how the family washes hands before meals.
Clean communities are a priority of local government, so families know the policies and recommendations well. In addition, mothers value clean homes but admit that they do not have the energy to clean the household in addition to their other ‘must do’ tasks and work. However, families see that other families allow their animals to roam freely, so also do not pen their own animals except at night.

**Program Implications and Considerations:** To achieve clean households for young children, other family members must take on responsibilities. Sharing tasks through family support would enable the family to treat drinking water – even if only for the mother and child 6-23 months – and to wash hands with soap before eating and feeding a child. Older siblings or other family members could be inspired to wash the child’s hands with soap through motivational and/or competition tools, fun shapes and colors of soap, and attractive reminders on the handwashing station. Over time, support for these shifts should also help families to move away from perceptions that others are ‘helping’ mothers with cleaning to see these as ‘family business’ where everyone has a role to play.

New or improved products will be useful in promoting hygiene behaviors. Handwashing stations with soap where family members wash their hands before eating and feeding a child would facilitate the use of soap, combined with promotional activities such as contests and games to make handwashing with soap fun and teaching moments. Dedicated places and utensils for treated drinking water, especially for children 6 to 24 months, may be useful to encourage giving young children only clean and safe water.

To ensure clean play areas for children, collective action around penning animals is needed. Community agreement and commitment on a local solution will serve to make this more realistic for families and as a core component of on-going Open Defecation Free (ODF) efforts. As this happens, families with children who can crawl or walk (children are typically not placed on the floor or ground until this stage of life) until they reach two years should decide, plan and recognize who will sweep areas where children play each day – not to leave it only to the mother – before the child goes outside.
Introduction

USAID Nurture Project
The U.S. Agency for International Development “Nurture” (USAID Nurture) project, led by Save the Children International (SCI) is aimed at contributing to a reduction in young child stunting. Over a three-year period, USAID Nurture will be implemented in all villages of six districts of two provinces — Savannakhet and Khammouane — in the central region of Lao PDR. The approach supported by this project focuses on: improving maternal, infant and young child nutrition (MIYCN) and water, sanitation and hygiene (WASH) behaviors in households with pregnant women and children under two years; increasing access to and use of quality nutrition and health services and WASH facilities and products; and strengthening the enabling environment, through human resource capacity building and strengthening multi-sectoral coordination and planning, particularly at provincial and district levels. Project efforts are underpinned by social and behavior change communication (SBCC), including addressing gender issues, and monitoring, learning and evaluation. The project works to build capacity of government at national, provincial, and district levels and non-governmental partners to ensure the ground is set for scale up within and beyond operational provinces.

The project provides interpersonal communication through house-to-house and peer group support, linkages with health services while improving the quality of health services, and a community mobilization approach for integrated nutrition and WASH that incorporates modified community-led total sanitation (CLTS). Communities appraise and analyze their own nutrition, water, sanitation and hygiene environment. This process spurs actions to address nutrition-related issues resulting from poor maternal nutrition and care, infant and young child feeding (IYCF) and care practices, inadequate water, sanitation and hygiene, including environmental enteropathy, diarrhea and other conditions that limit nutrient absorption. To ensure these are possible, the project leverages private sector relationships to facilitate supply of products needed for improved uptake of WASH practices.

This integrated delivery model supports the Lao PDR Government in its implementation of the National Nutrition Strategy to 2025, and the National Plan of Action 2016-2020 and the National SBCC Strategic Action Plan.

Nutrition in Laos
Nutritional Status of Women and Children: Despite significant economic growth, Lao PDR children remain some of the most undernourished in the region. Approximately one in three children are stunted nationally (36%), while one in four is underweight (25%), and one in ten are wasted (10%), according to the 2015 Lao Child Anthropometry Assessment Survey (LCAAS). In the project provinces
of Savannakhet and Khammouane, prevalence of malnutrition is similar: in 2015, 31% and 34% of children under five years was stunted respectively, 30% were underweight and 15% were wasted. Factors driving stunting in Laos are complex and multi-faceted. Stunting and poverty are related, with 61% of children in the poorest compared to 20% in the richest wealth quintile stunted. Low access, utilization and quality of health care services also contribute; rural populations without road access have the highest rates of stunting.

According to the 2011/2012 Lao Social Indicator Survey (LSIS), 15% of women are underweight and one-third are anemic, key contributing factors to the 15% of infants with a low birth weight. More than half of provinces have 55% prevalence of anemia among children under 5 years.

There are limited data on adolescent girls. Factors associated with nutritional status include age of marriage and pregnancy. In Laos, 37% of girls were married by the age of 18 years and 18% of adolescent girls had begun childbearing. Laos has one of the highest adolescent birth rates in the region–94 per 1,000 among 15-19 year olds, and even higher rates in rural areas of 111 per 1,000. Malnutrition in adolescent girls is also associated with inadequate nutrient intake (both macro and micronutrients), unequal intra-household food allocation, limited access to health services and childhood stunting.

**Infant and Young Child Feeding:** Immediate breastfeeding and exclusive breastfeeding practices are extremely low. Although less than half (39%) of children nationally get immediate breastfeeding, only 30% and 22% of children in Savannakhet and Khammouane are breastfed within the first hour after birth. Similarly, 40% of children nationally are exclusively breastfed compared to 17% and 13% of children in Savannakhet and Khammouane provinces. For children 6-23 months, minimum meal frequency is 43% nationally and 62% and 33% in Savannakhet and Khammouane provinces, respectively (LSIS, 2011/2012).

**Health Services:** Practices vary by province and district, with 37% of pregnant women nationally having received at least four antenatal care (ANC) checks, while 28% and 31% of pregnant women in Savannakhet and Khammouane received at least four visits. Rural women in areas without roads have less access to ANC (LSIS, 2011/2012).

**Water, Sanitation and Hygiene (WASH):** Young children living in households without improved water and sanitation have higher risk of diarrhea, underweight, and stunting (WHO Lao Country Report). Nationally 70% of households have access to clean drinking water sources compared to 48% and 57% of households in Savannakhet and Khammouane provinces (LSIS, 2011/2012).

Nationally 57% of households have access to an improved latrine while 39% and 40% of households have an improved latrine in Savannakhet and Khammouane provinces. Nineteen percent of households with young children nationally safely dispose of children’s stool. This same proportion do so in Savannakhet (19%); however, in Khammouane, it is only 10% of households.

**Formative Research Methodology**

**Purpose and Objectives**

This study aimed to learn with communities, families and women about the barriers and facilitators to optimal adolescent nutrition, maternal nutrition, IYCF, WASH, and health care seeking/use behaviors as well the feasibility of improving nutrition-enhancing behaviors. In addition, the study explored gender dynamics, including the roles and status of men and women, related to these nutrition, WASH and health care seeking norms and behaviors and how project activities could affect men and women. Specifically, the study sought to:
1. Garner an understanding of perceptions and practices of childcare, child growth and development, child illness and chronic malnutrition, as well as food, diet and well-being of adolescent girls.

2. Document parents’ and other caregivers’ aspirations and motivations to support healthy child growth, and adolescent girls’ aspirations for their lives, and explore levers for change including opportunities for support, perceptions of their roles, power and gender dynamics.

3. Gather information about gender roles and status of women and men, and girls and boys, in order to analyze the key dimensions of gender that can influence nutrition programming.

4. Observe and document the context for priority behaviors, including food access and management by season, calendars (schedules/timetables) and roles in the household, and the household setting (e.g., location of water supply).

5. Identify the behaviors feasible to improve, and the barriers and facilitators for these recommendations, with mothers and other caregivers (e.g., fathers, grandmothers, older children/youth), adolescent girls, and community members (influencers).

Research Team
Dr. Niramonh Chanlivong, Principal Investigator, led the core research team with four experienced field researchers, including two moderators and two note-takers, together with an experienced Mankong translator in Savannakhet Province. Provincial and district health officials accompanied the data collection team to oversee the arrangements in each village. Ministry of Health experts, Lisa Sherburne, Social Behavior Change Communication and Community Nutrition Advisor of Save the Children, Dr. Amy Weissman, USAID Nurture Chief of Project, and Thepphasone Chanthavong and Phonethip Vorachith, USAID Nurture Provincial Coordinators, guided the research design and implementation to ensure relevance and adherence within the framework of national policies and priorities.

Data Collection
Prior to data collection, the Principal Investigator translated the question guides into the Lao language and trained the research team in qualitative and projective methods. The team pretested the question guides in a remote village of Vientiane Capital and revised for the data collection. The research team conducted interviews, focus group discussions (FGD), and observations in four villages between November 28 and December 23, 2016.

The research team conducted interviews, focus group discussions (FGD), and observations in four villages between November 28 and December 23, 2016.

The team met with the Provincial Deputy Director of Health and team, and the District Director of Health prior to data collection. These meetings gave the research team an opportunity to discuss the objectives and plans and select villages.

In each village, prior to interviews, the team met the village leaders to make detailed plans. Individual interviews took place mainly in homes. The research team held FGDs in temples, village offices, homes or under a tree. The research team asked questions as a conversation, without reading from question guides. District health staff observed this new style and even checked the question guides and acknowledged that the researchers had covered all questions.

Researchers also observed the home environments of some participants. They visited the same homes up to three times to be able to observe cooking and child feeding.

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1 This report writes Mankong to reflect the way that the group pronounces their name, although most written text about the ethnic group spells the name as ‘Makong’.
Sample
Two main criteria guided site selection: lowland and midland areas and proximity to a health center. The project area encompasses six ethnic groups and languages, which can be loosely grouped as “lowland” and “midland”. The research team discussed village selection criteria, as well as the size of villages, with provincial/district authorities and health centers, to make the final selection.

The research team purposively sampled four villages:
- Two lowland villages: 1 village close (< 10km) and 1 far (>10km) from a health center;
- Two midland villages: 1 village close (< 10km) and 1 far (> 10km) from a health center.

The research team conducted 60 interviews and facilitated 12 FGD. Specifically, in each village the research team interviewed 4 pregnant women (16 total) split between first time and experienced pregnant women and 6 mothers (24 total) equally divided between first-time mothers of children under one year, experienced mothers of children under one year and experienced mothers of children between one and two years of age. The interview team also interviewed 4 adolescent girls in each village (16 total) divided between girls in school and girls out of school and conducted 1 FGD (4 total) with 6 to 8 girls in school per group. Interviewers talked with girls out of school with a close friend, in pairs. The plan changed from one-on-one to paired depth interviews after difficulty talking with the first girl out of school. Finally, in each village the research team facilitated two FGD with other caregivers of young children, one with grandmothers and one with fathers (8 FGD total), with 6 to 8 people in each group. Researchers also interviewed the village leader in each village (4 total).

Table 1 Sample

<table>
<thead>
<tr>
<th>Instruments Applied</th>
<th>Lowland Ethic Groups</th>
<th>Midland Ethic Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Near to Health Center</td>
<td>Far from Health Center (&gt;10k)</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• First-time pregnant woman interview</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>• Experienced pregnant woman interview</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Mothers</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• First-time mother, Child 0-11 mos interview</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>• Experienced mother, Child 0-11 mos interview</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>• Experienced, Child 12-23 mos interview</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Adolescent Girls (15-19 yrs)</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Out of school Interviews</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>• In-school interviews</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>• In-school FGD</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Influencers</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other caregivers FGD</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>• Fathers FGD</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>• Village Headmen interview</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

2 Friendship pairs can be interviewed in a paired depth interview when respondents are likely to be more open and articulate in the presence of a friend. https://www.aqr.org.uk/glossary/paired-depth-interview
**Ethical Considerations**
This study adhered to ethical standards under approval from the Lao PDR National Ethical Committee for Health Research and Save the Children’s Ethical Review Board (ERB).

Efforts were continually made to protect individual autonomy, minimize harm and maximize benefits, and equitably distribute risks and benefits by using procedures consistent with sound research designs that take these issues into consideration. The study ensured voluntarily consent prior to participation. Researchers read the consent form aloud and requested a signature or thumbprint to show consent. For adolescent girls under the age of 18 years, consent was secured from the girl as well as her parent (or guardian in the school setting).

Researchers informed potential participants that their and other communities would benefit from their participation because the information gained from this study would allow for informed decision-making in project design. At the end of the interview or FGD, participants also received a t-shirt as an in-kind recognition of involvement. The project provided refreshments during the interviews and FGDs.

**Limitations**
Given the scope and depth of inquiry on nutrition and WASH, the study could sample from only four villages. Local authorities and the research team carefully selected the villages to be representative of villages near and far from Health Centers and from lowland and midland areas. However, these may not fully represent all types of communities in the project area.

As a qualitative study, it was not possible to conduct extensive food recalls using validated recall instruments. Therefore, the findings from this report are presented as girls and women’s perceptions and preferences.

**Formative Research Findings**

**Description of Participants and Villages**

*Pregnant Women*: Pregnant women who participated in the in-depth interviews included eight first-time pregnant women and eight experienced pregnant women, who have other children. Interviewers talked to an equal number of pregnant women from lowland and midland villages and from villages near to a health center and far from a health center. Findings are presented in combination of all pregnant women, except when differences emerged based on location, proximity to a Health Center and/or experience with pregnancy.

The pregnant women interviewed ranged from 15 years (one of the eight first time pregnant women was 15 and three were 16 years old) to 36 years. Most had a few years of secondary school, but four women had no education and one completed high school. All are farmers and their husbands are also farmers, except two women whose husbands are soldiers. Most say that their husbands are a couple of years older except for one whose husband is three years younger.

Living situations differed by experience in pregnancy. First-time pregnant women live with extended family; lowland first-time pregnant women live with her family while midland first-time pregnant women live with their husband’s family. Some experienced pregnant women live with their husband and children only.

*Mothers*: Mothers who participated in in-depth interviews, and who permitted observation of their home compounds, included eight first-time mothers with children under one year, eight mothers
with more than one child, including a child under one year, and eight mothers with a child between one and two years. Interviewers talked to an equal number of mothers from lowland and midland villages and from villages near to a health center and far from a health center and mothers with girls and boys as the youngest child. Findings are presented in combination of all mothers, except when differences emerged based on location, proximity to a Health Center, the age of child and/or whether or not she is a first-time mother.

Most of the mothers who participated are in their 20’s, ranging from 22 years to 29 years. One first-time mother in a midland village says that she is 40 (but interviewers observed that she may not know her age), and a mother of an older child in a lowland village who said she is 40. One third of the mothers has no education while half completed some primary school and few completed some secondary school. All but two of the mothers are farmers and say that their husbands are also farmers. One mother in a lowland village is a merchant and the husband of another mother in the same village is a teacher.

Except first-time mothers, mothers have between two and five other children. Similar to pregnant women, living situations differed between first-time and experienced mothers. First-time mothers live with extended family while some mothers with multiple children live with their husband and children only.

Other Caregivers: Fathers who participated in FGD are farmers who ranged between 21 and 36 years old. Most had some primary school and some went to secondary school. All had children under the age of 2 years. Grandmothers were generally in their 40s and 50s, although participants ranged between 35 and 80 years. All of the grandmothers say that they and/or their families are farmers and they have little to no education.

Village Leaders: The four village leaders were men in their 50s and 60s. One village leader in a midland village is a different ethnicity than the majority of the village; he is of Mankong Ethnicity while most of the community is Katang. As fathers and grandfathers themselves, they expressed interest in children’s growth and nutrition for their own family as well as for their community.

Adolescent Girls: All but one of the girls in school who participated is 15 years old and lives in the village with their parents and siblings; some also live with grandparents. One girl is 18 years and lives in town with her aunt to attend upper high school.

The girls out of school who participated in interviews ranged from 15 to 19 years. All but one (16 years) is unmarried. All stay with their parents (including the married girl, as is customary in lowland villages) and help with farming. They left school in late primary or lower high school due to the distance to upper high school and the associated costs.

<table>
<thead>
<tr>
<th>Table 2 Sample Village Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Households</strong></td>
</tr>
<tr>
<td>Lowland, close to HC</td>
</tr>
<tr>
<td>Lowland, far from HC</td>
</tr>
<tr>
<td>Midland, close to HC</td>
</tr>
<tr>
<td>Midland, far from HC</td>
</tr>
</tbody>
</table>

The two lowland villages are primarily Lao while the two midland villages have Katang and Mankong ethnic groups. The numbers of households in each village ranges from 66 to 186, and populations between 321 and 1,000 people.
The villages close to health centers are located about 2km to 8km to the district town while the villages far from health centers are 10km to 14km to the nearest town. (Due to the condition of the unpaved roads, 10km took 45 minutes by car.) Families travel to health centers or towns by motorbike, boat or ‘iron buffalo’ (cart pulled by a hand tractor). During the rainy season, one village is accessible only by Iron buffalo and another is accessible only by boat. Many motorcycles had no headlights because the bulbs were spoiled due to the bad road; drivers used the torch from their phones to travel at night. All the villages have electricity.

One of the midland villages experiences high migration of adolescent girls and young women to Thailand. Girls leave for Thailand after they leave school, and return when pregnant or with a baby; some return to earn money for the family, leaving the baby with the parents-in-law. The girls in this village expect to work in Thailand if they cannot finish school.

**Observations of Village Environments:**

**Lowland Villages:** One village is 10km from the district center and one is 8km from the district center, on difficult roads. One of the villages has high toilet coverage. Researchers observed animal dung in and around household compounds in both villages. Most households keep cows and buffalo and other animals, such as pigs, goats and poultry next to or under their houses. Usually the animals sleep next to or under the house at night and roam during the day. Although there is a village well, people drink spring water from a spring that is a 15 minutes’ walk. Clay jars are used to store water.

**Midland Villages:** One of the midland villages is 8km from the district center. The other midland village comprises two smaller villages to form one official village. It is 2km from a health center and 11km from the district center on dirt roads, but most people say they travel to the district hospital if they need health care. As there are no paved roads, travel is difficult especially in the rainy season. Less than half of the households have toilets. Most houses keep animals next to the house; animal dung was observed in and around house compounds. Households drink water from uncovered jars. These midland villages have wet rice fields and also grow corn, tapioca, sweet potatoes, and cucumbers. One village has a reserve pond (resulting from holes created by bombs during the war) where they raise fish. As village property, they can take fish from the pond only for village events. One of the villages comprises two large groups of houses, about one kilometer apart from each other.

In one of the villages close to the border with Thailand, many young people travel to work in Thailand periodically or for longer-term. The village leader and other caregivers in this village mentioned high levels of migration, especially girls out of school, and girls themselves often spoke about it as part of their future plans to earn money. Some go before marriage while others go after marriage and/or having a child to send back money.

*Girls who cannot continue to high school have to stay home doing nothing so they go to Bangkok. They can earn 100-200,000 Kip to study later, build a house, buy a vehicle, and find a husband. But others come back with nothing. It depends upon fate.* Village Leader, Midland Village

**Food Availability:** Using calendars, Village Chiefs from the four villages shared food access.
Table 3 Food Calendar, reported by Village Leaders

<table>
<thead>
<tr>
<th>Food</th>
<th>Time Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bamboo shoots, mushrooms</td>
<td>All year, but less in Dec-May</td>
</tr>
<tr>
<td>Rattan sprouts</td>
<td>All year</td>
</tr>
<tr>
<td>Fruit (banana, papaya, tamarind, longan, coconut, mango)</td>
<td>Seasonal</td>
</tr>
<tr>
<td>Frogs (different types)</td>
<td>All year, but less in April-May</td>
</tr>
<tr>
<td>Small fish, crabs, snails, small shrimp, insects</td>
<td>All year, but less in April-May</td>
</tr>
<tr>
<td>Sweet potato, cucumber, garlic, lettuce, green onion</td>
<td>June-Dec; replant Feb-Mar</td>
</tr>
<tr>
<td>Corn</td>
<td>Plant in spring, harvest in Sept</td>
</tr>
</tbody>
</table>

Most households raise chickens and/or ducks, and some families also raise pigs, goats and cows. These are kept for selling, and are only slaughtered on special occasions.

Villages have informal shops where some dry goods (including oil, salt and MSG) and processed snack foods/sweets are sold along with noodles, and sometimes also eggs and dried meat skewers.

District markets have a variety of vegetables, fish and meat. Households eat meat from district markets 2 to 3 times per month after a household member earns money and visits the district town.

Other than processed foods, and dried meat skewers which they usually buy, households rarely consume preserved food. The exception is boiled bamboo shoots, which are common, yet have little nutritional value.

Adolescent Nutrition

The nutrition of adolescent girls is directly connected to the nutritional status of children in the first 1,000 days. Adolescents who give birth are more likely to be left nutritionally depleted than women who give birth at an older age. Evidence shows that adolescent girls cease linear growth during pregnancy, which increases their own risk during delivery and risk of poor perinatal outcomes. Pre-conceptual nutrition status is a determinant of fetal growth and level of risk for a preterm delivery, neonatal mortality and low birth weight. Targeting girls and women once they are pregnant is often too late to prevent poor outcomes, and to break the intergenerational cycle of malnutrition.
Recommendations to improve adolescent nutrition, related to the context in Lao PDR, include: achieve normal weight; improve diet quality; and ensure sufficient iron, iodine, vitamin A and folic acid intake. In addition, evidence suggests that delaying the age at first pregnancy allows girls to continue growth, leading to improved delivery and infant nutritional outcomes.

**Perceptions and Practices related to Adolescent Nutrition**

**Dietary Diversity:** Girls generally eat the same types of foods as their families which is fairly diverse most of the year, except the June and July dry and lean period: sticky rice and whatever the family collects that day, such as fish, snails, crabs and frogs. Some girls emphatically do not like to eat ‘yucky’ small frogs although their families often eat these. Families also eat parboiled vegetables and fruits each day. Except bamboo shoots which are available year-round, vegetables are available seasonally: green leafy vegetables like morning glory, yard long-beans, eggplants, pumpkins, corn and cabbage grown in home gardens and mushrooms, *phuk kha yaeng, phuk sa mek,* and *phuk ka don* gathered in forests. Families also pick fruits, sometimes every day, including bananas, papaya, mango, longan and sour fruits, such as tamarind, depending upon the season.

Once every few weeks the girls’ families may buy food, such as grilled chicken, pork or beef, and fried eggs. Girls in school get money to buy treats at school, such as noodle soup and nam warn (dessert) once or twice a week.

Girls describe breakfasts as sticky rice and some type of animal source food such as crabs, fish or whatever can be found. Girls in school carry rice with or without *jeow* (chili-based sauce) for lunch to eat at school. They eat dinner with their family that consists of sticky rice with sauce, soup with bamboo shoots or other vegetables, frogs, fish or other animal source foods, and parboiled vegetables.

Girls in lowland villages say that their mothers prepare meals, and their fathers collect food, while girls in midland villages note that both collecting and preparing food is the responsibility of their mothers or sisters-in-law. Only one girl in school sometimes helps her mother with cooking and one girl out of school helps her grandfather and brothers collect insects and crabs.

**Frequency and Quantity:** Girls in school say that they eat only two to three meals a day. Some girls in school skip breakfast in their rush to leave for school and/or their desire to leave available food for their family: “*I want my siblings to eat more because they’re still growing.*” Some also try to skip both breakfast and dinner to lose weight, but few practice this.

By contrast, most girls out of school eat three meals a day with their families. Their usual diet consists of several handfuls of sticky rice, and two to three bites of snails or fish (1/8 of a medium-sized tilapia, for example) and whatever vegetables were collected that day, such as five to six pieces of bamboo shoot and other parboiled vegetables. After meals, they eat fruit. Their family may buy eggs, grilled meats and other fruits (such as apples) from the market a few times a month.

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5 As described in the methodology section of this report, the study used qualitative methods to elicit experiences and insights from community members and participant groups themselves; it did not include quantitative food recall or food consumption analyses. However, due to the dearth of information on adolescent girls’ dietary practices, the self-reported practices from girls are presented. All findings should be taken and interpreted as such.
“Yesterday morning I had fried eggs with 1 handful of rice. At lunch I ate 4 or 5 bites of papaya salad. At dinner we ate fish soup with vegetables but I did not eat much.... There are times I feel hungry even after a meal but I did not do anything; sometimes I drink soft drinks.” Adolescent Girl Out of School, Lowland Village

All of the girls say that they do not each much food. Even girls in school who have breakfast eat ‘very little’ because they do not feel hungry in the morning. In contrast, girls out of school say that they eat more at breakfast than at other meals, before they go to work in the field. They are most concerned about feeling full, so eat bamboo and vegetables for this reason. They say these foods are widely available and 5 stalks of bamboo are better than a small bowl of snails to feel full longer, for example.

When asked if they could try to eat more food, most girls believe that would be difficult because they do not like to feel too full and there is no more food available, but some realize that they could eat more rice, fish and vegetables, which are available year-round, if they wanted to.

Girls feel well cared for by their parents and their extended families. This is especially evident during illness, when they connect care and good food with recovery from illness.

“My parents always have food cooked and at the ready for us when we are unwell... if they are too busy to prepare, there would always be sisters and grandparents to stay with us. They usually cook fish when we get sick, such as grilled fish and buy fruits from the market. If no one takes care of us we would feel that our parents do not love us, feel sad and get skinnier and weaker. But this rarely happens, most of the time mothers would take care of their kids and if they were really busy their older sister would take care of them instead.” Girl in School, Midland Village

Perceptions and Practices related to Growth and Development

Growing up: Girls in school learn about reproductive health through school as well as through friends and aunties or sisters. Nevertheless, all of the girls in school requested additional opportunities to learn more in depth and ask questions to experts especially about preventing pregnancy. Girls out of school learn about growing up from friends and aunties.

For all girls, menstruation signals that she has become an adult. This results in changes in how girls think of themselves as well as how they are expected to behave.

.... After menstruation starts, girls can marry and have children. Even if not married, if you sleep with your boyfriend, you could get pregnant too.... I was advised not to go and play or hang around at night because they [mother, elders] are afraid we will be fooled by boys or harmful spirits would hurt us from visitors from other villages. We should stay home and help with housework.” Adolescent Girl Out of School, Lowland Village

Girls in lowland villages mentioned more social support to navigate the changes, as well as admonishment to avoid going out at night and avoid being alone with boys. One girl remembered that her mother advised, “Now you are a fully grown young woman. You need to take care of yourself. Do not wander around. Do not go somewhere that is not good. If you go out with just you and a young man, then you could be raped and you could get pregnant.” Adolescent Girl In School, Lowland Village
Girls say they generally know how to manage menstruation, and that they buy and use pads during their periods.

“I got my period at age 13. At first I was a bit shocked and scared but I know that it is menstruation because I have seen other adults. That is when we know we are fully grown up. I did not tell anyone. When my mother found out she told me to get pads from the shop.” Adolescent Girl In School, Midland Village

**Aspirations:** Girls in school have high hopes for their future. They focus first on finishing school and getting a job; desired jobs range from a doctor to a government official to a singer. Then they hope to buy a house and motorcycle before getting married and having children.

“I want to be a doctor after finishing school. Then I will have my own family and own a pharmacy. To achieve my goal, I will save a lot of money for further education.” Adolescent Girl In School, Lowland Village

“I would like to be a teacher by the age of 20 and then have my own hair salon by 22. I want to buy a motorbike by the age of 25 and own a house by 30. I should finish high school or I will not have the skills to make money. I have to go and work in Thailand in order to buy the motorbike and build the house.” Adolescent Girl In School, Midland Village

Out of school girls wish they could have finished high school. With their current situation, most focus on how they could earn money to prepare to start a family. The girls hope to have a house and a motorbike or car, as well as a family in the future. One girl expressed interest in starting a business selling food in her village. The girls in midland villages expect to migrate to a city or Thailand to earn money to achieve their goals.

“I want a big house, a motorbike, lots of chickens and ducks so I can eat good food during Lao New Year, and a big rice field. I wish I could be a health staff and treat patients.” Adolescent Girl Out of School, Lowland Village
**School:** For all of the girls in school, staying in school is their first priority. They realize that most girls are not able to finish school, but hope that they themselves will find a way. Girls mentioned that grandparents and other elders have great influence on their parents regarding their schooling future. Girls believe that money is the primary barrier to girls continuing in school beyond lower secondary school. High school requires living in town, and the associated expenses. As a result, usually parents are the ones who decide when a girl leaves school, but some girls may choose to leave to help her family in the fields.

Out of school girls feel acute disappointment about having to leave school early; one girl cried when remembering. Although they recognize that families have no choice but to make that decision, they also spoke of other families who take on extra labor, raise animals or cut wood to send their children to high school. One girl expressed frustration that their community does not support girls or boys to continue in school through policy enforcement, suggesting that leaders should enforce the penalty of 500,000 Kip for any family who allows their child to leave school before year 4.

“I feel sorry [for myself] when I see other friends continue school. I want to go like them but now I cannot anymore… It is a pity I lost my future. Even if I wanted to go there is no opportunity, and if I go now I am too old and it is a shame.” Adolescent Girl Out of School, Lowland Village

“When I had to leave, I asked my parents one more time to make sure that they acknowledged that I truly wanted to stay in school. When they still said no then I really had no choice but to leave school.” Adolescent Girl Out of School, Midland Village

**Expectations for Marriage:** All of the girls had clear expectations for when they want to get married and have children. Girls in school say that they want to marry after school and become financially independent. Girls out of school also prefer to marry after they become financially self-sufficient.

Many believe that families prefer girls to wait until after age 18 or 20 to get married because they know couples may fight or break up if they marry too young, but that parents do not oppose a marriage out of fear that the girl would get pregnant before marriage. Girls say this would be ‘really difficult and a shame for the whole family.’ Grandmothers in a midland village also fear that girls would commit suicide if the family opposes the marriage. Village leaders confirmed that few families interfere with a child’s plans.

“The girl decides when to marry. Parents follow their children’s wishes. When people love each other, parents cannot do anything... But there are some families in this village who tell children to wait until 19 or 20 years before getting married in order to become self-sufficient first. In some cases, when the child did not listen, some separate the girl and send her to Thailand.” Village Leader, Midland Village

At the same time, however, girls acknowledge that it is common for girls to marry once they leave school because of social pressure and a lack of other opportunities.

“Villagers have bad views of those who are still single by 20, that they would never be able to find a husband.... That is why they marry early.” Adolescent Girl In School, Midland Village

A 16-year-old married girl shared her motivations to marry. Although she wanted to marry at age 25 to first enjoy and travel, she married just after leaving school “because I liked him and I was afraid that I would become an ‘old single’ if I did not agree... I told my parents after watching TV one night. My mother asked if was sure and then did not oppose.” Married Adolescent Girl, Lowland Village
Girls already have clear preferences for what they will look for in their future husbands, both appearance and characteristics. They say that marriage, at best, can provide additional income and support for the family, and give her someone to help take care of her and someone to grow old with. At worst, girls recognize that marrying the wrong man leads to fighting and stress raising children. In midland villages, girls see that even a good marriage means the end of her freedom.

“It would be good to have someone to help out at home and work in the field, and bring more income for the family. It is also good to have someone to take care of me when sick, and have a long-life friend when we get old. [But] marriage would be a headache if the husband is not a good person. I will have to do laundry for the husband and cannot go anywhere and whenever I would like to.”
Adolescent Girl Out of School, Midland Village

Out of school girls describe a good husband as well-off with good manners. Girls in midland villages also specify that they want a husband who does not drink too much or use drugs.

**Expectations for Children:** All of the girls want to delay children for several years after marriage. None wants children before the age of 19 or 20, and most want to wait until their mid-20s after becoming financially self-sufficient. Girls in midland villages added that they should wait until the marriage is stable and she knows that the husband will not leave. Like marriage, girls acknowledge that many girls have a baby earlier, usually soon after marriage. Some believe that it is because the parents or parents-in-law want a grandchild soon.

Girls understand that unprotected sex can result in pregnancy. Girls know about family planning methods and expect to consider using a method to delay their first child, if they do not feel economically and/or emotionally stable with the husband.

“We will take into consideration whether the family situation is stable in terms of income and the relationship with husband. If not, we will consult with those who take birth control pills in the village.”
Adolescent Girls In School, Midland Village

**Emotional Challenges:** Through discussion of stories, girls shared their own experiences and those of other girls. For girls in school, fear of being pulled out of school is often their first concern, while for girls out of school the pain of leaving school is still fresh. They all also noted that relationships can cause girls to be upset. Two girls also say that hearing their parents fight or feeling neglected by their parents causes them worry.

Girls feel better after talking with their friends—one girl was said to be comforted by a friend who suggested she get a pregnancy test from the pharmacy when worried about being pregnant—or having their parents comfort them; these experiences suggest ways to bolster girls’ social support networks at critical times.

“Girls this age are sad and worried when heartbroken. Some cry and do not eat. Her friends console and take her out look for another boyfriend. Also girls feel worried when a boyfriend has another girl, when parents scold them, and when they have arguments with a friend. But for me, especially I felt sad and disappointed not being able to continue studies [high school]. I was so upset when I had to leave school. I cried for 8 hours because I was afraid that friends will humiliate me.”
Adolescent Girl Out of School, Midland Village

Girls had heard of cases of suicide in their villages and nearby villages, among young men and young women. They believe that the suicides are driven by not feeling loved by family or boy/girlfriend. In one instance, a young man hung himself because he believed his parents loved his young brother.
more than him, having used all their money for the brother’s wedding. In one case, suicide was caused by shame related to not following gender norms.

“Some girls in this village have committed suicide because they were too depressed, did not talk to anyone about and felt trapped.” Adolescent Girl In School, Midland Village

“A married girl had a young baby and got pregnant again. She stayed home to raise the baby and her husband helped the housework. The villagers talked too much and called her ‘lazy’ and ‘let her husband work and do the housework’. Because she had ‘short-thinking’ she hung herself because of the villager’s gossip.” Reflecting on this situation, a girl said, “If it was me, I would also feel bad because of the gossip if I let my husband do all of the work.” Adolescent Girl Out of School, Lowland Village

Barriers and Enablers to Improved Adolescent Nutrition

To improve adolescent nutrition, it is critical to improve the girls’ health and diets to ensure catch-up growth during this critical period, as well as to delay childbirth.

Barriers to girls’ eating an adequate diet include the lack of understanding that girls experience another growth period during adolescence, that this growth period is critical to healthy delivery and children, and that this growth period is halted if a girl gets pregnant. Coupled with perceptions that menstruation signals adulthood, this situation means that adolescent girls are not eating enough to meet their growth needs. Findings show that some girls are even restricting their intake to sacrifice for siblings and/or to be attractive due to underlying social and gender norms about what it means to be a good girl and woman.

An equally strong barrier is the quantity of family food available at home. Attaining an adequate weight would require that girls eat enough nutrient-dense food, but this is limited by the amount of food that a family collects each day.

For both girls in and out of school, enablers to improving girls’ diets include raising awareness about the catch-up growth opportunity and benefits in adolescence, before getting pregnant and family support to do so. Girls depend upon their families to collect, grow and/or preserve enough food for them to eat adequate portions. Girls may also need family approval, even tacit, to eat more rice at each meal. Findings show that families value adolescents, including or even especially girls, for their work contributions to the family, which can be leveraged during programming.

Additionally, girls in school need tailored solutions for their situation related to skipping meals. Girls can bring food — even rice -- for breakfast, as well as for lunch, if they have to rush in the mornings. Eating more, and eating more diverse diets, can be framed to support their primary motivations which are to stay in school, and to look bright and fresh.

Girls hold positive attitudes toward delaying childbearing and believe that their family and communities also support waiting until after 18 years. Girls overwhelmingly want to wait until 19 years or older to have a child, mostly to become financially self-sufficient first. They also know that their bodies will be ready after that time. Some girls also prefer to be married for a few years to be able to trust their husbands before having a child with them.

The main barriers to delaying childbearing are related to early marriage, triggered by leaving school and social pressures to marry when they get a proposal. Families support marriage at any time as they are motivated to follow what children want but also to avoid premarital pregnancy. Once married, despite earlier wishes, girls tend to get pregnant within the year. The girls’ stories suggest that they lose hope for their future goals once married, and agree with their husbands and/or
parents-in-law according to cultural norms. It is also possible that the feelings of love and trust that come from a new relationship lessen the girls’ intentions to delay. In addition, this study did not explore the boys’ perspectives, who may not agree to delay having a child.

Findings suggest the need to engage young adolescent couples around the time of marriage in order to help them decide when they will have a child and how to reach their goals. While knowledge was high in all girls, out of school girls felt less confident in their ability to decide or advocate for their decisions. Building out of school girls’ confidence and belief in themselves will be critical, as soon as possible after they leave school – a major life change – as well as around the time of marriage. In the long-term, vocational training or other alternatives are needed because wider access to high school is not expected in the near future.

Maternal, Infant and Young Child Nutrition

Perceptions and Practices related to Nutrition in Pregnancy and Lactation

Feelings about Pregnancy: All of the pregnant women interviewed recognize pregnancy as a unique time in life that requires special care and attention, and customs related to different eating practices. Families receive the news of a pregnancy with joy. Each of the pregnant women say that their families are excited, and that they feel happy knowing they will have a new baby. But they often feel mixed emotions due to tiredness and concerns about childbirth and the additional responsibilities a new baby brings.

"[I feel] Very happy when my husband touches my tummy. My husband is even happier than me because he wants a baby... I feel scared and worried about many things. I am afraid of giving birth because it is the first time. People said it is very painful, and torturous when giving birth [but] it will be better after delivery.” First-time Pregnant Woman, Lowland Village, Near to a Health Center

Similarly, all of the fathers who participated recalled feeling happy and excited when they learned that their wives were pregnant. Lowland fathers love their wives more during this time and take special care of her, including ‘helping’ with housework and bringing her extra food. In all of the villages, some fathers also remembered feeling concerns about the health of their wives during pregnancy, and fears related to childbirth during late pregnancy. Three lowland fathers told of taking extra care of their wives when pregnant, especially when sick. One gives his wife a massage when she is not feeling well.

"Even though she wanted to go to the field with me I did not let her plant rice because she had a 'big tummy' and difficulty moving. ... Husbands carry water and firewood... a few people say that the wife is lazy [when they see us] but we don’t care, we still continue helping wives. Who would let his wife carry water? She may have a miscarriage.” Father, Midland Village

In some instances, however, taking special care means not being violent:

"I give her special care when she is pregnant. When she is angry I endure it, even though I want to kick her but do not do and I never argue with her... but when she is not pregnant sometimes I hit her during arguments.” Father, Lowland Village

To ensure an easy childbirth, a few participants explained that they access a mix of traditional and western medicine. Two fathers in a lowland village described a special ceremony led by spiritual healer for a wife when she has a big tummy. This entailed offering one boiled chicken, 1 bottle of alcohol and 50,000 Kip. They went on to explain that now many women go to see health staff in addition to or instead of this ceremony. Fathers in midland villages shared that they follow a
ceremony by a spiritual healer where he ties black and red strings around the woman’s wrist to prevent bad spirits to affect the mother or baby.

Fear of a difficult childbirth or death was one reason fathers reported seeking western medicine. In one case a lack of financial resources did not preclude doing so, though in other cases it did.

“When my wife had a ‘big tummy’ I was afraid that she would have a difficult childbirth and die because the baby would be breach. I have no money but I took my wife to the hospital anyway. I was happy because both my wife and baby were safe.” Father, Lowland Village

Experiences during Pregnancy: Other than one experienced pregnant women in a midland village, most pregnant women described difficulty with tiredness, morning sickness and food cravings, especially for sour fruits, in the first months (‘young tummy’). This is how some of the women recognized being pregnant.

Nearly all of the pregnant women recognized mood swings throughout pregnancy, and noted that it is the time in life when they are allowed to openly express frustration with their husbands.

“When I am tired and worried without reason. Sometimes I feel a bit sad and down but do not know why. I get angry at my husband or other people even when they did not do anything wrong. But still I feel happy knowing that I am pregnant. I enjoy talking to friends and feel good when eating with my husband and family.” First-time Pregnant Woman, Midland Village, Near a Health Center

All of the fathers recognized changes in their wife during pregnancy, in addition to eating more, especially difficulty moving around in late pregnancy and mood changes throughout pregnancy. Fathers spoke in depth about their wives getting “angry easily without any reason” or because of “small things like having no food at home or not doing what she told me to do”. In contrast, all of the fathers noticed that their wives feel happy when husbands earn money, collect food or do housework when she asks.

“Wives have good moods when we husbands help with household and childcare, go and look for food, look for income, water vegetables, and feed the pigs and chickens. And when we don’t go out and hang around...When I hang around and do not help with housework then she was in a bad mood. I don’t blame her because I do the bad things by myself. But I cannot really control myself.” Father, Midland Village

Fathers in midland villages shared that it is usual for men to seek out the company of other women by late pregnancy.

“Not us, but some people, when their wife has a really big tummy, the husband is concerned about sleeping with her [no sex]. When they have money or when the wife is in a good mood, they will flirt with girls, but they always prevent with a ‘helmet’ [condom]. When they go out they tell their wives the are ‘playing with friends.’” Father, Midland Village

Family Support: All of the pregnant women feel that they get some support from family members. The level of support, and when it starts in pregnancy differed between lowland and midland villages. In lowland villages, where first-time pregnant women and some others live with the woman’s family, women talked about resting when tired (although never napping) and some sharing of household tasks from the start of pregnancy. By contrast, in midland villages, where all women live with or near to their husband’s family, their workload does not change until the last month(s) of pregnancy.
when their husband assumes some responsibility. Typically, he will help carry water, get firewood, cook, take care of the baby and find food for his wife.

Fathers in all villages reassign work for pregnant women, but in midland villages this begins late in pregnancy.

“When the wife is up to seven months pregnant she still works in the field as usual. After seven months we do not let our wives go out. We let her do ‘light work’ such as housework like cooking, washing dishes, and feeding animals.” Father, Midland Village

Fathers in midland villages where couples usually live with or near his family raised challenges with family reactions to allowing pregnant women to do less housework. One midland father explained that others would praise sisters or mothers-in-law who do housework instead of pregnant women, but the sisters and mothers-in-law themselves would be unhappy and consider the woman lazy. He further explained that in these cases, husbands do the work instead because they love their wives. Fathers in lowland villages also take on more of the housework during pregnancy, and believe it is normal and expected, but only during pregnancy.

“People would say that the man [who helps with housework] is a good husband, he loves his wife and his children”. Husbands even wash clothes for wives when they have a new baby. Family members help and do housework when women are pregnant. It is normal. But when a woman is not pregnant this cannot happen. People would say that this family is a maid for the daughter or daughter in law [the family serves her].” Father, Lowland Village

Perceptions and Norms related to Diet during Pregnancy: All of the pregnant women interviewed expressed concern about what they eat and how much they eat at different times of pregnancy, loosely divided between the first trimester (‘young tummy’), when the baby moves, and the last months (‘old tummy’). Women shared food restrictions as well as norms for pregnant women’s eating practices.

Food Restrictions: Pregnant women in lowland villages describe food restrictions related to certain seeds, coffee, gecko, chicken eggs, and cow placenta. Pregnant women in midland villages explain that food restrictions are focused on not eating chicken and chicken eggs. They also mention alcohol, but it varies between restrictions and recommendations.

“My mother and relatives said one bottle of beer per month makes delivery easier, but I don’t drink it.” First-time Pregnant Woman, Lowland Village, Near to a Health Center

“I want to drink but people don’t give it to me. They said I cannot drink it.” Experienced Pregnant Woman, Lowland Village, Far from a Health Center

Rules for Pregnant Women: Pregnant women in lowland villages describe several guiding rules or norms for eating during pregnancy. They say it is important for pregnant women to eat quickly, finishing the meal first, before other family members, and sit in one place while eating. Also, pregnant women must eat from a bowl or plate; pregnant women are prohibited from eating directly from the mortar or pots. This is related to the round shape, which can be likened to a womb. Eating directly from these pots would mean that the baby would want to stay in the womb and not come out during delivery.

Pregnant women, mothers and grandmothers in lowland areas all mentioned the prohibition about napping during pregnancy.
“People say that walking a lot makes easy delivery and napping makes difficult delivery. Parents say that if you sleep a lot then the baby will come out through your mouth [difficult delivery].” First-time Pregnant Woman, Lowland Village, Near a Health Center

All fathers observed that pregnant women want to eat more food and most say that they go and look for food for their wives when pregnant.

“They are always hungry because they do not have enough food.... “If we want pregnant women to eat more fish or meat we have to go out more and find food, raise ducks and chicken, or make a big pond to raise fish. We cannot buy food from the market because we have no money.... “We let pregnant women go [to wedding parties] so they get to eat meat”. Father, Midland Village

Eating Practices: Many of the pregnant women believe that they eat more, especially after the fifth month, compared to before pregnancy. They respond to their cravings and believe that the baby is asking for more food. Many prepare extra food for themselves, and sometimes—especially pregnant women in lowland villages—get food from family members, including husbands who collect sour fruits and parents or brothers who buy noodle soup or meat from markets when they travel into town. For the most part, women report being able to find a variety of food, including fruits, vegetables and protein, and enough food, though sometimes their cravings cannot be satisfied.

“When I have food cravings, mostly my husband or my father go and look for [sour fruits for] me. If they cannot find them, I would cry. If we had money, I would like to eat other things such as bread, meat skewers, and noodle soup. If I could, I would eat 2-3 bowls a day. But I can only eat 1 bowl on certain occasions [when my brother brings it].” First-time Pregnant Woman, Lowland Village, Far from a Health Center

Diet during Lactation: No mother, father or grandmother mentioned giving extra or special foods for lactating mothers. Conversely, everyone interviewed listed food restrictions during lactation. Restrictions varied by village and the length of time imposed, but generally restrictions were strictest until the baby is five months. Some restrictions, such as on spicy foods, continue throughout lactation. Restrictions are intended to reduce the risk of illness in the child who could be affected by the mother’s breastmilk. Fathers usually blamed infant’s illnesses on mothers not adhering to food restrictions.

“When newborns are sick we buy medicine or "fire vaan" to apply on the tummy. This happens every second or third day, every time the mother eats something wrong like soup with khaobeua [powder from soaked raw sticky rice].” Father, Lowland Village

Barriers and Enablers to Improved Maternal Care and Nutrition

Although most pregnant women are concerned that they cannot follow health worker recommendations to avoid food restrictions, the findings suggest that women could nonetheless eat a nutrient-rich, diverse diet. Food restrictions are not as big a barrier to a healthy diet compared to the lack of understanding and support to consume enough calorie-dense foods in order to gain adequate weight during pregnancy as well as the continued workload of most pregnant women throughout pregnancy.

Most pregnant women say that they eat more food, and would agree to do so if a health worker advises this, but they do not differentiate between types of food. Women are already eating more sour fruits and boiled vegetables, rather than the additional protein and calorie-dense foods needed. While many pregnant women recognize the need for diet diversity, there is no understanding related to this need.
Based on these findings, it is likely that pregnant women’s food needs could be met through local resources including rice, their gardens and the animal source proteins they can collect in the rivers and fields including fish, frogs and snails, among others. However, when thinking about good food, women and others interviewed focused on meats, which are unaffordable to these families except occasionally.

There are times of the year, especially the dry and lean season, when fewer vegetables and fruits are available and it is more difficult to find frogs and fish. For these times of year, as well as other days (i.e., when going for ANC) knowledge and skills to preserve and store nutritious food for pregnant women are needed.

The findings show that pregnant women and those who influence them trust and want to follow what health workers advise. Focusing nutritional counseling during ANC visits to promote collecting and eating more of what families already have, with support from the family, would improve pregnant women’s diets. As much as possible, since husbands accompany pregnant women to ANC, counseling with the couple is key. Ideally the mother or mother-in-law can be engaged as well because, especially for first-time pregnant women, she guides or even makes the decisions.

Currently there is no awareness that breastfeeding mothers need additional calories each day. Again the calorie gap is likely possible to meet through local resources. As families trust health workers, during ANC health workers could add the recommendation to eat more family food, such as an extra meal each day when breastfeeding.

In addition, there is no support for breastfeeding after the hotbed period and when mothers return to work. This lack of support results in mothers breastfeeding while doing multiple other tasks. This likely contributes to feeds that are too short to give the baby full nutritional benefits from breastmilk, as noted in the breastfeeding section of this report. Most mothers could not make changes in their eating practices or their household responsibilities to sit down and give attention to breastfeeding without full family and community agreement and support.

Especially for first-time pregnant women and mothers, who live with extended family, additional family support is needed and theoretically possible during pregnancy and lactation to take over some of the work usually assigned to the women. Findings show that this will be more ‘doable’ in lowland villages compared to midland villages, but nevertheless, community engagement and sanctioning for this is needed in all communities. Few families can make these changes without agreement from the whole community out of concern for what others will say.

Simultaneously, greater father involvement is needed and desired by both pregnant and lactating women. Fathers expressed great interest in being good fathers, and some say that they help already. Engaging fathers as men, addressing their own interests and needs, would enable families and communities to begin to shift the concept from ‘helping’ to jointly sharing household and childcare. As pregnancy is a unique time when women can ask things from their husbands and express frustrations, this opens the door to additional negotiations.
Infant and Young Child Care and Feeding

Parenting Expectations and Experiences

Aspirations for Children: Fewer than half of the mothers interviewed could articulate what they would like for their children in the future. Those who did focused on the child being healthy and growing up healthy and strong.

In contrast, fathers were able to speak in depth about their hopes for their children’s futures. Most of the fathers want children, both daughters and sons, to get an education and a good job. Some connected this with support for their parents in old age. In midland villages, many fathers also added that they want their sons to avoid risks, such as drugs.

“I want my daughter to study as high as possible because girls are more vulnerable than boys. … actually I want both my daughters and sons to study as high as possible.” Father, Lowland Village

However, several fathers in one lowland village raised concerns about sending daughters away to complete high school due to potential risks, such as unintended pregnancy. They also considered their son’s education more important than that of their daughters. One father, however, felt that his son needs only a basic education because he should work with him in the rice fields.

Fathers envisioned what type of father they want to be, and how they want their children to think and talk about them in the future. Most fathers hope that their children will think about them as a good man who cares for his family. All of the groups brought up the issue of beating children, clearly understanding that children do not want that, but there were differences about whether or not to continue.

“I want children to talk nicely about Father such as ‘my father is good man who does not drink alcohol or use drugs. He takes care of his children.’” Another father continued on to say, “Therefore, as fathers we should treat children well so when they grow up they will take care of us when we are old. They may say ‘my father used to beat me but he educated me to be a good person. So as good children we should take care of our parents.’ Children would praise us, hopefully.” Fathers, Lowland Village

Child Care and Concerns: Mothers and fathers shared how they feel about infants and young children as they grow, and concerns they have at different ages. Mothers often added that there is no difference in the love and care they give to daughters and sons; they feel the same connection to all of their children. Most mothers spoke about child care in terms of ‘easy’ and ‘difficult’ and felt that it is difficult until the child reaches five months, and gets easier as the child grows. Ease seems to be closely linked to how much time and attention the child requires and how this affects being able to complete other work, as well as worry about illnesses.

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<th>Stage (defined by Mothers)</th>
<th>Mother’s Perceptions of Childcare</th>
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<tbody>
<tr>
<td>Newborn</td>
<td>Most mothers spoke about newborns with fondness, but also full of concern.</td>
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<tr>
<td>4-5 months</td>
<td>Many mothers saw five months as a milestone in terms of interactions with the child. Many recall this as their favorite period.</td>
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“By four to five months old, he smiles, eats better, and my husband likes to carry him.” Experienced Mother, Lowland Village, Near a Health Center
The most enjoyable time was around four to five months because I could leave him with anyone. This was my happy time.” First-time Mother, Midland Village, Far from a Health Center

“By four to five months old, he smiles, eats better, and my husband likes to carry him.” Experienced Mother, Lowland Village, Near a Health Center

<table>
<thead>
<tr>
<th>6 months – 1 year</th>
<th>Mothers described care for children of this age as slightly easier because the child can self-feed some foods and other people can take over some of the care.</th>
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<tbody>
<tr>
<td>1 – 2 years</td>
<td>All of the mothers felt that once the child is about one years old care is much easier. The child does not need to be carried all the time at this age, and others can help with caregiving.</td>
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Most mothers talked about concerns related to keeping children healthy, and most mentioned cough and colds during the dry season. Mothers recognize a sick child when the child cries often and has low appetite. Some mothers distinguish between cries that signal hunger and illness.

A few mothers also mentioned concerns about safety and hygiene once the child begins moving around the village after the age of 1 year. “I worry about him eating dirt, playing with electric wires, and getting hit by cows and buffaloes, and diarrhea. Kids under two years do not wash their hands and feet, and big mother does not feed them enough. He cries for parents when we work in the field.” Experienced Mother, Lowland Village, Far from a Health Center

Mothers and Father’s Roles in Raising Children: Pregnant women described a mother’s role as love, care and feeding, even when her own needs are not met: “A good mother wants children to eat good food so she looks for food and feeds children even when she does not get to eat.” First-time Pregnant Woman, Midland Village, Near a Health Center

“I do not want my kids to be dirty and hear others say, ‘this woman’s kids are so dirty’. I want to hear, ‘this woman’s kids are beautiful. They have nice clothes.’” First-time Pregnant Woman, Lowland Village, Far from a Health Center

A father’s role was described as providing for children, and paying attention to needs, such as going out at night to get medicine when the baby is sick. Some pregnant women also mentioned that good fathers help with childcare, while mothers in all villages repeatedly requested more ‘help’ with household tasks from their husbands.

“I want my husband to help with cleaning the house when he does not work. If I tell him, he would do it but when I do not tell him, he does nothing. I do not dare to tell others in the family because I am the daughter-in-law. I wish he would help carry water. Sometimes he does but usually he does nothing at home! Only sleeps. I want him to help with whatever work he could do especially when the baby is crying.” First-time Mother, Midland Village, Far from a Health Center

Child Growth Perceptions

Mothers in all of the villages watch and track their child’s growth, especially in the early months. Mothers connected children’s linear growth with genetics and weight gain with food. Although nearly all expressed desire for their children to grow and develop well and fast, few mothers
believed that they could do anything about children’s growth, even weight gain, other than buy meat, which is beyond their resources. One mother placed the blame for a child’s lack of growth on the lack of time for feeding, while another mother attributed her child’s poor growth to the quality of her breastmilk, or heavy work when she was young and/or parasites.

"Being too small is because the child does not get enough food or maybe because the parents are small too. People do not do anything if children are too short. They think it is because parents are short. But if the child is too skinny, people will say it is because you do not give your child enough food so people will give more food to the child.” Experienced Mother, Midland Village, Near a Health Center

Fathers also expressed desire for children to grow healthy and fast, both in height and weight, but were not aware of a small window of opportunity and recounted taking action – to no avail – after realizing a child around five years is malnourished. All of the fathers attributed growth in young children to food and genetics. Some fathers likened the genetic link to children’s growth with a breed of animals.

“I want him [my son] to be tall but whatever I do he is still short. It is because of the breed. It is like the chicken, when you raise the short chicken you cannot expect that chicken to become the fighting cock.” Father, Midland Village

Perceptions and Practices related to Infant and Young Child Feeding

Early Initiation of Breastfeeding: All of the mothers interviewed were aware of recommendations to give breastmilk to their infant soon after delivery. Mothers get advice from health staff during ANC and/or vaccination outreach. Among the 24 mothers interviewed, four gave breastmilk soon after delivery. Two of these mothers gave birth in district hospitals: a first-time mother in a lowland village and a mother with two other children in a midland village. The other two mothers felt their breastmilk came in so they could ‘follow doctors’ advice’. Not all women who delivered in a hospital initiated early breastfeeding.

“For the first child my breastmilk did not come in so we gave water instead, and after one day we gave rice and water. When this baby was born, my breastmilk came in so when the baby wanted I let her suckle. The doctor in the Health Center told us about exclusive breastfeeding.” Experienced Mother, Midland Village, Far from a Health Center

Most mothers, however, gave water and rice—often Cerelac or generic rice powder—until their breastmilk came two to three days later. These mothers described concerns about not being able to breastfeed and tried several strategies to get their milk to come in, including drinking hot water, showering with warm water, and massaging her breasts.

“My mother-in-law soaked a needle in a bowl of water then wet cotton wool and gave the baby drops of water to make the baby sharp. My breastmilk came the next day. Experienced Mother, Midland Village, Far from a Health Center

Fathers shared their family experiences with breastfeeding. Like mothers, they knew the recommendations for early initiation of breastfeeding, but most felt it is not possible because mothers need to recover from childbirth. Three believe that colostrum is not milk.
Exclusive Breastfeeding: All of the mothers interviewed have breastfed their child and know the recommendation to give only breastmilk until the child is six months old. However, none could achieve this. The usual pattern described was to give water and ‘rice’ in the first days after birth, and then taper off to only breastmilk while the mother stays home with the newborn. When the mother returns to work in the fields after two months (depending upon the season), the child again gets a breastmilk substitute and premasticated food, with breastmilk.

The desire to satisfy a crying baby and women’s work demands drive supplementation. Beliefs that breastmilk is not food may contribute to supplementation with rice or rice powder (including Cerelac or the generic version). Observation found that 1 bag of Cerelac was sold in the village at 15,000 Kip but generic bags were 3,000Kip. While the original package may note that it is for children over six months of age (in Thai), the bags do not contain writing. Families are highly motivated to stop a baby from crying and believe that crying during the early months is due to hunger. Consequently, nearly all of the mothers, fathers and grandmothers believe that they have no choice but to give ‘rice’ and that breastmilk does not make a baby feel full. Another driver of early supplementation is the perception that breastmilk is not food, but rice is food and children need food to grow.

“Exclusive breastfeeding... we cannot do. We are busy and want to go for work sometimes. The baby also wants to eat other things too. We are country people who do not have everything like city people.... I have never seen someone breastfeed only for 6 months.” Experienced Mother, Lowland Village, Far from a Health Center

Everyone interviewed had been advised to practice exclusive breastfeeding. Mothers, fathers and grandmothers all asserted that the doctor’s advice is not right because babies do not cry after they get rice. While mothers and grandmothers lamented that they could not follow exclusive breastfeeding, fathers wanted answers.

“Why does a child cry after breastfeeding? But after giving rice the child stops crying and sleeps well. Why? ... Most people want their babies to breastfeed only but have to give rice after delivery because the baby cries. There is not enough breastmilk.” Father, Lowland Village, Near a Health Center

Fathers shared an additional recourse that families will follow when a baby cries ‘a lot’. “If a baby cries a lot, then we have a ceremony. We take baby to the spirit healer to get a white string tied around the wrist every "Van Sin" (8th and 15th day of a full moon and a crescent moon)." Father, Lowland Village, Near a Health Center

A key barrier to exclusive breastfeeding is that women must return to the fields shortly after giving birth. One mother interviewed explained that she was able to remain home after delivery because her baby was born after the harvest. This allowed her to avoid giving her child rice until six months.

“I gave only breastmilk and water until six months and the baby did not cry. My three children were born after harvest, so it was easy just to breastfeed and give water but no rice. I stayed home with the baby and my husband went out to find food. I would go find food when the baby was sleeping and my husband stayed with the baby. I returned home quickly to breastfeed the baby.... My brother’s baby was born later than mine but they gave rice earlier so he is now my baby’s size. Some people said that my baby is thin, not fat as other children. But all of my children are tall, they said because of breastfeeding and I also think the same.” Experienced Mother, Midland Village, Near a Health Center

Continued Breastfeeding: Some of the mothers knew recommendations to continue breastfeeding a child until two years, while others believed that they should breastfeed until the child is one year. Many mothers wanted to stop breastfeeding just after the child is one year, potentially related to
her workload as well as preferences to eat without any food restrictions. Other reasons given for stopping at one year were that the mother may be pregnant again making the breastmilk “sour,” pressure from the husband or friends, a perceived lack of sufficient breastmilk, or because the husband or grandmother wants the child to eat more rice and get “fat.”

Fathers weighed in on stopping breastfeeding. Some fathers felt that it is good to continue to two years, but most followed what the mother or child wanted.

“Sometimes a child just stops breastfeeding but it depends upon the mother and the child. The mother may not have enough milk and there is nothing to help increase breastmilk so she must stop breastfeeding. To stop, the husband buys sweets or biscuits so the children will not cry and get used to not drinking breastmilk.” Father from Midland Village Far from a Health Center

**Diversity of Complementary Foods:** Children’s diets, as reported by mothers and observed during interviews, lack diversity. As children begin to eat family food diversity seems to increase. Children are given parts of the family meal from the age of one year and the full meal around the age of two years.

Mothers described patterns of introducing foods to children. Except one child who did not get rice until five months, most children are given premasticated sticky rice from the first days, and are gradually given other foods along with the rice and breastmilk. By the age of six months, most children get rice and small bites of other food to eat themselves, but no longer pre-chewed. However, two mothers specified that they continue to chew food for children past one year because of concerns of choking.

Few mothers with children under one year say that their children eat animal source foods regularly, and only one mentioned feeding the children vegetables. Usually the children eat sticky rice and other foods which they can hold and eat themselves such as fruits and packaged snacks. One mother sometimes gives shrimp if available, and another mother occasionally gives dried meat or fish and eggs that they can buy in the village.

“By one year the child will be able to eat by himself and eat adult food but without the spices. Now he eats more snacks than food and I give him fruits and vegetables, too.” First-time Mother, Midland Village, Near a Health Center

Around one year of age, most children self-feed, but still get help rolling sticky rice into small balls. Consequently, by one year, children’s diets become more diverse, but still not as diverse as the rest of the family. Due to spices in family food, children are given only some of the food that the whole family eats and some mothers noted several foods that they do not give children at all.
“By one month old, children eat premasticated rice and by two months they eat grilled meat and rice with a little bit salt. After six months there is no need to chew first anymore. By one year he can eat everything. For breakfast and dinner, I feed the child with some small crabs and at lunch he self-feed rice only. Sometimes he has fruit and biscuits because he can chew now. ...Normally we eat fish, frogs and shrimp but I will not give eggs to the child before she learns to walk because this could cause a stomachache.” First-time Mother, Lowland Village, Near a Health Center

**Frequency and Quantity of Complementary Feeding:** All of the mothers report that children eat three times a day. Mothers feed the child breakfast and dinner, and another person, usually the grandmother or an older sibling, gives the child lunch. When asked how much food the child eats at a meal, mothers expressed desire for children to eat enough, but do not track the quantity of food consumed or actively encourage children to eat more. No mother differentiated for the child’s age or growth needs in these discussions, but followed what they perceived as the child’s wants.

“I do not monitor how much the baby eats when self-feeding or eating with siblings. If I feed, I know the baby gets more food. For example, my baby can eat one handful of rice and two small frogs, and drink water and breastmilk.” Experienced Mother of a 22-month-old, Midland Village, Near a Health Center

“I never set the amount of food baby must finish. I want the baby to eat as much as he can. I want him to grow big. My baby feels full with just one handful of sticky rice. When he is full he spits out the food.” Experienced Mother, Lowland Village, Far from a Health Center

**Processed Foods:** Mothers and fathers say that they often give children sweets and ‘biscuits’ sold in the village shops. Although they frequently mention the household’s inability to afford foods from town markets, such as meat, families report spending 2 to 10,000 Kip a day ($0.25 to $1.25), or more, on these processed foods for young children.

Parents try to give the child whatever s/he wants and to stop the child from crying. Several mothers and fathers notice that when children eat many processed foods they have little interest in meals.

“Now she eats more biscuits than food.” First-time Mother of a 7-month-old, Midland Village, Near a Health Center

Researchers observed that shops in all villages carried a wide assortment of individually packaged, low-cost processed foods.

**Child-led Feeding:** Mothers, fathers and grandmothers alike explain what they do in relation to what the child requests or wants. All caregivers try to keep the child from crying or stop the crying. One mother went so far as to say that what she wants for her child is to not cry and the most important part of childcare is to ensure the baby does not cry.

Especially in the early months, families interpret a baby crying as hunger for food. The mother who was able to delay giving rice until five months (only breastmilk and water) could do so because her baby did not cry much, whereas the other mothers and fathers feel compelled to give rice powder or rice from early days because their child cried.
“My son stopped crying after drinking breastmilk but later he still cried. If we gave him rice to eat, then there was no more crying.” First-time Mother, Lowland Village, Far from a Health Center

Even adolescent girls, before having a child, expect to need to give anything a child wants to stop the child from crying.

“Babies cry and want sweets and then you go and buy sweets all of the time. Mothers or fathers must try to get what the child wants to stop crying.” Adolescent Girl Out of School, Lowland Village

**Sick Child Feeding Perceptions and Practices:** One mother says that her baby drinks extra breastmilk during illness and for few days after illness, but most mothers are not aware of the need to give children additional fluids and food during and after illness. Their concern was on getting children to eat or drink something at all.

“My baby drinks more breastmilk and eats less rice when she has diarrhea. I feed my child normally after being sick. I do not give more and for two or more days after illness she eats less and drinks more.” Experienced Mother, Midland Village, Near a Health Center

Many mothers describe active feeding practices for sick children and children with low appetite. They stay home from work to care for a sick child and use a variety of creative feeding techniques to get the child to continue to breastfeed and eat during illness, such as telling the child someone else will eat if s/he doesn’t, giving sweet drinks and snacks, providing supplements or medicine believed to stimulate appetite, or foods with different taste than usual.

**Barriers and Enablers to Improved Infant and Young Child Feeding**

**Breastfeeding:** Barriers to early initiation of breastfeeding include the length of time before the baby is returned to the mother after delivery, as well as beliefs about the first breastmilk and colostrum. Two of the three mothers interviewed who delivered the baby at the hospital practiced early initiation of breastfeeding. But after a home delivery, the grandmother and other relatives care for the newborn while the mother recovers through a series of traditional practices. Most felt that the mother is too sore and exhausted to let the baby suckle yet, and adamantly stated that there is no milk yet.

The primary barriers to exclusive breastfeeding are expected reactions to children’s crying and women’s workloads. Strong beliefs that crying is a sign of hunger and that breastmilk is not ‘food’ leads to early supplementation with rice in a variety of forms, including rice powder (Cerelac or the generic versions) and premasticated rice. One mother noted the influence of a shopkeeper who sold formula or rice powder to stop the crying. Once a mother returns to housework after the hotbed, she juggles breastfeeding with multiple other tasks. Soon after, when she returns to work in rice fields and/or foraging for daily food for the family, she has little opportunity to pay attention to breastfeeding. A few mothers noted that it is possible to return home to breastfeed when they forage for food, but not during the planting/harvesting season.

Consequently, length of feeds is often inadequate, sparking the cycle of a child crying after breastfeeding, getting rice and sleeping. This practice confirms families’ beliefs that exclusive breastfeeding is not possible. Nevertheless, many mothers and grandmothers expressed desire to practice exclusive breastfeeding and ‘follow the advice of health workers’, and are open to trying new practices if feasible within the reality of their lives.

Two mothers described symptoms of what could be a common mental disorder (CMD) and/or postpartum depression. Both of the mothers recalled that their anger toward the baby lessened by
around 4 months and entirely dissipated several months later. Although their experiences did not result in different infant feeding practices, as no mothers currently exclusively breastfeed, it is likely that these feelings affected other child care and attachment needs. As importantly, they needed additional care and support from the health system.

“When I first saw his face it was really angry. It was very difficult to give birth. I nearly died. After delivery the doctor told me to give the baby breastmilk but I said ‘no’. I really hated him. After three to five months later, I felt fresh and it is easier to care for him.” First-time Mother, Lowland Village, Far from a Health Center

Most mothers and fathers believe that it is normal to continue breastfeeding until the child is two years. However, more than half of the mothers interviewed wanted to stop after the child was one year or one year and a few months. They had stopped or wanted to stop to be able to do housework without holding the child, and to return to eating spicy family food without restrictions.

**Complementary Feeding:** In addition to beliefs about what children need to eat, especially before one year old, women’s workload and child-led feeding preferences lead to inadequate diversity and quantity of children’s diets.

Between 6 and 11 months, beliefs that children primarily need to eat rice, along with breastmilk (and often other milks), guide feeding practices. Few mothers realized that the amount of food other than rice is important for children’s growth and development. Some mothers or grandmothers add bites of banana, fish, crab or other things they forage, but by eight or nine months it is likely that the amount of these other foods, as described, would be insufficient to meet the growing child’s needs. After one year, children are encouraged to self-feed (with assistance to prepare bites by some mothers) and eat most family foods. However, even then, the quantity of food that children consume—including animal source foods and vegetables— is not tracked.

Except a few first-time mothers who were willing to prepare special food for children, mothers tended to follow time and labor saving practices that fit into their busy schedules. Most mothers, and other caregivers, feel relieved once the child can self-feed and give them finger food and other food to self-feed as much as possible.

On top of these barriers, child-led feeding practices predominate. Mothers and other caregivers are poised to respond to the child, or what they believe to be the child’s wish, in order to stop or avoid crying or simply because they want the child to be happy. For example, when a child cries, caregivers give rice. When the child asks for sweets or biscuits, the family buys sweets or biscuits. When the child spits out food, the mother stops feeding. As a result, the child is largely in control of what she or he consumes.

However, when children are sick, many mothers stay home and can pay attention to the child. During illness, mothers described ideal active feeding practices and success in getting children to eat nutritious foods.

To enable families to feed children 6-24 month olds diets with age-appropriate quantity and diversity, including animal source foods and vegetables, mothers and grandmothers, especially, need to see from those already practicing it that giving young children eggs, fish and other animal source foods does not make them sick, and helps them grow faster.
Options for food storage and preservation with locally available options such as insects, fish and vegetables, would make this practice easier for mothers who do not have additional time or energy to prepare special foods.

Deeper and sustained improvements in infant and young child feeding practices need shifts in the underlying gender norms related to women’s work and social norms around child-led feeding. Currently, women’s ‘light’ work is not valued as much as men’s ‘heavy’ work and women are expected to handle multiple tasks at the same time. When women have time to focus on a sick child, they show good skills in child feeding. To extend this practice into daily life, which is necessary for children to grow well, families need to redistribute tasks and place higher value on childcare.

Health Care-Seeking

Perceptions and Practices related to Health Care-Seeking

Antenatal Care (ANC): Most participants, including village leaders, are aware of the importance of Antenatal Care (ANC) and value the services. Fathers-to-be and pregnant women travel to Health Centers or district hospitals for ANC by any means necessary, including ‘iron buffalo’, motorbikes and/or boat. Although two first-time 16-year-old pregnant women have not yet sought ANC, one due to fear of vaccinations, the other pregnant women interviewed like to go for ANC. Those in the villages near to a Health Center share that community members encourage them to go often for ANC, highlighting that the service is free.

“During my first pregnancy I did not go to ANC. But for my second baby I started to go last month because the first delivery was difficult. The health staff advised me not to do hard work and gave me medicine. Next month I will go again. Neighbors often tell me about free ANC and encourage me to go often because there is no need to pay.” Experienced Pregnant Woman, Midland Village Near a Health Center

Some pregnant women believe that ANC is necessary to get assistance during delivery in case of emergency.

“The doctor and midwife say that if it is a difficult delivery we cannot blame our husbands or anyone else. [If my husband will not take me] I would talk to him many times to tell him that health staff advise to go and that ‘other women go why don’t you take me to ANC? If anything [bad] happens during child birth the health staff won’t take me.’” Experienced Pregnant Woman, Midland Village Far from a Health Center

Most pregnant women go for ANC only with their husbands. They want to go with their husbands for practical transportation reasons, and also associate husbands taking them for ANC with care and love. Several reflect further that if their husbands did not go with them they would feel disappointed and sad.

“My husband will take me there... I tell him to take me for ANC. It feels good when going for ANC because [when I go] my husband pays attention to me.” Experienced Pregnant Woman, Midland Village Near to a Health Center

Although ANC is generally valued and sought out, the recommended timing and frequency of ANC is not well known or accepted. Across all villages, people believe that ANC is for the baby and begins after the baby moves or kicks: “when the child in womb becomes human” (Experienced Pregnant Woman, Lowland Village Near a Health Center). It is only at this time that they believe the baby needs a check-up, which happens between 4 and 6 months of pregnancy. Some mothers had heard
that if they go to a Health Center before this time the health workers ‘would not accept’ and send them away.

Few pregnant women, fathers or leaders realize that pregnant women are advised to seek at least four ANC checks during pregnancy. One mother from the village had only one ANC check in Thailand; “the Thai doctor told me that the baby in my tummy is good and healthy...My parents and my husband encouraged me to go for ANC [here] but I did not go because I knew my baby was healthy.”

First-time Pregnant Woman, Midland Village Near a Health Center

Fathers shared their perceptions about ANC as well. Most fathers recognized the importance of ANC but weighed the costs of care-seeking, including the loss of gathering food to eat that day.

“We all want our wives to get four ANC checks... [But] Each time we go for ANC means no food that day. They know that other women are going, but they cannot go because they have to work.”

Father, Midland Village

Child Birth: In one lowland village, pregnant women say that women usually give birth in the nearby Health Center. In the other villages, families hold strong preferences for home delivery because of the desire for extended family to be present for the birth. This is a special time when the family comes together and gives attention and spiritual protection to the woman. Most women give birth surrounded by family and are attended to by their mother or mother-in-law as well as sister and aunts. The other primary reason for home delivery is that institutional delivery—district hospitals—is believed to be only for emergency cases. Even those living near a Health Center did not consider the option to deliver in a health center, but expressed willingness to travel to the district hospital in case of emergency.

In case of prolonged labor, the family decides when to go to the hospital. They make that decision by weighing costs and the perceived risk. Costs include travel, accommodation for relatives who need to be present and also hospital fees. Families are not aware that there are no fees for delivery. Many decide to travel to the hospital only after more than 12 to 36 of labor or ‘severe’ pain. Mother’s fear of the hospital and preference to stay with extended family may influence this decision.

“I delivered my first baby in the hospital because I was scared and had no experience. The second baby I delivered at home with help from my mother and husband and relatives came to help, too. This baby, I don’t know where I will give birth. If there is no problem, I will deliver at home. I don’t want to go to the hospital... I feel shy. I was not shy with the first baby because I had pain for 2 days so my parents and my husband took me to the hospital.” Experienced Pregnant Woman, Midland village far from a Health Center

Other fathers shared considerations related to the presence of relatives. “Relatives want to go and visit in the hospital but I would have to spend money on food and transport for them. And there is nowhere for them to sleep.”

Father, Midland Village, Near a Health Center

Preventive Child Health Services: Half of the mothers interviewed in villages far from a Health Center share that sometimes health workers come for outreach activities including immunization and growth monitoring and promotion (GMP). If there is a routine schedule the mothers are not aware of it; they wait for announcements from the village leader.

“We go to GMP every month following the announcement. Not all children go. When children cry at GMP the next time parents do not take them again. Health staff come to the village leader’s house
and they tell us to cook vegetables, fish, meat for children. They show us how to cook porridge with eggs and meat. When come back home we cannot do it because we do not have eggs or meat and children do not eat vegetables.” Experienced Mother, Midland Village, Far from a Health Center

All of the other mothers and grandmothers like health outreach activities, and request more opportunities to have their children seen by health workers. They would like to be informed of the day in advance to make arrangements for relatives bring their children or stay home from fields. Mothers also request information about their children’s health and growth during outreach. One mother felt that currently outreach is rushed and health workers just “inject, inject and leave.”

“If health staff come to the village, I will bring my baby to be seen. If we know beforehand that health staff are coming to the village we will wait for them. If I have to go out my mother can take baby to them.” First-time Mother, Lowland Village, Near a Health Center

“My baby never had GMP. I weighed my baby at home using the scale for crabs. People say it is good to know the baby’s weight. Maybe this time he weighs this much, maybe next time more. If his weight decreases it means he does not eat and if he eats more, his weight will go up. I have seen health staff in the village but no one told me to bring the baby. If we knew the day and time when health staff will come, ‘big mother’ could take the baby to them.” First-time Mother, Midland Village, Far from a Health Center

Few families consider taking their children to Health Centers. Mothers believe that health workers are usually away from Health Centers doing outreach to other villages so there would be no point in traveling to the Health Center with a young child.

**Sick Child Treatment:** Children who are sick with usual and mild illnesses, such as diarrhea, fever and colds, are cared for at home. Mothers often stay home to care for sick children. When a child is very sick or will not eat, mothers report that the father or grandfather buys medicine from the district hospital. The type of medicine varies; some mothers say vitamins or micronutrient powder and some mention Paracetamol. A few families have taken a sick child for treatment.

“We take the baby to Mahaxay Hospital because it is near (6km). I go with my husband or parents and the baby. We assess the need to go based on the child’s appetite. No appetite shows the baby is unwell and has a fever and cough. I buy supplements and cough medicine for baby. I care for the baby. After illness I give grilled rice and make soup. I try to play and talk with the kids while feeding. If they do not really eat well, we bring them to the hospital and get prescribed supplements.” Experienced Mother, Lowland Village, Far from a Health Center

Some fathers acknowledge spiritual healing as a first recourse during illness.

“When the baby is sick a healer comes. For a stomachache the healer uses traditional medicine on the tummy to pass wind (fire vaan), or places herbs mixed with water around the belly button. If the child is not better, our parents would tell us to take the baby to the hospital. Father, Midland Village, Far from a Health Center

**Barriers and Enablers to Health Care Seeking**

Although most people have positive attitudes toward ANC from Health Centers, the timing and frequency of ANC visits need to be addressed. In addition to general shyness to seek health services by women, especially first-time pregnant adolescent girls, a strong barrier to recommended use of ANC is the belief that it should begin later in pregnancy, only after the baby moves. This delay limits the total number of visits possible.
In the study villages, women and their families know the woman is pregnant due to morning sickness. Engaging leaders and families — including fathers-to-be and mothers/ mothers-in-law — to encourage early care-seeking would be a strong support. A possible motivation is to be able to listen to the fetal heartbeat.

For childbirth and sick child care-seeking, overall, as the quality of health services improves and the availability of health workers in Health Centers increase, it will be important to promote these changes to communities including the presence of health workers in Health Centers during certain times. In addition, discussions about how to manage extended family members in case of institutional delivery would be useful for families to keep in mind when making care-seeking decisions.

**Water, Sanitation and Hygiene (WASH)**

**Perceptions and Practices Related to Clean Households**
Interviews, FGD and observation focused on the components of clean households⁶: clean and safe drinking water, handwashing with soap, and clean children’s areas, except sanitation. The USAID Nurture WASH Assessment conducted an in-depth exploration of sanitation⁷.

**Drinking Water:** All villages in the sample, and all households observed, have access to well water and water from springs or rivers. Some of the well water is salty so it is used for washing but not drinking. Households usually store water for all purposes on a platform located in between the house and the kitchen, which is located in a separate, smaller raised building. The platform is used for washing and preparing food. Most households have numerous pots, pans and buckets filled with water for washing and cooking on this platform, as well as clay jars with drinking water. Many households cover the container for drinking water.

Village leaders believe that most, though not all, households boil water or buy bottled water. Several of the villages had previous projects that taught the risks of drinking untreated water and distributed water filters. None of the filters observed are still functional; people say it takes too long to filter.

About half of the mothers and only one leader interviewed say that they usually drink treated water. Some mothers boil water with roots from the forest (called “hot water”), if they have time or wood to boil water. Others report that they do not have time to boil water for drinking.

“I collect water from the deep well for daily use and to boil for drinking. Sometimes I drink ‘raw’ water because there is no wood to boil water. Boiled water tastes better [than untreated or filtered water]. If I drink boiled water the children will follow me. I am the one who boils water... the health workers tell us to do it.” Experienced Mother, Midland Village

“I collect drinking water from the spring with ‘gold water’ every morning. I carry water from the spring, filter it with white cloth and keep in a jar cover with a lid. I just drink it without boiling. It is difficult to boil, and I have no time.” Experienced Mother, Midland Village

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⁶ Save the Children’s Clean Household Approach (CHA) provides an umbrella for a host of household WASH interventions that aims to reduce contaminants that children ingest by ensuring clean drinking water, safe disposal of children’s stool, handwashing and clean play areas.

The village leader who drinks boiled water, and carries boiled water to the fields, has not been able to persuade others to drink boiled water. His family members prefer “raw” untreated water directly from the spring.

“In father’s [my] house, I drink boiled water but my wife and children drink ‘raw’ water. I am teaching my grandson by giving him [boiled water]. But when I am away, my children and wife give the child ‘raw’ water.” Village Leader, Midland Village

This same leader also describes frustration with giving hygiene recommendations to community members who do not change. “I tell people information from the district and the Health Center in village meetings but they don’t do it. In the morning, I explain, in the evening I explain, but still they don’t care because they are lazy, or prefer the taste of the ‘raw’ water.” Village Leader, Midland Village, Near a Health Center

Many mothers explain that since they do not get sick from the water they do not believe it is a problem. Indirectly, when speaking about children’s illness, mothers and grandmothers shared that there are no concerns about child diarrhea; they see it as natural and a way for children to develop tolerance to water and food.

**Handwashing with Soap**: It is common practice to rinse hands with water before and after eating meals and sometimes after defecating. However, no one interviewed washes their hands or their child’s hands with soap before eating. They save soap for bathing. Mothers said that they wash children’s hands if they see their hands are visibly dirty, and even then they rarely use soap due to cost and the time it takes to wash with soap.

“Washing hands with soap makes you clean without any more smell. But sometime I am in too much of a hurry and I just wash my hands with clean water only.” Experienced Mother, Lowland Village

“For me, I have a lot of difficulties preparing food, getting food ready, and baby care. There is no time to wash hands with soap.” First-time Mother, Midland Village

All of the village leaders confirmed that community members have good knowledge about handwashing and connect handwashing to cleanliness and health. Most do not use soap for handwashing because people are not used to it and do not see visible dirt on their hands. One mother sees that her family members will wash hands with soap if they have touched something ‘really dirty’. One village leader sees that households usually have one piece of soap and keep it in the bathing spot; there is no specific place for handwashing. He believes that washing children’s hands is important but could only happen if older siblings or parents could be motivated to wash the children’s hands.

**Children’s Play Areas**: All of the mothers interviewed value clean homes. As one described, “A clean household means no disease, no one gets sick and it is beautiful no matter if it is a big or small house. It is not dusty, and has no animal feces, the sleeping area is swept and the utensils are clean... friends want to visit a clean house and the children are healthy.” First-time Mother, Midland Village, Far from a Health Center

However, many mothers admit that they do not have the energy to clean the household when they are responsible for numerous other daily household and childcare tasks in addition to field work. As the discussions on gender and women’s roles illustrates, women are required to do certain household tasks each day including cooking rice, preparing and serving food, and childcare. All other
tasks can only happen after these ‘must do’ tasks are completed. Some mothers feel that their husbands and other family members could take on some of the cleaning responsibilities. Currently, they get “help” in this only occasionally from husbands (Lao) and during pregnancy (Lao and ethnic groups).

“My house is not so clean because when get tired I will not do cleaning.” First-time Mother, Lowland Village, Far from a Health Center

Homes are raised off of the ground. Homes in Lao villages tend to be raised higher than in ethnic villages; underneath Lao homes animals are sometimes penned at night. House floors are made of bamboo or wood and in some Lao villages, brick. Inside the home some, but not all, families have plastic sleeping and eating mats. Outside of the home, infants are not placed on the ground, but rather held, carried in a sling or put in hammocks. Once a child begins to crawl or walk near or at one year of age, they are allowed to move around. Observation found that the areas where children are allowed to occupy are generally unclean due to animal feces. Most compounds had animal feces lying in the open at the time of interview. In all of the villages, families fence their gardens but do not fence compounds. Although instructed to pen animals by local authorities, animals are usually penned only at night; they allow their own and neighbors’ cows and buffalos, pigs, chickens, ducks, and some goats to roam freely in the daytime.

All of the village leaders believe that their community members have good knowledge about disease from animal feces and instructions to move animal pens away from the house, yet animals still roam during the daytime. Once a household sees neighbor’s animals roaming they do not pen their own animals. Leaders believe that families are concerned about clean play areas for children but currently “just tell children not to play with dogs or animals and not to play at dirty or dusty places in the village.”

Barriers and Enablers to Clean Households

Most of the families and village leaders have good knowledge of the recommended clean household behaviors explored, but few practice consistently. Barriers to treating drinking water and handwashing with soap include women’s time and labor as well as personal preferences. The numerous competing tasks assigned to women/mothers results in prioritization based on immediate needs and ‘must do’ activities, such as cooking and serving. Sharing tasks through family support would enable the family to treat drinking water – even if only for the mother and child 6-23 months – and to wash hands with soap before eating and feeding a child. To encourage sharing tasks, some type of motivation and recognition targeted at fathers and older children may be useful. Dedicated places and utensils/supplies for treated drinking water and for soap with the handwashing bucket with attractive reminders would also support turning these practices into habits.

Barriers to clean play areas also relate to women’s time and labor. Sharing compound cleaning – at least the areas where children from 9-23 months crawl, walk or play, would help to reduce contaminants that children ingest. To encourage sharing tasks, some type of motivation and recognition targeted at fathers and older children may be useful. Additionally, an important barrier to clean play areas is neighbors’ behaviors. Mothers and fathers see that neighbors do not pen animals so feel that there is no point to pen their own animals. This issue requires collective action to agree on a local solution and mobilize community-wide commitment, as a core component of ongoing Open Defecation Free (ODF) efforts.
Nutrition and WASH Information Sources

**Adolescent Girls**: Girls in school learn about nutrition (food groups) and hygiene (including the three-cleans: eat clean, live in a clean house and wear clean clothes) from teachers, health workers and TV. Reproductive health is included in the school curriculum during year 4. Girls out of school learn about hygiene from teachers, mothers and friends. One girl in school in a lowland village near a health center and an out of school girl in a midland village near a health center add that health staff advise about health and hygiene. However, for both groups, friends are a key source of information about “female things” such as menstruation and romance.

“Doctors, nurses and sometimes older girls in the village or our friends are good to give us advice regarding health and well-being... Girls usually listen to their parents and friends. But, whenever they have problems, most of the time they talk to their friends rather than parents because they perceive that their friends have had the same experience and feel a bit embarrassed to talk to parents.” Girl In School, Lowland Village, Far from a Health Center

Girls get regular information and advice from parents, grandparents and friends about growing up safely and avoiding pregnancy before marriage. All of the girls say that parents and grandparents warn them about risks when going outside the home. They advise girls to be careful when walking around, to avoid drugs, and go “two-by-two” with girl friends to never to be alone with a boy as they could be raped. Ethnic girls’ parents emphasize being more careful at festivals and events, where people drink more alcohol than usual. They are told to avoid dark spots and always stay with girlfriends because parents say “you could get pregnant if you have sex.” In-school girls in a Midland village also advise friends not to join weddings or festivals too often “because you need to spend money wisely because it is difficult to earn.”

Regarding menstruation, girls get advice from their friends. Some girls do not like to attend school when menstruating due to cramps and because “it is a bit troublesome when having to change pads in the school toilet” but friends encourage them. On romantic issues, girls want to talk with friends, but some also like when their mothers comfort them.

“Girls listen to their parents most because they raised us and [we] believe that all they do is because they mean well, except [having us] leave school, they really had no choice.” Girl Out of School, Midland Village

After a break-up one girl’s parents comforted her by saying, ‘It is okay because you still have your parents who love you. This made me feel better.’ Girl In School, Midland Village

Girls in school describe strong social networks of friends in school, family in their household and extended family in their village. For example, girls say that in case they are sick and parents are busy, grandparents, siblings, cousins or neighbors bring food without having to ask. Girls out of school feel closest to their mother, aunt, sisters and some close friends.

**Pregnant Women and Mothers**: Most pregnant women and mothers overwhelmingly prefer information and advice from their parents, especially mothers or mothers-in-law. Some also cite health workers and village leaders for certain topics and a couple of experienced pregnant women said that they talk to sisters and peers.

“I always listen to mother because she has more experience. She is my best advisor because she raised many children before us. For other women also their mothers are the best advisors.”

Experienced Mother, Midland Village, Near a Health Center
“If the Village leader and Doctor tell us things we will follow, like sister Pheth. She comes once a month to give vaccination.” Experienced Pregnant Woman, Midland Village Far from a Health Center

**Other Caregivers:** Fathers say that they hear about newborn care and clean drinking water from TV and Lao Radio, and get general advice from their parents and other elders. One father also looks at the Maternal and Child Health book for information.

Grandmothers hear hygiene and malaria prevention information from TV and learn about vaccination and ANC from friends and, in two villages, the Lao Women’s Union promotes vaccination.

Fathers and grandmothers trust information from district health staff most. Others said that they prefer elders or ‘those who were born before’ to educate them and give advice. Grandmothers note that they themselves are influential in the communities.

“Comparing between health staff and elders, it is better when health give staff advice. Then we listen. But, when it comes to practice, we listen to both. We listen to the health staff 2 parts and to parents 3 parts.” Fathers, Midland

“We discuss children’s issues with relatives. I give advice to others. I told my nieces that they should not take a nap when pregnant and to drink a lot of hot water on the hotbed.” Grandmother, Lowland Village, Far from a Health Center

**Community Recommendations**

**Adolescent Girls:** All of the girls in school who participated request more education and information on reproductive health, self-care in relation to menstruation and nutrition. Some girls recommend activities at their school during breaks at 10:00am while others suggest weekends so more people could participate, including elders.

“We would feel delighted to have someone, like this time, to come talk to us about the issues and would love to have more to give us advice.” Girls In School, Midland Village

Girls out of school want similar activities. Topics of interest include health, well-being and self-care during menstruation, the suitable age for marriage, childbirth and child care, cooking and nutrition. Some midland girls also want a cooking and tailoring course to be able to earn an income and to address community development concerns. Out-of-school girls say that they need their parents to attend these sessions so that they can all learn the same information.

All of the girls suggested practical, hands-on and interactive sessions with questions and answers, games and visual aids.

**Pregnant Women and Mothers:** All of the pregnant women and most of the mothers express interest in participating in activities related to pregnancy and childcare and feeding and hygiene. Women in midland villages need permission from their mothers-in-law to attend.

“If she [mother-in-law] agrees I will go, but I do not know who would be able to talk to her.” Pregnant Woman, Midland Village, Near a Health Center

Most suggested twice a month, although some pregnant women request twice a week. Nearly all of the women recommend mornings for activities because they are afraid to go out in the evening, and
because they go to the field and/or to collect food in the afternoons; but two pregnant women in a lowland village suggest afternoons. Several women in lowland and midland villages recommend inviting both women and men.

“I want my husband to join too... The village leader must specify that both husband and wife must attend. This will be very good because we will hear the same thing ...and together can practice at home.” Mother, Midland Village, Near a Health Center

Specific topics of interest include child feeding, what to eat during and after pregnancy and how to self-care during pregnancy, child care including how to talk to children and keep them clean. Some mothers also want to learn about cultivation of vegetables and animal husbandry and fisheries.

“I want to learn about childcare, sick child feeding, food to help children grow and gain weight faster and be healthier. I also want health staff to come and tell the family that pregnant woman should not do heavy work.” First-time Mother, Midland Village, Far from a Health Center

All of the women with recommendations want visual aids and interactive activities as opposed to ‘just talking’, as well as regular support from health care providers.

“If you give examples and show pictures I can understand. Videos are better because we can see actual experiences.” Pregnant Woman, Lowland Village

Other Caregivers: Fathers and grandmothers express interest in learning about child health, care and nutrition and hygiene. Some fathers also request information on how to raise poultry. And, similar to several of the women, a few men suggest mothers and fathers attend together.

“Nearly all fathers want to know how to raise kids to grow up healthy and tall. Both the husband and wife should attend. Father, Lowland Village, Far from a Health Center

Everyone recommends that the project give advance notice about the time and who should attend so that they can stay home from the field or other work to participate.
Gender Analysis

Background
Gender refers to socially constructed roles, behaviors, and characteristics that a society considers appropriate for men and women and boys and girls.

To effectively and sustainably improve nutrition, USAID Nurture conducted a gender analysis, a “systematic analytical process used to identify, understand, and describe gender differences and the relevance of gender roles and power dynamics in a specific context” that answers:

1. How the different roles and status of men and women within the community, workplace and household will affect the project?
2. How the project will affect men and women differently?

USAID Nurture conducted the gender analysis as part of a larger formative research study to maximize resources. The same people interviewed in four rural villages sampled as part of formative research, including pregnant women, mothers, other caregivers and village leaders, also shared their opinions and recommendations related to gender roles and responsibilities, how gender and nutrition interact and how best project activities could meet the needs and interests of all community members. The findings are supplemented with a review of existing information and cited as such.

The analysis will guide project design, implementation and monitoring plans, including content and delivery decisions for social and behavior change communication (SBCC) to meet the different needs and priorities of women and men, and girls and boys, and support communities to address inequalities in ways that work to improve nutrition for women and children.

Policy and Cultural Context
There is a strong policy and legal framework for gender equality in Laos. The Constitution of Lao PDR recognizes equal rights of women and men and this declaration is reflected in numerous policy and strategy documents. In the health sector, the National Nutrition Strategy to 2025 and Plan of Action 2016-2020 promotes equitable gender roles, placing emphasis on women’s access to health services, to nutrition and food security information, and to food.

USAID Nurture supports villages in the central region, including both lowland and midland villages. The population in lowland villages is primarily Lao-Thai who follow matrilocal post-marriage traditions, where daughters remain living in (or near) their mothers’ house until the youngest
daughter settles there permanently with her husband. Sons usually live with their in-laws. There are also matrilineal customs and inheritance. The youngest daughter traditionally inherits the house and land, and thus invests in this property. An anthropologist characterizes the culture as ‘women-centered’: while men are given authority and leadership, women have resources and family support. Her analysis identifies protective aspects of women living with or near their own families. Daughters are welcomed because girls will take care of the parents and manage their resources in old age. In turn, parents care for their daughter believing that blood relatives give the best care and concern during illness and the most vulnerable times: pregnancy, delivery, and the period immediately after birth. As a result, some community and household decisions include elders and women, without participation from sons-in-law, although this may be changing in some areas and some families.

Living arrangements are different in midland villages where couples live with the husband’s parents (patrilocal) and the wife takes on the role of daughter-in-law. They may build their own house and move out, but remain close to the husband’s parents. In these villages, mostly men participate in community and household decisions.

Gender Roles and Status

HOUSEHOLD LEVEL: Gender roles in these communities become more defined after marriage, especially for women; women and men describe married women’s roles in greater detail than married men’s roles. Married women have several non-negotiable or ‘must do’ daily tasks: steaming rice, cooking and serving her husband in addition to field work. Married women are also expected to perform ‘light work’: cleaning the home, collecting water, watering the garden, feeding the animals, washing dishes and clothes, and child care (including feeding, washing, keeping them safe and caring when sick).

“A wife should be hardworking, clean the house, cook rice and prepare food for husband and children. She should not go out chatting. She also carries water for drinking and for household use and feeds animals. This is enough.” Mother, Lowland Village

Married men are expected to provide food for the family and do ‘heavy work’. Heavy work consists of building a house, plowing the fields, handling cattle and operating machinery. Some people add that a husband should earn money, help with housework when he has time, take care of a pregnant wife, buy medicine when a family member is ill and not hit his wife.

Although men are expected to provide food for the family, and are the ones who collect frogs at night, in reality most of the food foraging and collecting is left to women. When a mother stays home to care for a sick child, for example, the family eats only rice that day. Mothers in all villages wish that husbands would share more tasks during ‘difficult times’ of pregnancy and illness.

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“When we are pregnant or tired we would like to have just a little help, just a little bit of this or that. This makes us happy.” Mother, Midland Village

For girls and boys, mothers and other caregivers hold some similar expectations; they want all children to listen to adults and be polite to elders, do well in school, and help the family: girls with housework and boys with field work. But in reality, many parents expect more from girls and less from boys.

“There is no difference between sons or daughters. But we cherish girls because they are trustworthy, do not go wild and do not spend more money than they can afford. But we love them equally.” Mother, Midland Village

Status in the household is a function of age hierarchy, followed by gender. In all villages, the head of the household is the oldest man. The head of household can delegate participation or duties to the next highest in status, his wife. When a couple lives on their own, the husband is the head of the household. In midland villages, daughters-in-law have the least status among adults in the household; daughters-in-law do the majority of household work as well as field work.

“If her husband does not do anything, the wife should do everything. She works hard and goes to work even if other family members do not. She does all of the housework.” Mother, Midland Village

Key differences in gender roles and status emerged between lowland and midland villages. First, while ideal roles are similar for men and boys in all villages, people in midland villages have lower expectations. People in midland villages talk about men engaging in activities contrary to family interests such as gambling and alcohol use.

“A father should help with housework, take care of children, do not go and drink outside....But it is very rare that any father would not go out and drink.” Fathers, Midland Village

A second difference between lowland and midland villages is that some mothers in lowland villages do not feel that they have to embody all expectations of women.

“A good wife should work a lot [and] not be lazy, do all of the housework, except when she is pregnant, cook for her husband when he comes home from field, clear the meal, think about her husband’s tiredness from work outside and let him rest... But if I am not seen as good wife it does not matter to me.” Mother, Lowland Village

Unlike women in lowland villages, married women in midland villages are seen as daughters-in-law who are not expected to manage family resources in the future. However, recent migration trends of girls and young women from some midland villages may be catalyzing changes in how girls are perceived and valued; these communities know that some of these young women can earn income for their families and themselves. Girls intend to use the money they may earn to build their own houses.

WORK AND EMPLOYMENT: Most households engage in subsistence agricultural production. Division of labor is based on gender; women and men’s roles are seen as complementary to each other. Generally, women work in the rice fields (planting, weeding and harvesting crops), tend to home gardens, raise small livestock (poultry, pigs, and goats) and do housework. Men are responsible for
the heavy work; men plough, prepare seedbeds for home gardens and look after cattle and buffalo. Men also work with women in the rice fields to plant and re-plant rice.

Outside of young women who migrate, and stories of parents selling animals or excess rice, the study found only men earn income from supplemental income generation. Some men earn income through paid seasonal labor and selling what they catch in the forest, such as squirrels. This finding is consistent with a 2012 national Gender Analysis that classified 64% of economically active women and girls as ‘unpaid family workers’, compared to only 27% of economically active men and boys. Women work 6.4 hours per day while men work 5.2 hours a day.

Women and men interviewed for this study described women’s work as light but steady, while men’s work is heavy but only at certain times.

“A wife has lots of trivial work [small tasks]. No matter how tired she is she has to cook and have food ready for her husband when he comes from work. Men do not have much work, but do the heavy work.” Grandmother, Lowland Village

Work is more imbalanced in midland and upland villages; a 2015 Gender Analysis found that in ethnic villages women and girls perform 70% of agricultural and household tasks.

COMMUNITY LEVEL: In communities, status is related to age hierarchy as well as gender according to women, other caregivers and village leaders. Leadership roles go to men except women’s union positions saved for women; older men usually hold the formal positions, while grandmothers say Women’s Union positions are for women in their 30s and 40s.

Invitations to community meetings or activities usually go to heads of households: the oldest man. He can delegate to his wife if he is unable to attend. Thus, women let ‘big father’ or ‘big mother’ (elders) attend meetings or delegate others to attend. Women living with their husbands in a separate home say their husbands go as the head of the household, unless husbands delegate to them (common in lowland villages).

Gender Analysis Domains
ACCESS TO RESOURCES: Intra-household food distribution between men and women is unequal, especially during pregnancy and the postpartum period when women have numerous food restrictions. A 2013 study found that women also eat less during times of scarcity, sacrificing for their husbands and children.

According to 2012 data on health service use, few women or men sought care for a health problem in the past month, although slightly more women than men went for care. Among women, access to maternal health services is lower in rural areas, among ethnic groups, the poor and those with lower levels of education. Most women interviewed for this study can access some antenatal care

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11 Baldwin, 2015
12 The Six Domains of Gender Analysis is a framework that USAID’s Interagency Gender Working Group (IGWG) developed and uses to collect and organize information pertaining to gender differences in the health area.
13 Stoeber, 2013
14 ADB, 2012
15 Baldwin, 2015
despite distance and time constraints, although not as soon as or as frequently as needed. Most women depend upon husbands for transportation to facilities. Access to facility-based delivery is more limited due to family decisions on when to go to a hospital, usually reserved for emergencies.

While women and men have equally limited access to WASH services and products, women are the most affected. Married women are the primary collectors and users of water in the household and garden, and responsible for household hygiene—such as by bringing water in a bucket for family members to wash their hands before eating—and infant and young child WASH. Furthermore, women are the primary caregivers for sick family members, including children. Women are the immediate beneficiaries of improved, labor and time-saving WASH products.

The literature identifies increasing importance of cash income in rural villages. A 2013 study found that 20-30% of fruits and vegetables and up to 50% of fats consumed are bought at markets in central villages. Yet there are limited income generation opportunities for rural woman. In some areas, some women sell vegetables that they grow or collect and use the income to purchase other food for the family, mainly rice. Even if women sell the harvest from their gardens, they give the money to their husbands, because men are seen as in charge of income generation. 16 However, another study found that in many ethnic groups women often hold the money and are able to make small purchases, but do not have equal decision-making, particularly on larger or more expensive items. In all areas, women tend to have more control over income they have earned themselves.17

Mothers interviewed for this study have access to small amounts of money to buy things in the village such as biscuits for young children. For larger items, such as refrigerators, they may make the request to husbands who do the actual purchasing.

**KNOWLEDGE, BELIEFS AND PERCEPTIONS:** Girls, women and men know about food groups and believe that nutrition is related to food intake. They lack knowledge about nutrient-dense foods or the linkages between nutrition, care for women and children, and WASH.

Women and men hold similar levels of basic knowledge on nutrition for adolescent girls, women and children. Both women and men lack knowledge on adolescent nutrition; none recognize that adolescents experience another period of growth and that girls need adequate amounts of healthy food to catch up growth and develop fully. Women and men are aware of the need for pregnant women to eat well, avoid heavy work and get antenatal care (ANC), but neither women nor men recognize the importance of gaining adequate weight during pregnancy or know how to achieve or support this gain. Both women and men want their children to be healthy and grow well, but neither is aware of the importance of the first 1,000 days to take action. Finally, women and men alike know breastfeeding recommendations, especially exclusive breastfeeding, but react differently; while women lament that they cannot follow the advice, men openly question health worker’s advice based on their own experiences.

Perceptions about health services other than ANC differ. Women want more health and nutrition services for their children in the community, and arrange for their child to see health workers any time they come to the village if given advance notice. Women also prefer to take children who are sick to the hospital while men do not see the value in outreach health services, and visit spiritual healers and/or buy medicines before seeking treatment from health services for a sick child.

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16 Silke Stoeber, Engsone Sisomphone, Chusana Han, 2013: Women, Food and Land: Understanding the impact of gender on nutrition, food security and community resilience in Lao PDR, Food Security Risk and Vulnerability Survey- Summary Report, Vientiane, Lao PDR.
17 ABD, 2012
Aside from some men in leadership positions who actively promote improved WASH and have in-depth knowledge about water, sanitation and hygiene, most women and men also hold similar levels of basic knowledge about WASH. Women and men know about treating drinking water and handwashing, but tend to drink “raw” water, and both prefer to wash hands without soap.

PRACTICES AND PARTICIPATION: Village meetings are an important formal source of information and decision making in rural areas. Participation is often restricted to the head of the household, the oldest man, or his designate, usually his wife. First-time parents have never attended a meeting or activity except vaccination outreach. Among experienced parents, who are no longer living with parents or parents-in-law, participation in village meetings differs between villages. In lowland villages, men usually leave meetings to women.

“A maximum of 10 older men would show up and the rest would be women, even when the leader specifies the head of the household, which means the man... we would feel uncomfortable to be the minority... they are not busy and they are not afraid but they are just not used to attending meetings.” Father, Lowland Village

In midland villages, however, only men or divorced or widowed women attend, unless it is believed to be a ‘woman’s topic’ such as vaccination or cooking.

Many mothers are willing to attend meetings if the leader requests her to join and her family agrees.

“I have never attended a village meeting and do not want to because I am afraid people will ask questions. There are only elders there.... if it is about mothers and children, then it would be me to join. If the village leader specified that the housewife should attend, I would go.” Experienced Mother, Midland

TIME AND SPACE: There is wide recognition of women’s multiple roles including unpaid productive work and household activities and the resulting “time poverty”. This situation limits girls’ education and women’s activity participation and paid employment opportunities.18

Mothers interviewed in this study accept their busy schedules and characterize their activities in terms of labor and energy, rather than time. Some say that no woman wants to have nothing to do. They do not imagine a situation where they could have more time and/or energy to focus on self-care or child care and feeding. Nevertheless, many express feeling tired sometimes and request help to reduce their workloads, especially during pregnancy and illness. They also want ‘help’ with household tasks, especially when a child is crying.

Of note, a project that effectively reduced women’s workloads through labor saving tools and processes led to frustration among some men who expected that women would use their time savings to help with traditional men’s tasks such as cutting trees and building.19

In general, women’s space is in the home and men’s space is outside the home. In reality, though, women work in the fields and forage for food each day. Since it is unpaid work, it is not recognized and does not translate to status in the household. Once adolescent girls start menstruation, they are encouraged to stay home or near home but can still join festivals. After marriage, women are no longer allowed to go to festivals and enjoy life -- ‘we cannot dance anymore’ and generally do not travel outside of the village.

18 ADB 2012
19 Stoeber, 2013
POWER AND DECISION-MAKING: Families and communities follow hierarchies based on age and gender. The head of the household is the oldest man – either the grandfather if living together, or the husband if living as a couple. Power in decision-making mirrors the hierarchy; decision-making and control of resources, including money, is generally given to men.20

Fathers interviewed for this study speak about hitting wives and children as common but undesirable. The literature shows a dearth of statistics on domestic violence, in part because domestic violence is often not categorized as a crime. Village committees or mediation units handle disputes formally or informally “where the focus is more often on maintaining family unity than on protecting women.”21 An anthropological analysis makes a case for lower levels of violence against women in lowland villages because of living arrangements with or near their families.22

Potential Impact of Gender Norms on the Project

Gender could impact the USAID Nurture project through several important ways: nutrition and hygiene as women’s domains coupled with limited time and agency (capacity to act) of women; decision-making by families informed by social mindsets; and gendered participation in community activities.

Mothers are primarily responsible for all household and care related issues, including nutrition and WASH (except the construction of toilets). Any new responsibilities fall to women, but mothers are already overloaded with work in the fields and at home. As one mother says, “We women, we rest at night” and a father explains, “my wife washes clothes while she rests.” As a result, even with knowledge, skills and positive attitudes, few mothers would be able to adopt new behaviors unless they are easy (labor-saving) and/or fun, or if other family members share their workloads. Further affecting potential uptake of most nutrition and hygiene behaviors is the perception that these are related to care and ‘light work’ which should be done by women and are not as difficult, or as highly valued, as men’s work.

In addition, most pregnant women and mothers prioritize family interests and advice and do not make their own choices or decisions. Pregnant women, especially first-time pregnant women who live with parents or parents-in-law, follow what their mothers or mothers-in-law say during pregnancy, childbirth and immediately after birth. Experienced mothers have more space to talk to others, but still often prefer follow their families’ advice. While some mothers in lowland villages say they would take action if their family does not support their needs, more mothers put family interests and ‘must-do’ tasks as a wife first, before self-care or child care.

Decisions about health care seeking are often done as a family, and led or affirmed by the head of the household. Women have limited capacity to act around health care seeking, especially outside of the village, and rely on family members to decide and arrange transportation.

Underlying these gender dynamics are social norms or society mindsets about girls and women. For example, adolescent marriage is partly related to families’ fear of girls getting pregnant before marriage which would be shameful to the whole family, and girls’ fear of becoming an ‘old single’ so they take marriage proposals once out of school. There are also mindsets that impact breastfeeding; mothers-in-law make decisions about early infant feeding based on beliefs that mothers need to be cleansed before breastfeeding. Mothers must stop children from crying and should return to work soon after childbirth or communities would say they are ‘lazy’, which limits exclusive breastfeeding possibilities.

20 Stoeber, 2013
21 ADB, 2012
22 Loes Schenk-Sandbergen, 2012
The recent trend of young women who migrate to cities or Thailand for work could also influence the project. Mothers of infants and young children who migrate potentially leave children especially vulnerable to malnutrition. In addition to breastfeeding, the mothers interviewed note that only they, not grandmothers, take care to give other foods than rice to children and keep children clean.

Gender norms also influence who participates in community activities, and differs between lowland and midland villages. In all villages heads of households are prioritized, usually men, but in lowland villages husbands prefer to delegate to their wives to participate. Yet few mothers interviewed had ever participated in a meeting or activity except health outreach in midland villages. Mothers and grandmothers recommend that the project work with the village leaders to actively invite all household members to participate, with advance notice.

Potential Impact of the Project on Women and Men, Girls and Boys

Nutrition and WASH activities, as women’s domains, have the potential to add to mothers’ already demanding workloads or to damage family relationships if mothers do not do what is recommended. In this context, reducing women’s workloads is needed, but experience shows that this must be carefully facilitated through family and community discussion and agreement. CARE in Laos has experience reducing women’s workloads by “bringing together men and women to assess workloads, often with the result that men take a more active role in supporting what previously had been the work of women.” An unanticipated result was men’s frustrations that women should then help with their tasks, such as cutting trees and building houses.

Mothers who spend more time focused on self-care or childcare and feeding may face negative repercussions. Some women note gossip toward a woman who lets her husbands do ‘their work’ even when it is to care for her child. But the project has potential to engage communities around children’s healthy growth and development, a concern shared by both women and men, and to contribute to increasing the value of childcare and feeding.

For men, if programs address nutrition and hygiene to mothers, this could indirectly discourage their engagement in household tasks. Currently some fathers in lowland villages already share selected tasks, but may quickly relinquish all to women if there is more focus on mothers. On the other hand, the project has the potential to positively impact fathers in all villages through additional involvement in their children’s care and lives. Fathers universally want their children to respect them and look back in the future to say good things about them as fathers. While they did not have ideas about how to ensure this other than to pay for things for the child, fathers seem open to more involvement.

Girls want support to stay in school and delay marriage and childbearing until they are financially self-sufficient, but lose this focus and goal after marriage. Strengthening girls’ assets and skills to delay children may have unintended consequences on the girls such as harming relationships with their husband and families, or generating community gossip or driving girls’ migration. By putting attention on adolescent growth and nutritional needs, and building skills in family dialogue and support, girls and boys will benefit through more supportive environments.

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23 Stoeber, 2013
Conclusions and Implications

Adolescent Nutrition

Adolescent Girls’ Diets: Girls eat nearly the same food as their families, but often eat less than other family members. Girls in school, especially, say that they often skip breakfast in their rush to school and sacrifice of food for younger siblings. Some girls in school also talk about skipping other meals to diet, but few practiced this. Neither girls nor their families realize that adolescents are still growing, and need additional nutrient-dense food daily.

Improving girls’ nutrient intake will require family engagement; families grow, prepare and provide food for girls. Specific ways families could support include giving girls rice to carry to school and eat at mid-morning break if she skips breakfast and collecting additional food daily and/or preserving food. Family engagement can be fostered through the value that families already place on girls for their contributions to family resources (current contributions in both lowland and midland villages and future contributions in lowland villages), as well as their excitement for future grandchildren. Girls also recommended peer-to-peer learning on nutrition as well as support to eat an adequate, balanced diet each day. These support groups should also work to challenge gender norms that underlie girls’ sacrifice of food for others, and desire to be thin to promote a healthy body image.

Delayed Childbearing: Most girls get married and have a child soon after a girl leaves school. Although they know about family planning, girls describe little agency to make decisions after they get married. To support girls to delay marriage, and thus childbearing, vocational training or business opportunities are needed for longer-term efforts to delay the age of marriage. In the short-term, to delay childbearing and have direct impact on nutritional outcomes, strengthening the confidence and efficacy of girls just out of school and then at the time of marriage would help girls to remember and work to achieve their life goals, including preparing for communication with their husbands. In addition, new adolescent couples need greater access to family planning; although available in villages and known to girls, their stories suggest that once married they tend to follow what their husbands and parents say; and need preparation and support to have their voices heard.

Maternal Nutrition

Diet and Care in Pregnancy: All women and families interviewed in this study know the recommendations to support pregnant women through reduce workload and an improved diet, but few women or families understand the importance of adequate weight gain during pregnancy. Most families believe that they help to support a healthy pregnancy; especially once the fetus moves, families pay special attention and effort to take care of the baby.

However, families often interpret recommendations differently than intended. Most pregnant women say that they already eat more food and more variety of food. However, this is usually sour fruits and parboiled vegetables, rather than the additional protein and calorie-dense foods needed. When advised from health workers to eat more food, women interpret this as a call to buy high-value food from markets (i.e., pork), which they cannot afford regularly, rather than more locally available, nutrient-rich food of which they could eat more most of the year. Of note, it is likely that there are shortages of food, especially fruits and vegetables, during the dry season, which should be explored further. For these times of year, as well as other days (i.e., when going for ANC) knowledge and skills to preserve and store nutritious food for pregnant women are needed.

Women generally work hard throughout pregnancy. Although late in pregnancy families assign pregnant women reduced ‘heavy’ work and field work, women continue to labor around the house and garden throughout pregnancy. Pregnant women in lowland villages, especially those who live with their own parents, have more support to share work and/or stay home on days they feel unwell.
compared to pregnant women in midland villages. Some families in midland villages share field work with pregnant women late in pregnancy, and this causes resentment of the daughter-in-law.

To increase pregnant women’s consumption of calorie-dense foods, women and families alike need greater understanding of the need for pregnant women to gain adequate weight during pregnancy. Pregnant women and their families trust health workers and district health officers. Therefore, focusing nutritional counseling during ANC visits on helping families decide to collect and allocate more locally-available food to pregnant women could realistically improve diets. As much as possible, since husbands accompany pregnant women to ANC, counseling with the couple is key. Ideally the mother or mother-in-law can be engaged as well because, especially for first-time pregnant women, she guides or even makes the decisions.

To reduce pregnant women’s workload to the extent that would impact nutritional status, women, especially first-time pregnant women and mothers who live with extended family, family support is critical. Families can reallocate tasks as well as encourage fathers-to-be to support pregnant women’s work more, at least from the second trimester when the baby moves. Such change may be more realistic in matrilocal lowland villages than midland villages. Positive recognition of families who reduce the workload of pregnant women earlier in pregnancy could help to minimize resentment toward the woman. Greater father involvement is also possible. Fathers want to be good fathers, and some say that they already help their wives during pregnancy, although women would like much more support. Engaging fathers during pregnancy, when it is socially acceptable to do more, would enable families and communities to begin to shift the concept from ‘helping’ to jointly sharing household tasks and childcare.

**Diet during Lactation:** Mothers know that health workers recommend avoiding food taboos which vary by village, but face strong social pressure to follow restrictions, especially in the first weeks after birth. For example, a child’s stomachache is blamed on a mother not following restrictions. Women and families are not aware that a lactating mother needs additional nutrient-dense food each day to maintain her health or that unrestricted locally-available food could provide the needed calories and nutrients except during the first weeks.

To support lactating mothers to eat more food, health professionals should not advise to disregard food taboos, but instead advise mothers and families to collect or preserve and allocate additional locally available family food to mothers. Advice to disregard taboos is difficult for women to follow; first-time mothers especially must follow household norms but all mothers follow norms as they will be blamed for problems with the child’s stomach.

**Infant and Young Child Care and Feeding**
Mothers and fathers want their children to grow up healthy and strong; some mothers watch their child’s growth and weigh with home scales (for crabs) in the early months. However, few believe that they can do anything due to genetics and their situations. None understand the period of the first 1,000 days for life-long impact.

**Breastfeeding:** Most mothers and other caregivers know to begin early initiation of breastfeeding soon after delivery; mothers learn from health staff during ANC and/or outreach. Some mothers interviewed practiced early initiation because they gave birth in a district hospital or because they felt breastmilk come in. Most families, however, give water and rice – often Cerelac or generic rice powder (usually called ‘rice’) – until breastmilk comes in two to three days after birth. The mothers worry about not being able to breastfeed and tried several strategies to get their milk to let down, but none mention letting the baby suckle. Fathers and grandmothers believe that mothers need to recover from childbirth before breastfeeding the baby. A few shared that their family discards colostrum.
Mothers and other caregivers also know about exclusive breastfeeding from ANC and/or health outreach, and many wish to practice it, but families give a breastmilk substitute and premasticated rice, along with breastmilk, from early months. Desire to satisfy crying babies and women’s work demands drive early supplementation. Families believe that crying during the early months is due to hunger and that only rice satisfies hunger and makes the child fatter. This may be in part due to inadequate length of breastfeeds; mothers often breastfeed the child while engaged in multiple tasks, resulting in less than adequate intake of breastmilk. Mothers return to work outside the home soon after childbirth, when other caregivers, often the grandmother, need to give something to the child.

Social and gender norms govern mother’s limited options to change workloads in order to exclusively breastfeed. Even mothers whose families would agree to let her spend more time breastfeeding, feel strong social pressure to work in the fields. Community perception of mothers who care for a child and do not go to the fields is that she ‘does nothing’. Mothers say that they can arrange to return home more frequently to breastfeed if the family agrees, between rice planting and harvesting seasons. During rice cultivation, some grandmothers may be willing to take the child to the field to be near the mother.

Mothers and fathers have mixed information on the recommended length of breastfeeding, but most mothers prefer to wean a child by 12 to 15 months to more easily work around the home and to stop all food restrictions and eat usual family food again. Mothers also stop breastfeeding if pregnant again when they believe the milk ‘sours’.

Multiple levels of support are needed to improve breastfeeding behaviors. To motivate families to initiate early breastfeeding, family and community confidence in breastmilk to satisfy children’s hunger, as well as women’s agency to nourish her child, are needed. As family elders decide what to feed newborns and young children, interventions need to reach and support women as well as their families. Findings point to the need for counseling at health centers, community discussions and household agreements before delivery and return to work. Community engagement is key; families could make such changes only when they do not worry about community reactions.

**Complementary Feeding:** By six months when complementary food is ideally introduced, children are already eating premasticated rice and bites of other food such as banana and fish or meat when available, in addition to breastmilk. As a child gets closer to one year, and teeth come in, premastication stops and children increasingly take foods themselves. By the age of one year, many children feed themselves – mostly rice and finger foods – with assistance to prepare bites. Children begin to eat some family foods after this and by the age of two years are eating the full range of family foods with spices. At the same time, children are frequently given processed sweets and biscuits from one year or earlier, and some children also get milk (sweetened condensed or Lactasoy). As a result, children lack adequate diversity and quantity of food to meet their nutrient and energy needs. Few children get animal source foods or vegetables until after one year of age until even later.

Child feeding practices are driven by labor and time-constraints of mothers. Gender norms that require mothers to do multiple tasks at the same time; child feeding is one of many priorities for mothers. Feeding practices are also driven by child-led feeding norms, meaning that caregivers follow a child’s lead in deciding when and what to feed; whatever the family believes a child is asking for the family will give to the child. For example, an infant’s cries are interpreted as hunger, so families buy breastmilk substitutes. A toddler who spits out food is telling the caregiver he is not hungry, so they stop feeding him. Many mothers know how to encourage children to eat more, but
mostly do so only when the child is sick (when she can stay home and have time to pay attention). A child who asks for sweets several times a day gets what she wants. While it is the mother’s primary responsibility to keep the child from crying, most families feel that it requires family effort.

To support increased quality of complementary feeding from six months, and increased quantity as the child ages, a combination of interventions is called for: access to easy-to-use preserved food, parenting skills and tools to better read child ‘cues’ and make child feeding more fun. In addition, like nearly all of the behaviors in nutrition and WASH, gender norm shifts are needed, including increased maternal confidence and father involvement, which would indirectly contribute to increasing the perceived value of childcare and feeding. Given the strong influence of family and community norms, family support as well as community sanctioning are necessary to adopt and maintain new behaviors.

**Health Service Care-Seeking**

**ANC:** Most women and families interviewed in this study value ANC at facilities, and seek ANC despite distances and lost work. However, families believe ANC is needed or available only after the baby moves at 4-5 months. Late care seeking limits the total number of ANC visits possible. In addition, some women do not believe that multiple checks are necessary.

Early ANC could be increased through discussions with the family, and the promise to hear the foetal heartbeat. Women-to-women testimonials and encouragement, and community recognition of families who start ANC early would contribute to changing the belief that ANC is available only after the baby moves. Invitations from health workers through outreach or invitation cards to families of pregnant women may also support family decisions.

**Facility-based Delivery:** Usually families consider hospital delivery only in case of emergencies. Family elders and husbands make the decision about whether and when to go. Multiple factors contribute to their decisions, including transportation, costs and preference to have extended family at the birth. Family presence is related to strong beliefs in the protective nature of ‘blood’ relatives, and contributes to the fear of leaving their own village during this vulnerable time. Further, women know and fear worst-case scenarios as late care seeking for emergencies is usual, yet there are women in each village who delivered successfully in hospitals.

To promote facility-based delivery, family dialogue and agreement with the village chief and health workers before childbirth starts may be useful. In particular, these trusted authorities could help families to plan how extended family members could participate.

**Sick Child Care-Seeking:** A combination of home care, traditional medicine and modern medicine is used. When first line treatment at home does not work, fathers buy medicine from or near district hospitals, and take children to a hospital or health center at last resort. Fathers first buy vitamins at the market in case of low appetite.

Care-seeking for sick children at health centers would benefit from information on improved quality of care, including hours that staff are available at health centers.

**WASH**

Knowledge about water, sanitation and hygiene (WASH) is good among families and communities interviewed in this study, but the need to focus efforts on the first 1,000 days in order to have maximum nutrition and health impact is not understood.

Barriers to treating drinking water and handwashing with soap include women’s time and labor as well as personal preferences. The numerous competing tasks assigned to women/mothers results in
prioritization based on immediate needs and ‘must do’ activities such as cooking and serving. Sharing tasks through family support would enable the family to treat drinking water – even if only for the mother and child 6-23 months – and to wash hands with soap before eating and feeding a child. To encourage sharing tasks, some type of motivation and recognition targeted at fathers and older children may be useful. Dedicated places and utensils/supplies for treated drinking water and for soap with the handwashing bucket with attractive reminders would also support turning these practices into habits.

Similarly, sharing compound cleaning tasks – especially the areas where children from 9-23 months crawl, walk or play, would reduce contaminants that children ingest. To encourage sharing tasks among family members, some type of recognition for fathers and older children and positioning these as ‘family business’ is recommended. For all activities, making tasks fun through new products and/or games and community contests should be explored.

An additional barrier to clean play areas is neighbors’ behaviors. Mothers and fathers say that when neighbors do not pen animals, there is no point to pen their own animals. This issue requires collective action to agree on a local solution and mobilize community-wide commitment, as a core component of on-going Open Defecation Free (ODF) efforts.

**Activity Recommendations**

All of the pregnant women and most of the mothers would like to participate in community activities and/or women’s groups to learn about pregnancy and childcare including feeding and hygiene. Women listed specific topics of interest: diet during and after pregnancy and self-care during pregnancy; child feeding; how to talk to children and how to keep children clean. Some also want to learn about growing vegetables, animal husbandry and fisheries. Women prefer visual aids and interactive activities as opposed to ‘just talking’, as well as regular support from health care providers. Women in midland villages need support to seek permission from their mothers-in-law to attend.

Fathers and grandmothers also want to learn about child care, nutrition and hygiene. Some fathers also requested information on how to raise poultry.

All of the adolescent girls desire to learn more about reproductive health, self-care during menstruation and nutrition with peers using interactive sessions with visual aids. Girls out of school focused on topics such as childbirth and child care as well as cooking. Out-of-school girls want their parents to attend so that they can all learn the same information.

Most people suggest activities to be held in the late morning. All emphasize the need for advance notice from the village chief about the day and time and who should attend. Pregnant women want to join activities twice a week, while the others prefer twice a month except during harvesting, when they could participate only once a month.

**Gender**

Based on the analysis, several focal themes and interventions can help to reduce gender-based constraints to nutrition and WASH, and increase gender equality. As nutrition and WASH projects have the potential to reinforce gender inequalities and women’s role in the home by adding responsibilities to women, USAID Nurture should frame nutrition and WASH as ‘family business’. At the household and community level, this concept will facilitate and motivate discussions about everyone’s part to play and let the family and community decide who will do what, and how given available time and other resources. Children’s healthy growth and development can anchor these family business plans in a shared interest among women and men.
It will be important to steer away from discussing male engagement in nutrition and WASH as ‘helping women’ as that may reduce workloads but would reinforce current roles and make longer-term shifts more difficult. Gender reflections at the household and community levels can be incorporated through games and interactive activities to facilitate couple and family communication and raise the value of nutrition and WASH without explicitly addressing ‘gender’ which may result in pushback or low participation of men. Along with increasing the value of nutrition and WASH, to make it more acceptable to put energy and attention on these, greater appreciation for women’s efforts and contributions – and the family members who support them -- would help to create a more supportive environment for women to practice needed self-care and child care as well as to get more food and resources. This appreciation could be done through community recognition of families who achieve key behaviors as well as involved fathers and grandmothers and their mentors.

The project should work closely with village leaders to schedule activities to ensure women can actively participate. Mothers request activities to be organized mid-morning after morning chores and before they prepare lunch and forage for food. Women and men (and not only the head of the household) need to be proactively and explicitly invited by the village leaders to attend. To ensure women can actively participate in meetings and activities, the project can help women prepare for events and meetings through improved communication and advocacy skills starting with Community Facilitators, pairs of women who will be selected to reach first 1,000 days families in each village; skill-building and practice can be built into their training as volunteers and then into community visits so they can represent the needs of families in their village. In addition, communication skills for all adolescent girls and women can be enhanced through peer groups.

Girls want support to stay in school and reach their dreams for the future; they want to delay marriage and childbearing until they are financially self-sufficient, but lose this focus after marriage. Delaying childbearing calls for enhancing girls’ confidence and communication skills as well as identifying opportunities to realize their aspirations to become a mother once they are ready. As husbands and families play a role in making decisions about when to have a child, it is also important to work with young couples and their families to facilitate couple and family dialogue to listen to girl’s future goals, agree on their family aspirations and access services as needed.
Annexes

QUESTION GUIDE: ADOLESCENT GIRLS

Guiding Research Questions for Adolescent Girls
- What are adolescent girls’ dietary practices (by season, setting and marital status)?
- What are adolescent girls’ experiences and expectations for growth and development, desired body size/body image? In what ways do perceptions of growth and body image influence girls’ food choices and life planning?
- How can adolescent girls get enough, and the right kind of care, nutrition, and what are the barriers and facilitating factors that support these changes?
- What are girls’ expectations for marriage and childbearing?
- How can girls be supported to delay childbearing, and what are the barriers and facilitators to support changes?
- What is girls’ sense of their own and other girls’ well being, key concerns or risks to well-being and their coping strategies?
- What are girls’ life plans, values and aspirations for their future?
- What and who influences girls’ beliefs about nutrition, body image, marriage and health service use? Through which communication channels and/or social networks?
- What and who influences gender expectations for girls? What are the barriers and facilitators (including potential role models) for girls to adopt more equitable attitudes and practices?
- How do gender norms and roles affect girls’ dietary intake, school and marriage plans/practices?
- What are girls’ recommendations for the project to promote nutrition, empowerment and participation in the family and community?

Introduction

Hello! Thank you for agreeing to talk with us today. I hope our time together will be as meaningful to you as it will be helpful to us. We will be asking you some questions directly and others questions in the form of stories. This is not a test! These questions have no right or wrong answers. We only ask that you share what you truly think and feel.

Your answers will represent the thoughts and feelings of hundreds of girls just like you, and those girls need you to speak for them. Your ideas will help us to prepare a program useful for all girls like you.

Our time together may last about 2 hours. Our job is to ask you questions and listen well. We do not want to talk much; we want you to do all the talking because we care so much about what you have to say.

[After your self-introductions] Please introduce yourselves to us:

<table>
<thead>
<tr>
<th>Girls in school:</th>
<th>Girls out of school:</th>
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<tr>
<td>• Age</td>
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<td>• Ethnic group</td>
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<td>• Whom you live with at home</td>
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<td>• Grade in school</td>
<td>• Whom you live with at home</td>
</tr>
<tr>
<td>• How far is your school from your home</td>
<td>• Marital status and number of children</td>
</tr>
<tr>
<td>Your favorite food</td>
<td>• An activity you enjoy</td>
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</table>
Food
1. On flipchart paper or in the ground, ask girls (individual or small groups) to draw usual meals in one day.
2. Lead a discussion for each food mentioned:
   a. Where do you get this food?
   b. Who decides what food is prepared each meal?
   c. How much do you usually eat of this food in one meal?
   d. How are the meals different by different days of the week or times of the year?
3. Do you eat other foods between meals (snacks)? What foods and when?
4. Let’s imagine that you are advised to eat more fish or meat, eggs and vegetables each day. Is that possible?
   a. How? (Probe for: Collect foods in the wild.)
   b. Who could help you to eat more of these foods?

[Please take note of the number of meals and amount of foods eaten.]

Growing Up Drawing:

5. Imagine yourself in the future, when you have achieved your goals. Please make a drawing of the life you would like to have in the future. (For FGD Encourage any type of drawing, even just colors).
   a. Can you explain the picture to me? (Probe for: Age in the picture? Goals? How old will you be when you marry and have a child? Who will you live with? How will you feel?)
   b. How can you achieve your goals?

[Please collect the drawings or take a photo.]

Growing Up Stories:

6. Please tell or write a short story about growing up about yourself or other girls (individuals or small groups).

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<thead>
<tr>
<th>Girls in school for example, consider:</th>
<th>Girls out of school for example, consider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When did you know you are growing up to become a woman, and how did you feel?</td>
<td>• When did you know you are growing up to become a woman, and how did you feel?</td>
</tr>
<tr>
<td>• What advice did you get about growing up or becoming a woman? From whom?</td>
<td>• What advice did you get about growing up or becoming a woman? From whom?</td>
</tr>
<tr>
<td>• What advice would you give to other girls?</td>
<td>• What advice would you give to other girls?</td>
</tr>
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</table>

[Suggest to include advice they did not get, but was needed. Please collect the stories or take note.]

Now I will read you short stories and ask you a few questions after each story.
7. Noy’s story

One day when Noy was 14 years old she saw blood on her skirt. She felt scared and embarrassed at the same time. Aunties had told her that girls bleed when they become a woman, but she did not know if this is the reason she was bleeding. She decided not to tell anyone.

a. Does this happen sometimes for girls? Why?
b. What is different for girls here?
c. What do they think will happen when they begin bleeding?
d. What will their family do? Why?
e. (In school girls) Can girls who begin bleeding continue to go to school? How do they manage? How do you describe girls who continue to go to school?

8. Pheth’s story

Pheth attends primary school with friends. She does well in school and always scores highest in her class on the mathematics exams. Her teacher encouraged her to continue to lower secondary school and she felt excited to go next year. Later her family asked her to work in the fields instead. They said there is no one to help in the family now, but she could return later. Pheth feels disappointed!

a. Does this happen sometimes for girls? Why?
b. What is different for girls here?
c. Who can girls go to for advice or support from? Why this person?
d. Do you know girls who complete high school? How can they manage to do this? How do you describe girls who complete school?
e. Who can support girls to complete high school? How?

9. Mai’s story

Mai is 17. Her mother took her to a health center when she was sick. The health worker gave her medicine and advised her to gain weight because Mai is too thin (underweight). This can make her get sick easily. Also, it is good for her to get stronger since she may get married and want to have a child in the future. At home the next day, her mother collects extra frogs and eggs for Mai, and encourages her to eat more rice too.

a. Does this happen sometimes here? Why or why not? –
   (Probe for: the influence of other decision-makers)
b. If girls do not get support from the mother, what would they do? Why?
c. How do you describe girls who get health care when needed?
   (Probe for: internal characteristics /skills)
d. Who can girls go to for advice or support?

10. Vanna’s story

Vanna is 16 years old. Her family says it is time to get married. They would like extra hands for helping in the fields. She wants to make her family happy, but she also wants to complete school.
a. Whom could she ask for advice or support? Why this person?
b. What is a good age to get married according to elders? Girls themselves? Why?
c. What is a good age to become a mother according to elders? Girls themselves? Why?
d. Do you know anyone here who waited until after 19 or 20 years to have a child? Why?
   What do you think about this? What do people say about her?
e. What are the good things about getting married? What are the challenges?
f. What are the good things about having a child? What are the challenges?
g. What qualities do girls look for in a husband? How can girls find a good husband who will love and care for her? How do girls know if a man will be a good husband who will love and care for her?

Discussion

1. Please tell me about any girls you’ve heard about who feel very sad or scared. What happened?
   (Probe for self-harm)
   a. Why did she feel this way?
   b. What kinds of support did she receive and from whom?
2. What have you learned about nutrition, health or hygiene? From whom/what source?
3. Who is the best source of information for girls like you to learn about health and care for themselves?
4. Who do girls believe the most? Why?
5. What do you recommend for this project to help other girls like you learn about these things?
   (Probe for: who, where, when, how often).
6. What topics would you like to learn more about?

Thank you for your time. Now do you have any questions you would like to ask? I am not sure I will be able to answer them all, but I will try. (Record all questions.)
QUESTION GUIDE: WOMEN

Guiding Research Questions for Pregnant Women

- What are pregnant women’s perceptions and practices related to pregnancy, health care-seeking/use and diet?
- What are the key barriers and facilitating factors related to recommended practices, including perceptions of health services, as well as seasonal and gender considerations?
- What are women willing to do to improve care, health services utilization and nutrition during pregnancy?
- Who influences pregnant women and through which communication channels or social networks?

Guiding Research Questions for Mothers

- What are women’s perceptions and practices related to diet after pregnancy and what are women willing to do to ensure they get enough food and the right kinds of food?
- What is preventing early initiation of breastfeeding and how might breastfeeding be begun within the first hour of birth, and reduce pre lacteal feeds, especially for women who do not deliver at a health center?
- What are current perceptions and practices, including barriers and motivations, of exclusive breastfeeding, and opportunities to increase?
- What are current perceptions and practices, including barriers and motivations, of continued breastfeeding, and opportunities and facilitators to lengthen?
- When, why, and with what is supplementation occurring during the first six months and what would motivate a delay in supplementation until six months?
- What are current perceptions and practices related to feeding young children breast milk substitutes and milk products?
- What are the key barriers and facilitators to increasing the frequency, quantity and consistency of complementary food for children of different age segments (6-11 months and 12-23 months)?
- What are the opportunities to improve food diversity problems, focusing especially on animal-source food and fats?
- What are feasible recommendations, and the barriers and motivations, for feeding more food/liquid after illness?
- What are perceptions and practices for child growth monitoring and promotion (GMP), and what are opportunities and facilitators to increase regular GMP utilization?
- What are perceptions and practices for sick child care-seeking?
- Where/what is the household drinking water source, and what are mothers’ perceptions of clean drinking water and opportunities and motivations to treat water?
- What are the perceptions and practices related to hand washing and hygiene (including clean homes/play areas) in the home, and the opportunities and motivations to change?
- What are women willing to do to ensure children get enough, and the right kind of food, feeding and care?
- What are the aspirations, perceptions around parenting/child care, child growth and chronic malnutrition, by different stages/age segments?
- What are women’s expectations of their roles and responsibilities?
- Who influences mothers, and by which communication channels or social networks?
- What opportunities can support women’s empowerment and participation?

Introduction

Hello! Our time together may last about 1 hour. I will ask you some questions. I will not say much; I want you to do all the talking because I care about what your answers are. The questions have no right or wrong answers. I only ask that you share what you truly think and feel.

Your answers will represent the thoughts and feelings of hundreds of women just like you, and those women want you to speak for them. Your ideas will help us to design a program that is useful for all women and their children.
[After a self-introduction, ask:] Please introduce yourself: age, how many children you have and their ages, who lives in your home.

[FOR PREGNANT WOMEN, SKIP MOTHERHOOD SECTION. CONTINUE TO SECTION 3. FOR MOTHERS, SKIP PREGNANCY. CONTINUE TO SECTION 2. NOTE: PREGNANT WOMEN WITH CHILDREN UNDER 2 CAN COMPLETE THE FULL INTERVIEW.]

1. PREGNANCY

Photo-based Discussion

First I will show you some photos, and ask you a few questions about these photos. (Feel free to share your own experiences if you feel comfortable.) Show photos of pregnant women.

   a. Do you think she feels happy sometimes? What makes this woman feel happy?
   b. Do you think she feels sad or confused sometimes? When and why?

8. Which women will go for 4 check-ups at a Health Center? Please explain. What do people say?
   If she mentions that husbands or families decide, ask:
   i. Who influences the husband/family?
   If she mentions that families agree only when there were previous complications, ask:
   ii. What do people say about women who go for health services, even when it is their first pregnancy?

9. Which women will deliver the baby at a Health Center? Please explain.

10. Which women will drink alcohol during pregnancy? How often/much, usually? Why?

11. Which women will eat more rice and other foods during pregnancy? Please explain.
   a. Why do they eat more?
      (Probe for: someone recommended? Someone supported? How?)
   b. What types of rice and other foods would they eat more?
   c. How can they do this?
      i. Any wild food available around the house or fields?
         (Probe for: greens, crickets, frogs)
      (Probe for support from others: encouragement, providing more food, giving more money to purchase more food, etc.)

Story

Now I will tell a short story. Please help me to finish the story by answering some questions after.

12. Noi’s Story

Noi was pregnant with her first child. She continued to work in the fields, carry firewood and cook. Her friends advised her to go to the health center for a check-up. The health worker advised her to eat more rice and eggs or meat, and return again in 2 months. But her husband did not agree because she seems fine.

   a. How does Noi feel when her husband does not agree?
b. What could Noi do next?
   (If getting other support or other ideas are mentioned, ask:
   i. Is it possible? How?
   c. What support do pregnant women want from their families?
      (Probe for: specific actions; who-mother/ mother-in-law, husband, other women, etc.)

2. MOTHERHOOD

Questions
1. How old is your youngest child?
2. Is this child a girl or boy?

Let’s talk about this child during our discussion today.
3. Does anyone else help to watch or care for your child?
   a. If yes, Who?
   b. What do they do with the child?
   c. When/ how often?

Story
Now I will tell a short story. Please help me to finish the story by answering some questions after each part of the story. (Please feel free to share your own experiences, if you feel comfortable).

4. Lani’s Story

Lani had a baby! Although she felt tired, she put the baby on her chest, and hoped the baby would take breastfeeding. When she said that did not feel the milk coming in, her mother-in-law gave the baby premasticated rice and some water instead. Later she gave the baby to Lani to breastfeed. But, Lani was unsure if the milk was enough for the baby.

a. Does this happen here sometimes?
   i. Why or why not? (Probe for: confidence of mother, influence of others)
   ii. When does it happen? (Probe for: place of delivery, experience of mothers)
   b. Do some mothers give only breast milk after birth? How is that possible?
   c. What do you think Lani should do?
   d. Where would Lani or her mother-in-law get advice about breastfeeding?

After birth, Lani stayed home from work and gave the baby only breast milk—no other food or drinks. Then, after 2 months, her father-in-law said it is time for Lani to return to work in the fields. Although she continued to breastfeed when she was with her baby, sometimes, when she went out, her mother-in-law cared for the baby, and gave the baby other liquids and some rice.

a. Does this happen here sometimes?
   i. Why or why not? (Probe for: seasons/time of year)
   f. What food and liquid are children given before 6 months?
   g. What should Lani do to be sure the child has only breast milk until 6 months?
   h. How could her family support her?
   i. What do people say when a child is given water, or fed rice at 6 months and not before?
   j. Do some mothers wait until the child is 6 months to give other water or food? How can they do this?
   k. What rice and foods do mothers usually eat?
   l. How much of these foods each day?
m. What is different from when the mother was pregnant?
   (Probe for: Amount of rice? Frequency of eating?)

n. What are the different foods that mothers would not eat? For how long after delivery? Why?

When the child was 12 months, Lani was busy and tired from working in the field, doing chores and cooking. She let the child eat rice by herself, anytime. The child was always playing, and seemed fine.

a. Does this happen here sometimes?
   i. Why or why not?
   ii. When is it more likely to happen? (and at what age?)
      (Probe for: first child vs other children)
   iii. What other foods, in addition to rice, do children of this age sometimes eat? Why?

b. Could Lani find a way to give more food, different foods, and track the amount of food her child eats a day?

c. Why or why not? How could she do this?

d. How could her family support her?

Lani decided to try giving her child more rice and other foods. To be sure her child ate all of the food each meal, she fed the child while talking and playing with her. She enjoyed this time very much! She kept track of how much food the child ate.

e. Do some mothers decide how much food a child gets each meal or day? How can they do this?

f. How do they know when a child is hungry and full?

g. Could her child eat more rice and other foods? If yes, what foods could families give more of? (Probe by: season, type of animal source foods: egg, fish, frog, etc.)

When Lani’s child was over 1 year, she stopped giving breast milk even when the child was still asking. The family bought condensed milk for the child and gave some of that instead.

h. Does this happen here sometimes?
   i. Why do mothers stop breastfeeding?
   ii. When is it more likely to happen?
   iii. How do you think Lani felt when the child stopped breastfeeding?
   iv. Do some families give children condensed milk or milk powder? Why? Where is it purchased? How is it prepared?

i. Could Lani find a way to continue breastfeeding until the child reaches 2 years or older?
   i. Why or why not?
   ii. How could she do this?

j. How could her family support her?

k. Do some mothers here breastfeed the child until 2 years? How is this possible?

l. Where do children like Lani’s child usually defecate? Why?
   i. What do families think about children’s feces? Why?
   ii. Where could Lani or another family put the child’s feces?
      (Probe for: toilet, bury? How often?)
Sometimes Lani’s child is sick with diarrhea. Her neighbors advise her to give less liquid and food during illness. The diarrhea goes away. But for a few weeks after the illness, the child does not want to eat. Lani is concerned, but she does not know what to do.

i. Does this happen here sometimes?
   i. Why or why not? (Probe for: Why less food and liquid after illness? When – ie, caregiver or season?)
   ii. What food Lani would likely not give to her child during these illnesses? Why?
   j. After illness, could Lani give the child more food and breastmilk than usual?
   iii. Why or why not? How could she do this? (Probe for: pressure to eat; get advice; play with child; give favorite foods; give up)
   k. During illness, could Lani take the child to a health center? Why or why not?
   l. How could her family support her to seek care and feed extra food after illness?
   m. Do some mothers give children more food and breastmilk after illness? How do they do this?

Photo-based Discussion
Now I will show you some photos, and ask you a few questions. Feel free to share about yourself as well.

Show photos of children.
5. How do mothers feel about having children of different ages? (What color describes how mothers feel with a child of this age? Why do you select this color)?
6. What do mothers enjoy about interactions with a child of this age? (Ask about: cute, loving, quiet, etc.)
7. Can this child feed her/himself? Which foods?
8. Do mothers have any concerns for a child of this age? Please explain.
   (Ask about: Differences by girls and boys?)
9. How do you know if a child is fine at this age? Not fine?

Show photo of stunted child.
13. How do you think this child looks?  
   (Explain that the child is stunted, with chronic malnutrition).
14. What do people usually think and do if a child looks like this?
15. Do people here think that all children can grow well? Why or why not?
16. What can the child’s family do to ensure that s/he grows well? Please explain.
   (Ask about: Who should act?)
17. What do people say about GMP for children?  
   (Probe for: good and bad things?)
18. What could families do to help mothers take children for GMP every month?  
   (Probe for: Challenges and solutions?)

WASH
10. Where is your water source? Can you show me?
11. Where is the water for drinking?
   a. Is it boiled for drinking? If yes, how often? Who drinks the boiled water?
   b. Besides boiling, what are other ways to make your water good to drink? Please explain.
   c. What do people in your family say about drinking treated water?
12. Can you show me everywhere you can wash your hands in this house? (check proximity to eating and cooking areas, soap, soap recently used, access for children)
a. When do you usually wash your hands?
b. When do you wash hands with soap?
c. Do your children wash their hands? With soap? When?
d. What are the good things and bad things about washing hands with soap?

13. When I say a ‘clean home’ what does that mean to you? Can you describe it?
   a. What are the good things about having a clean home? What are the challenges?
   b. What support would you need from family to have a clean home?

3. COMMUNICATION AND RECOMMENDATIONS

14. How would you describe a good Wife? A good Mother?
15. How would you describe a good Husband? A good Father?
16. What do fathers usually do around the house?
17. What would mothers like fathers to do more of?
18. Has anyone advised you about being a mother?
   a. If yes, who talked to you? What did they say?
19. Has anyone advised you about raising children?
   a. If yes, who talked to you? What did they say?
20. Who is the best source of information for others like you to learn about child care and feeding?
21. Sometimes pregnant women and mothers do not get the support they need to rest and eat
    more. What would you advise to women who do not get the support they need? Who could
    help?
22. When do you attend village meetings?
23. Who decides if you attend village meetings?
24. If there are new activities for mothers about health and nutrition, would you like to participate?
   a. If yes, when?
   b. What topics would you like to discuss and learn about?
   c. What would make it fun and interesting to learn and discuss?

Thank you for your time. Now do you have any questions you would like to ask? I am not sure I will
be able to answer them all, but I will try. (Record all questions.)
QUESTION GUIDE: INFLUENCERS

Guiding Research Questions for Influencers

- What are the beliefs about children’s growth and development, and chronic malnutrition?
- What are beliefs about pregnancy, childcare and women’s and children’s diet, and opportunities to improve family support during these times and issues?
- What are the perceptions, barriers and support for early, exclusive and continued breastfeeding, complementary feeding and sick childcare and feeding?
- What are families and communities willing to do to ensure women and children get enough, and the right kind of, food, care, health services?
- What are perceptions of clean drinking water and opportunities and motivations to treat water?
- What are perceptions of clean homes/ hygiene in the home, and what and how are influencers willing to change?
- What are families and communities willing to do to support adolescent girls continue school and delay childbearing?
- What are the gender roles and expectations of men and women, boys and girls, and timetable/schedules by season, especially related to food, household and childcare and decision-making?
- How do gender norms and attitudes influence nutrition, WASH and health care seeking?
- What are barriers and opportunities to increase women’s empowerment and participation, and women/girl and men/boy’s and participation in nutrition, WASH and health care seeking?
- What community structures support nutrition, WASH and health issues, if any, and how do they function?
- Who influences families, and through which communication channels or social networks?

Introduction

Hello! Our time together may last about 2 hours. I will ask you some questions. I will not say much; I want you to do all the talking because I care about what your answers. The questions have no right or wrong answers. I only ask that you share what you truly think and feel.

Your answers will represent the thoughts and feelings of hundreds of caregivers /fathers just like you, and those women want you to speak for them. Your ideas will help us to design a program that is useful for all families.

[After a self-introduction, ask participants:] Please introduce yourselves, and tell us your age, how many children you help to care for and their ages.

Photo-based Discussion (Fathers and Other Caregivers only)

Now I will show you some photos, and ask you a few questions to learn what is common here. Show photos of pregnant women.

19. How does the pregnant woman feel at this time of life?
20. What does her husband and family think when they learn she is pregnant?
21. Does her family do anything different or special? Please explain. (Probe for: time in pregnancy early and late; events and traditions; support from husband, others.)
22. Let’s imagine that a father helps his pregnant wife with chores (such as carrying firewood or water) and eating more, what would people say about him? (Add more examples appropriate to the setting.)
23. Let’s imagine that an older woman such as sister or mother-in-law supports the pregnant woman with chores so she can rest and eat more, what would people say about her?
24. Which of these women would go to a health center for check-ups? Who would not go? Please explain.
25. Which of these women would eat more food during pregnancy? Why do you say this?
26. We hear that pregnant women often do not eat enough fish/meat, eggs and vegetables.” Why do you think this happens? Or if you disagree, why do you disagree? How could families help pregnant women eat more fish/meat, eggs and vegetables? (Probe for: What could they do – which foods specifically and how often?)
27. Which of these women take rest during pregnancy? Why do you say this?

28. Across Laos there are many pregnant women who do not go for 4 check-ups or deliver at health centers. Why do you think this is? For those who go, why do you think they go? What could families do to ensure more women get health care? Who could do this?

29. Would most families help pregnant women go for 4 check-ups? Deliver at a health center? Why or why not? (Probe for: What could they do to ensure women get more health care, who could do this?)

Show photo of the children by age:

<table>
<thead>
<tr>
<th>Newborn</th>
<th>Under 6 months</th>
<th>12 months</th>
<th>22 months</th>
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<tbody>
<tr>
<td>How old is this child?</td>
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<td>How do families feel about a child this age?</td>
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<td>What is important for a child this age? (Probe for: ceremonies; breastfeeding; affection; health care)</td>
<td>What is important for a child this age? (Probe for: ceremonies; breastfeeding; play; affection; health care)</td>
<td>What is important for a child this age? (Probe for: ceremonies; breastfeeding; food/drinks; play; affection; health care)</td>
<td>What is important for a child this age? (Probe for: ceremonies; food/drinks; play; learning; health care)</td>
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<td>What is important for the mother of a child of this age? (Probe: support to eat more and the right foods – which foods, social support, etc.)</td>
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<td>What concerns do caregivers/fathers have for children of this age? (Probe for: differences by girls and boys?)</td>
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<td>How often are children of these ages sick? When sick, what does the family do? (Probe for: breastfeeding, health care – where; who makes the decisions?)</td>
<td>How often are children of these ages sick? When sick, what does the family do? (Probe for: health care – where; who makes the decisions?)</td>
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<td>How soon do you think the child was breastfed? Why do you say that? Some children take liquids or food first,</td>
<td>What is this child drinking or eating? Why do you say that? Some children get other food and drinks before</td>
<td>Some children stop breastfeeding before the age of 2, right? Why?</td>
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<tr>
<td>Newborn</td>
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<td>before breastmilk, right? Why?</td>
<td>6 months. What is the reason? Do some children get only breastmilk until 6 months? Who are these families?</td>
<td>Would families help mothers continue to breastfeed until 2 years? Why or why not? (Probe for: Advice, taking child to work, other? Who could do this?)</td>
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<td>Would families be willing to help mothers breastfeed the child immediately after birth, and not give other liquids or food first? Why or why not? How could families help?</td>
<td>Would families be willing to help mothers give breastmilk only to the child until 6 months? Why or why not? What are some ways families could help mothers give only breastmilk until the child is 6 months? (Probe for: wet nurse, bring child to mother’s work, mother wait until 6 months to work, other?)</td>
<td>Let’s imagine that the child should eat more food each day. How could families help ensure that the child eats more food each day? Would most families be willing to do these things? Why or why not? (Probe for: specific type of food and amounts, challenges and solutions)</td>
<td>Let’s imagine that the child should eat more food each day. How could families help ensure that the child eats more food each day? Would most families be willing to do these things? Why or why not? (Probe for: specific type of food and amounts, challenges and solutions)</td>
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<td>What age should the child eat semi-solid food? (Probe for: What makes you give children food-signs from child, mother’s work situations)</td>
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<td>What are challenges to wait until a child is 6 months to give food and liquids, in addition to breastmilk? Would families wait to start food and liquids when the child is 6 months? Why or why not? How?</td>
<td>How could families help? (Probe for: specific type of food and amounts, challenges and solutions) (Probe for: Most enjoyable interactions? Feed child sometimes-why or why not?)</td>
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</table>
What is the term here (what do you call) for a child just born? What is the next stage for the child? (Probe for: age, term) [Continue until age 2].

Show a photo of a stunted child

30. How do you think this child looks?  
(Explain that the child is stunted, with chronic malnutrition).
31. What do people usually think and do if a child looks like this?
32. Do people here want children to grow tall and strong? Why or why not?  
(Probe for: girls vs boys?)
33. What can the child’s family do to ensure that s/he grows well? Please explain.
(Probe for: Who should take action, what action?)
34. What do people say about GMP for children?  
(Probe for: good and bad things?)
35. Would families help children until 2 years go every month for GMP? How?  
(Probe for: Challenges, solutions)

WASH Stories: 
[Read the stories. Then ask participants to complete the answers.]

36. Pech’s story  
*Pech has a child nearly 2 years old. Usually the family drinks water from the stream or rainwater jars. Sometimes she boils water to give the child for drinking, but not often.*
   a. Who makes the decision in the family to treat drinking water or not?
   b. Why do you think she does not treat drinking water for her child?  
      (Probe for: taste, clean)
   c. What could other family members do to ensure the child only drinks treated water?

37. Vatsana’s story  
*Vatsana learned about the importance of handwashing from her village leader. She set up a handwashing station with soap near the cooking area, like she learned, but no one in the family uses it.*
   a. Why do you think no one is using the handwashing station?
   b. Who makes the decision in the family to set up a handwashing station? Who buys soap?
   c. What type of handwashing station do you recommend for the family that they would like to use?

38. Keo’s story  
*Keo has four children. He also raises some goats and chickens that run around the house area. He sometimes wonders if it is good for children to play there.*
   a. Do you agree with Keo? Why or why not?
   b. How could Keo keep the children’s play area clean from animals?
   c. Is this solution for other families? Why or why not?

Food and Events Calendar (This part is for the village leader only)

39. What foods are available from the market, fields, gardens and the wild and when?  
[Draw or list on paper by month/season or put on the ground with stones and leaves].  
(Probe for: When is the lean season? What is available?)
40. What foods can be preserved or saved and eaten later?  
41. What events are organized in the community and when? Who attends?
GENDER AND COMMUNICATION

Sometimes men and women have different roles and opportunities. Now let’s talk about these differences.

42. How should good young girls and young boys act? Adolescent girls and boys?
43. What is a good man? Father? Woman? Mother?
44. (FATHERS ONLY)
   a. How should a good father of children under 2 years old look like or what should he do?
   b. What do you want for your sons in the future? Daughters?
   c. What should your children say about you, as their father, in the future?
45. Are there some women who participate in the community activities? Can you describe them?
   (Probe for: age, position, education)
46. When do women participate in community activities?
47. Could communities encourage more women to participate in activities and events? What would be the challenges to this? Who could solve the challenge?
48. What do people say if a girl completes high school?
49. What are the good things and bad things for her family when a girl leaves school early?
50. What is a good age for a girl to get married? Please explain.
51. How do families decide when a girl gets married?
52. What do people say if a girl waits until 19 or 20 years to have a child?
53. How can communities help girls to wait until after 19 years to marry and have a child?
54. Are there families in this community or nearby who delay their daughter’s marriage until after 19? How can they do that? What do people say about them?

This is the final set of questions. I would like to learn from you about how you get information.

55. Where do you usually get information about issues like health care?
56. Who is the best source of information for others like you to learn about nutrition for children?
   (Probe for: village leaders, health workers, volunteers, friends, relatives, other groups, TV, radio)
57. Who else do you really believe about issues related to nutrition and children?
58. Who do you talk to about your family and children, usually? Where/how often?
59. What do you recommend for this project to help others like you learn about caring for children?
   (Probe for: who, where, when, how often).
60. What are the groups in this community?
   (Probe for: unofficial groups, groups of friends)

Thank you for your time. Now do you have any questions you would like to ask? I am not sure I will be able to answer them all, but I will try. (Record all questions.)
**OBSERVATION CHECKLIST**

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Village</td>
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<tr>
<td>Number of People in the Household</td>
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<tr>
<td>Age of Mother</td>
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<tr>
<td>Age of Child under 2</td>
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**Surroundings:**
- Does the household have small animals? □ Yes □ No
- Is there a chicken coop? □ Yes □ No
- Does the household have goats or cows? □ Yes □ No
- Is there an appropriate goat or cow shed? □ Yes □ No
- Are there visible animal feces on the ground? □ Yes □ No
- Is there a home garden? □ Yes □ No

**Kitchen:**
- Are all water jars covered with a lid? □ Yes □ No
- Is there a drinking water container? □ Yes □ No
- Is there a water source for hand washing? □ Yes □ No
- Is there soap or ash for hand washing? □ Yes □ No
- Is any food covered? □ Yes □ No
- Would cooking smoke get to the child? (ie inside)? □ Yes □ No

**Latrine (if any):**
- Is there a water source for hand washing? □ Yes □ No
- Is there soap or ash for hand washing? □ Yes □ No

**Child**
- What is the child under 2 doing during your visit?
  □ eating  □ sleeping  □ playing □ other, please specify: ____________
- Where is the child doing this? ____________
- Who is looking after her/him? ____________