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HEALTH AND SOCIAL WELFARE REPORT IN LAO PDR

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HEALTH AND SOCIAL WELFARE REPORT IN LAO PDR

I. Background
The population of Lao PDR is 5,609,997 as of the census 2005. Its growth rate reduced from a high of 3.1% for 1994 to 2.0% for 2005. The total fertility rate decreased as well to 4.9 per woman as of 2000. The downward trends were seen in crude birth rates, crude death rates and percent of rural population.

Health Status: Through the years, Lao people have become healthier. Those born in 2000 may expect to live 19 years longer than those in 1960 up to 59 from 40 years old, respectively.

However, compared to the people in other ASEAN countries, it seems Lao people are the least healthiest. They have the shortest life expectancy at birth. Infants have the lowest probability of surviving. Women suffer the most pregnancy-related illness with its maternal mortality rate the highest in the region. Their children under the age of five have the second lowest probability of survival, next only to Cambodia.

The most common causes of morbidity are malaria, pneumonia, influenza, diarrhoea, and dengue haemorrhagic fever. Except influenza, these are also the most common causes of deaths. Moreover, the number of malaria cases per 100,000 people exposed to malaria-infected environments has remained high. In 2002, death rate associated with malaria was 3.5. Morbidity rate due to malaria 48 per year per 1,000. These imply the difficulty in controlling malaria.

Table 1 Comparison of Health Conditions of Men and Women

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentages</th>
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<tbody>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Population with previous illness</td>
<td>2.3</td>
</tr>
<tr>
<td>Population with injuries and/or accidents</td>
<td>0.5</td>
</tr>
<tr>
<td>Road accidents</td>
<td>25.2 (of road accidents)</td>
</tr>
<tr>
<td>Population with fever</td>
<td>1.8</td>
</tr>
<tr>
<td>Population with fever and other malaria symptoms</td>
<td>53.8</td>
</tr>
<tr>
<td>Positive blood test for malaria</td>
<td>2.8</td>
</tr>
<tr>
<td>Children with ARI</td>
<td>0.7</td>
</tr>
<tr>
<td>Children with ARI and taken to appropriate health provider</td>
<td>37.5</td>
</tr>
<tr>
<td>Children with diarrhoea</td>
<td>5.7</td>
</tr>
<tr>
<td>Children with diarrhoea and given any recommended home fluids or ORS</td>
<td>95.4</td>
</tr>
</tbody>
</table>


II. Maternal and Child Health and Welfare
1. Current situation of mother and children
A chronological examination of the health status of mothers and children in Laos indicates steady progress during the past three decades. The infant mortality rate (IMR) has declined from 146 in 1970 to 82 in 2000, and the under 5 mortality rate (U5MR) from 218 to 106 in 2000. The maternal mortality rate (MMR) declined from 650 in 1990 to 530 in 2000,
while the total fertility rate (TFR) also fell from 6.2 to 4.9. The figure is still one of the highest in South-East Asia.

<table>
<thead>
<tr>
<th>Table 2 IMR, U5MR and MMR by Reproductive Health Survey 2000</th>
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<tr>
<td></td>
</tr>
<tr>
<td>IMR</td>
</tr>
<tr>
<td>U5MR</td>
</tr>
<tr>
<td>MMR</td>
</tr>
<tr>
<td>Source: SPC and NSC, 2001, Lao Reproductive Health Survey 2000</td>
</tr>
</tbody>
</table>

The survey shows significant differences between rural and urban areas. The IMR and U5MR in rural areas are twice and 2.3 times the rate for urban areas. Both rates are lower in the central region than in the south and north. MMR statistics also show a significant disparity between the urban and rural areas with the rural rate 3.4 times the urban rate.

1) Safe Motherhood: Pregnancy and Delivery
In principle, to lower MMR and prevent neonatal deaths, it is essential to ensure the following: 1) antenatal care (ANC) and postnatal care; 2) clean and safe delivery; and 3) emergency obstetric care. Below are brief overviews of each issue.

1.1 Antenatal and Postnatal Care
(1) Antenatal Care (ANC)
In Laos, however, only 24 % of births receive antenatal care. The gap between urban and rural areas is stark with 73 % for the urban women and 18 % for the rural women. The proportion of births receiving antenatal care closely correlate with the mother’s educational level, with 8 % for mothers with no education and 98 % for mothers with higher secondary education. At the moment, antenatal care is available at provincial MCH clinics, district hospitals, and health centres, or from MCH outreach activities at village level. In addition to lack of awareness amongst pregnant women and their families, the low proportion of mothers receiving antenatal care is due to the shortage of health personnel to provide such services and lack of availability of antenatal care.

(2) Reproductive Health / Birth Spacing (B/S)
The high MMR is closely associated with a high fertility rate. The figures for Laos for both are amongst the highest in the region. With regard to birth intervals, 31 % of births occurs within 24 months of the previous birth.

The Birth Spacing Programme was launched in Laos in 1994 and the National Birth Spacing Policy was adopted in February 1995. According to the Lao Reproductive Health Survey 2000, 40% of married women practice birth spacing. Urban women (69%) are more likely to practice birth spacing than rural women (35%). The use of birth spacing methods is also closely linked with the mother’s educational level. Only 17.5% of married women with no education use birth spacing, while 85% of married women with higher secondary education do so.
Since 1994, the Birth Spacing Programme has rapidly expanded its coverage in cooperation with UNFPA and birth spacing services were available at all provincial and district hospitals and at 542 health centres by the year 2000. The services available at these facilities are shown in the table 3. Only specially trained medical doctors, medical assistants, midwives and nurses are allowed to apply intrauterine devices (IUD).

Table 3 Available Birth Spacing Methods at Each Health Facility

<table>
<thead>
<tr>
<th>Provincial Hospital</th>
<th>District Hospital</th>
<th>Health Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Consultation</td>
<td>- Consultation</td>
<td>- Consultation</td>
</tr>
<tr>
<td>- Pill</td>
<td>- Pill</td>
<td>- Pill</td>
</tr>
<tr>
<td>- Injection</td>
<td>- Injection</td>
<td>- Injection</td>
</tr>
<tr>
<td>- Condom</td>
<td>- Condom</td>
<td>- Condom</td>
</tr>
<tr>
<td>- IUD</td>
<td>- IUD</td>
<td>- IUD</td>
</tr>
<tr>
<td>- Female sterilisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male sterilisation</td>
<td></td>
<td></td>
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</tbody>
</table>

Source: MCHC, MOH, 2001

1.2 Clean and Safe Delivery
In Laos, 86% of women give birth at home. Regionally, the figure is 79% for the central region, 92% for the north and south. The Policies on Maternal and Child Health particularly Safe Motherhood in Lao PDR (the Safe motherhood Policy) promotes “the five cleans”, which ensure cleanliness of attendant’s hands, clean delivery area, clean perineum, clean cutting of the umbilical cord and care of cord. At medical facilities, emphasis is put on clean hands, clean delivery surface, and clean cutting and care of cord, known as “the three cleans”.

1.3 Emergency Obstetric Care
(1) Assistance at Delivery by Health Staff
In Laos, 55% of births are assisted by relatives (usually mother) or friends and 8% of births are done alone without any assistance, while only 17% are assisted by health professionals (doctor, nurse, midwife, health worker). There is an urban-rural disparity in receiving assistance by health professionals, with 64% for urban and 12% for rural areas.
(2) Providers of Emergency Care. The Safe Motherhood Policy designates provincial and district hospitals as the providers of emergency obstetric services. The role of health centres is restricted to assistance to normal delivery and referral in case of complications.

2) Child Health
The key indicators of child health - MMR and U5MR - demonstrate a gradual decline in Laos. Major causes of child morbidity and mortality are infectious diseases such as malaria, acute respiratory infections (ARI) and diarrhoea diseases. The Expanded Programme on Immunisation (EPI) is one of the major factors in lowering child morbidity and mortality.

As a measure against the diseases which are the major causes of child morbidity and mortality, the MCHC combined all the independent programmes (ARI, control of diarrhoea, EPI, nutrition) to form the Integrated Management of Child Illness (IMCI) Programme and has been conducting pilot projects in 3 districts in 3 provinces.
There is a strong correlation between the health of the newborn and the mother’s health. To prevent neonatal tetanus, tetanus toxoid immunisation for 15-45 year-old women was introduced. Coverage has been steadily increasing (37% by 2000) but is still amongst the worst in Asia.

3) Expanded Programme on Immunization (EPI)
The Expanded Programme on Immunisation (EPI) began in 1979. EPI was targeting 22 districts in 10 provinces by 1985 and covered 97 districts (80%) by 1991. Full EPI coverage was achieved in 1997.

The rapid development of the EPI Programme can be explained by the joint efforts and commitment of the MOH and donor agencies (WHO, UNICEF, JICA, AUSAID) for the major goal of polio eradication, in taking various measures including vaccine provision, setup of the cold chain, staff training, promoting outreach activities and strengthened surveillance systems.

A declaration on the eradication of polio in the Western Pacific Region was made in 2000. However, there is a danger that Laos risks being struck again by polio given that it shares borders with China and Myanmar, where polio is still endemic.

2. Situation of Children

2.1) Children in Especially Protection
(1) Child trafficking: Laos is particularly susceptible to trafficking as it is situated in the fast developing region, with young population, and relatively low economic indicators. Regional disparities in development, coupled with increasing modernization and exposure through media encourage young people to pursue a more materialistic lifestyle. Much of the trafficking from Lao PDR takes place within the context of large, seasonal labour migration to Thailand. This migration is grounded in a long history of cross-border movement and cultural similarities. Tens of thousands of young people migrate to Thailand on a seasonal basis. Despite similarities in language and culture, the irregular nature of this migration, and the lack of protection for migrant workers in many sectors, contributes to making young Lao people vulnerable to exploitation and abuse. Many young people start their journey as voluntary migrants, only to be tricked, cheated or forced into trafficking situations. Recognizing that at least some of the willing supply of labour in Lao PDR is matched to demand for labour in Thailand. The main age range of young Lao people working in Thailand, and of those trafficked, is 15-20 years.

Since a formal repatriation system of trafficking victims from Thailand began in 2000, over 300 women and girls have been officially identified as victims of trafficking and formally assisted and repatriated. However, research indicates that a considerable number of trafficking victims may not come to the attention of the official repatriation programme. It appears that many may be either deported as illegal migrants, or find their
own way home and many of them disappeared. All official victims to date are lowland Lao.

There are also anecdotal reports of Lao being trafficked into China and of Chinese girls being trafficked into northern Lao PDR where there is a well-established and growing Chinese commercial presence. Both require further investigation. Lao PDR is a transit country for China and Viet Nam to Thailand. There are no reports of internal trafficking in Lao PDR. In addition, there are anecdotal evidence which suggest that internal trafficking is occurring as well.

(2) Street Children
Children living, working, begging and sleeping on the streets of cities is a very new recent phenomenon in the Lao PDR. While there are no figures available, a recent survey published by the ministry of labour and social welfare revealed 18 children on the street, half of them in the capital city, Vientiane.

The range of the contributory factors identified by this survey included poverty, increasing rural-urban inequality, dysfunctional families, substance abuse, disability and breakdown traditional family and community networks due to urbanization.

It is significant that most street children do have parents that is 55% and the rest is divorced or separate, orphan. Most of their parents knew what they were doing and knew where they were living. Family problems were cited by many children as a reason for being on the streets and many of them had been physically abused, away by their father.

Poverty was also a significant factor, with 24% of children reporting that they beg and work on the street to support their family, while a further 13% sad they had to support themselves on the street because their family cannot afford to feed, shelter and close them.

Disability also appears to be a factor leading to children living and working on the streets. One in ten street children interviewed had a disability and some children reported that their parents had a disability of some kind. As the process of urbanization gathers pace across the country, it can be expected that the number of children living and working on the streets will increase.

(3) Orphans
The combined effect of poverty, poor nutrition, inadequate sanitation, malaria and other health problems together limited access to quality health care services means life
expectancy in Lao PDR is low, especially their mother or father or both at a young age.

The number of orphan in Lao is hard to determine since data collection system are weak. There is added terminological confusion since two Lao words (khampa-single orphan) khamphoy-double orphan) are often used indiscriminately to describe double orphans, single orphans and children in single parent families due to divorce or separation.

This assessment has estimated the number of orphan by analyzing data collected as part of recent multiple indicator cluster survey, which included a detailed household survey. Analysis of this data shows about 3.5% of Lao children under the age of 15 are orphan with one or both of their parents dead. There are 85,292 orphans under 15 years old in Laos. About two-third of these children have lost their father(parental orphans), about half as many have lost their mother(maternal orphans) and a small proportion have lost both parents(double orphans).

III. Frameworks for maternal and child health and welfare

1) Access to MCH services
Women and children are prevented from using MCH services by factors in their environment. Access to maternal and childcare services remains poor despite efforts of MOH and various donors to extend and expand coverage.
(1) The economic burden of using the services of a health facility is too heavy for most women and families who largely depend on subsistence agriculture. The family not only loses important labour but also has to bear the cost of transportation, food and medical fees.
(2) Distance and transportation difficulties are major deterrents to utilization of MCH services.
(3) The social status of women and children within the household is generally low. Decision making on when and where to seek for care rests primarily on the couple’s parents.
(4) Socio-cultural beliefs and practices hinder women and newborns from getting access to health services. Information on health and health services rarely reach women and families.
(5) Many women do not want to deliver at health facilities because they are “shy” and the services do not offer psychological support. Communication is poor between the woman and her family and the health staff about the condition of the woman and the procedures and treatment that she is getting.

2) Quality of MCH Services
(1) There are no standards for most basic preventive and promotive activities. Procedures and treatment for common causes of maternal and child mortality and morbidity are not well established. Antenatal, delivery and postpartum care, child care and management of obstetric emergencies need to be upgraded and standardized according to the current best practices that can practically be implemented in the country. Monitoring and supervision is limited or none at all and logistics support for operation is very little.
(2) Routine MCH services that include antenatal, delivery and postpartum care, basic child care services are available to a limited extent at provincial hospitals but to a lesser extent at the district and much lesser still at health centres. Facilities need to be transformed so that it supports the delivery of effective MCH services. Modest areas for the accommodation of women and children have to be made available and the set-up should be made more considerate to women and children.

(3) The capacity of facilities to manage pregnancy-related complications is generally inadequate. In addition, referral system is largely non-functional. Most district hospitals do not have the means to transport women with obstetric complications. Haemorrhage is the most common obstetrical emergency. However, most provincial hospitals do not have available blood for this eventuality.

3) Coordination, Integration and Management
MCH coordination, integration and management need to be improved. The nature of the vertical programmes, the intrinsic characteristics of donor agencies and the weakness of the MCH infrastructure all contributes to this drawback.

(1) Management mechanisms that promotes efficiency are lacking. Leadership and unity of directives are not well demonstrated from the central level down into the hierarchy of health units. Planning, monitoring, supervision, implementation and evaluation of MCH activities need to be further developed and established in relation to the MOH management system.

(2) The flow of communication and support mechanisms within and between CMCH, Department of Hygiene and Prevention (DHP), other departments within MOH and the donor agencies need to be improved. MCH care and services is currently provided as vertical programs that needs to be coordinated or integrated to facilitate the delivery of services and promote efficient use of resources. Health workers are confused and overwhelmed and are unable to deliver an integrated MCH services.

(3) Operation cost is very little and almost none in health centres. Furthermore, there is an imbalance in donor assistance. Logistic support to recurrent cost and the development of management systems in health facilities is minimal compared to support accorded to other concerns. Where support is available it is usually not used to the maximum benefit.

(4) Management capabilities of MCH officials and senior staff need to be upgraded. Technical knowledge on management and knowledge on the maternal and child health situation need to be improved.

4) Human Resource for MCH
The need to reach women and children requires capable and dedicated health staff, teamwork and good organization. The capability of MCH staff needs to be drastically improved and the MCH staff organization needs to be developed so it encourages and supports MCH activities.

(1) Majority of health workers providing MCH services in health centres and district hospitals are auxiliary nurses who lack the proper preparation and training for MCH work. Their pre-service training generally consists of a 3-6 months affiliation in the district or provincial hospital. Performing routine MCH services such as antenatal care, delivery and postpartum care already poses a big challenge. Managing most obstetrical problems and emergencies are way beyond their present capacities.
(2) Relating to women, families and communities is a difficulty for most MCH staff. Communication skills is inadequate. Giving MCH information, advice or counselling is hampered and the ability to coordinate and facilitate community mobilization for health and other health related action is weak.

(3) Village health volunteers (VHVs) and traditional birth attendants (TBAs) are recognised as essential collaborators in the delivery of maternal and child services but should not be seen as replacements of health workers. In the face of the difficulties of health facilities to reach women and families in villages, the tendency to relinquish responsibilities to VHVs and TBAs is huge. There is a need to clarify their qualifications, roles, functions and relationships with the health system.

IV. Inter-sector collaboration

Within the MOH, the Maternal and Child Health Centre (MCHC) and the MCH Division of the Department of Hygiene and Preventive are responsible for maternal and child health affairs.

1) Central Level
The provision of MCH services is in the overall charge of the MCHC at central level. The MCHC is composed of the MCH Hospital and the Promotion Section. EPI is a division of the MCHC Promotion Section. The Promotion Section consists of 6 divisions (administration, training, IEC, technical supervision, planning/statistics and research).

The MCH Hospital has pediatrics and an obstetrics and gynecology department and caters for both in-patients and outpatients. It has 30 beds. The MCHC as a whole places more emphasis on research than treatment.

2) Provincial and District Levels
At the provincial level, the MCH Unit (administration) is responsible for planning, disbursing funds for and supervising the district MCH Unit. Provincial hospitals provide MCH care services. The MCH Clinic provides preventive services including antenatal care, birth spacing, EPI and child growth monitoring. An MCH Clinic is located in each province - in most cases, in the compound of the provincial hospital.

At district level, the MCH Unit of the District Health Office is responsible for general administration. The District Health Office also conducts outreach activities for EPI and birth spacing, training village health volunteers (VHV) and monitoring. Although the District Hospital provides both preventive and curative services, more emphasis is placed on preventive services and the level of curative services is limited. In the EPI Programme, staff of the District Health Office visit every target village. Target villages are classified into Zones according to distance from the nearest health facility. The EPI Programme has begun the Zone 0 strategy, in which people within Zone 0 (all villages within a 3 km radius of a health facility) are encouraged to attend the MCH clinic for EPI services as well as other MCH services rather than waiting for an outreach team to come to them. In some districts, when visiting villages for vaccination for EPI-PLUS, the team also conducts other activities such as health education and child growth monitoring.
At the peripheral level, health centres conduct mainly preventive activities such as antenatal care, birth spacing, EPI and child growth monitoring. MCH activities are one of its major activities and some centres also handle delivery depending on the skills of health staff and the availability of equipment. At the village level, trained village health volunteers and traditional birth attendants (TBA) gives health information and health education to the villagers. Village health volunteers and traditional birth attendants serve as the focal point for the outreach team from the district health office and health centre.

3) Policy framework for child welfare

3.1 For child trafficking: National committee for trafficking is established. Lao does not yet have national plan of action on trafficking. However, national plan of action on commercial sexual exploitation of children is currently being developed. The new law on protection and development of women, which include provision on trafficking women and children. The national assembly approves the new law on money laundering. The government of Laos has joined the Coordination Mekong Ministerial Initiative Against Trafficking (COMMIT). Currently the Government of Lao PDR and Kingdom of Thailand have comprehensive bilateral MOU on combating trafficking in person especially women and children. The Government's response to trafficking to date has been led by the Ministry of Public Security and the Ministry of Labour and Social Welfare. While the ministry is the focal point for six out of the twelve existing anti-trafficking project in the country.

Lao PDR has ratified several important international treaties, which relate to the trafficking issue. These are: 1) UN Convention on trans-national Organized Crime, 2) Supplementary Protocol to the above to prevent, suppress and punish trafficking, 3) CRC, 4) CEDAW and UN convention on the worst form of child labour.

To summarize the response to the trafficking issue the government has a comprehensive components or areas which, includes prevention, protection, suppression, repatriation and reintegration to ensure the protection of the rights of the Lao women and children.

3.2 Street children; Currently ministry of labour and social welfare with supporting of UNICEF and Friend's International (Mith Samlan) running a drop in center in Vientiane Capital, which allow street children to come in (daytime only). The center provides some basic need such primary health care, food and clothes. The social workers there at the center have many activities with children like role play, telling story, games and some time give counseling or provide them a good information in order to reintegrate them to the their community. Some case we have supported their family in term of schooling. The data collection or follow up case on this issue is being conducted regularly and information distribution is also important thing to do the same time. The center has
provided a mobile school/street educator in order to get in to the street children because some of the street kids they don't like to come to our centre.

3.3 Orphanages;
SOS children villages have been established under the supervision of the Ministry of Labour and Social Welfare in five provinces. The capacity houses of the five sites are about 670 persons and now are full as the capacity with 343 boys and 327 girls. Children admitted to these institutes are double and a single orphan whose surviving parents is unable to care for them. They must be under 7 years of age or the older sibling of the child under 7 years old. SOS operates primary and secondary schools on-site (with are open to non-residential children), kindergarten also operate, a small vocational training facility, and social centre.

V. Partnership between government and non-government organization

WHO has given technical support to various programmes, such as the Safe Motherhood Programme, and Integrated Management of Child Illness (IMCI).

UNICEF has been working with a special focus on child health. In addition to nutrition related programmes and the EPI programme, UNICEF has been actively involved in maternal health.

UNFPA has been working on reproductive health, closely collaborating with the MCH mainly on the birth spacing programme. As reproductive health covers not only birth spacing and Safe Motherhood but also various aspects of life such as sex education for youth, UNFPA has also been conducting information education communication (IEC) activates in close collaboration with not only the MOH but also other ministries.

JICA has been working on maternal and child health in two provinces (KIDSARILE Project) and has supported equipment and drugs for reproductive health.

VI. Prospective actions
The first initial steps will concentrate on interventions that will further develop the package of services at each level of care. This package of services will be the focus of training of MCH staff and the basis of the development of health facilities and health management in line with MCH care and in collaboration with the Curative Department and the Department of Organization and Personnel. Lessons learned from various projects and programmes and simple, cost-effective and globally accepted MCH interventions will be used as the guiding principles in the development and implementation of the initial package of services. Selected areas will used as models for the implementation of these services.

The next steps will be devoted to finding the most appropriate and practical approaches to implement the package of services and how this can be expanded into other areas with sufficient logistical support.
PHC is seen as the ultimate approach for reaching women, children and families. However, there is a need to sort out how MCH and PHC can be packaged best. At this step, reintegration of MCH as a component of PHC already starts. However, at this phase it is not yet sensible to propagate approaches that have not been tried. It is important that before propagation of selected approaches, such approaches are clear so that health facilities and health workers and the community can be prepared well for their roles and responsibilities.

Many MCH activities are preventive and promotive in nature. To charge fees for these services in the light of the financial and socio-cultural situation of the population is not feasible. Funds from the drug revolving fund cannot be depended on in the near future and if available, the cost of just one obstetrical emergency can easily deplete the accumulated funds of a health centre or a district hospital. At this step, resolutions on where and how logistic support can be funnelled to MCH interventions should be developed. Finding these resolutions is within the main responsibility of the health finance framework. However, vigilance and collaboration from the MCH sub-sector is equally important to ensure that MCH is allocated a reasonable budget for its operations.

The next succeeding steps will be directed into the full reintegration of these services into a practical and operational component of PHC. When MCH services are already well established and approaches to reach more women and children are set-up, its integration and/or coordination with other PHC components will be facilitated. A basic level of infrastructure is necessary for quality MCH services to be delivered. Currently the MOH infrastructure is being strengthened through several PHC projects scattered throughout the country. The timing of this full reintegration is appropriate when a viable level of infrastructure is in place. After the establishment and implementation of the basic, standard packages for MCH at health facilities, continuing development will still be pursued in line with the realities in the MCH sector. It is expected that by the time MCH services is already re-integrated into PHC, the scope of services is also broadened.

Securing a strong foothold in the critical steps needs the support and assistance of NGOs, UN agencies and other external donors. Apart from DHP and CMCH, specific guardians for each of the critical steps should be identified. For example, the World Health Organization (WHO) may be able to shepherd the development of the basic standard package of services at each level of care. UNICEF and Non-government Organizations (NGO) may be in the best positions to find approaches on how to implement the package of services in the field, United Nations

Population Fund (UNFPA) may be able to facilitate the improvement in the management of reproductive health activities and ensure the availability of contraceptive commodities. It is important that the outputs of these critical steps are processed, applied and eventually incorporated into regular MCH activities and services for the entire country.

The end goal of the framework is to see quality MCH services provided as an integral part of PHC, supported at all levels of MCH facilities and implemented in all facilities throughout the country and largely utilized by the population.
Mobilization of Communities for MCH

The achievement of good health for mothers and children will remain far off if the burden of health services fully rest on the shoulders of health workers and the MOH organization. The participation of communities is essential and can be achieved if communities are empowered and mobilized to take the health care responsibility. Change is a slow process and communities don’t respond or develop overnight. However, the active pursuit for change in MCH or health in general should be started at once.

Community transformation for MCH or health in general has to be mediated by change agents or movers. Waiting for changes from within communities might take a much longer time. There should be initiator/s of change who should intercede for the desired transformation. The health organization particularly health workers in health centers and district health units are in a good position to help initiate this change in partnership with village health volunteers, traditional birth attendants and healers, local authorities, mass organizations and local government agencies.

The following steps should then be undertaken to help facilitate the change process:

1. Ensure that communities are organized to undertake collective decision making and actions;
2. Awareness building for MCH is undertaken targeting initially leaders and eventually communities;
3. Leadership skills of key change agents (health workers, village health volunteers, local authorities and/or other community leaders) are upgraded;
4. Local planning, implementation, monitoring of health and health related actions should take place; and
5. Village health volunteers, traditional birth attendants and village authorities are made keepers of particular community interventions.

It is important that all community activities for MCH be undertaken through collective community processes to enhance further people’s participation.

Village health volunteers and traditional attendants are key collaborators in community empowerment and mobilization for health. With some training they may be able to perform specific but limited interventions for MCH such as providing iron and folate supplements for pregnant and postpartum women, supplying oral contraceptives and condoms to the community or encouraging pregnant women to submit for antenatal care in health facilities. However, their knowledge and skills will not be sufficient to perform most MCH interventions and therefore should not be groomed to become main health providers in communities. Their strength however, lies in the fact that they are in the communities and are more accessible to the women and families and to health workers. This makes them the best mediator between the community and health services.

To train health volunteers and traditional birth attendants requires a big investment. It is best that their roles and functions should be first made clear and specific so that training will be focused and training sessions will not be wasted on subjects that they do not have much use for. Mobilization of communities is a main focus of the PHC framework.
However, MCH because of the nature of its services is a very good vehicle for the delivery of PHC and should be then made as its integral component early on in PHC development.

VII. Health and Welfare Services for People with Disability

1. Current situation of people with disability

Rehabilitation in Lao PDR was started in 1962 to response to prosthetic needs of injured soldiers. Previously all prosthetic services had been performed out of Vietnam. The first buildings of the present National Rehabilitation Centre were constructed in 1964. However, the services provided were initially extremely limited, as there was no qualified Lao staff at the Centre. It was not until 1966 that the Centre started to give regular services in prosthetics production and fittings and physiotherapy. In 1968 the Centre started schools of prosthetics and physiotherapy (3 and 4-year programmes respectively). The concept of community-based rehabilitation (CBR) was formulated in 1985 and became part of the NCR’s work in 1988. In 1990 the NRC began to include orthopedic surgery in its services at the Centre.

The services provided by the NRC today include: 1) disability diagnosis, 2) prosthetics production and fitting, 2) physiotherapy, 3) orthopedic surgery, 4) community-based rehabilitation programmes, and 5) the deaf and blind school. In addition, it coordinates with Lao organizations and international NGOs working in the area of rehabilitation.

To date, approximately 55 prosthesists and 350 physiotherapists have graduated from the NRC. Rehabilitation is also one of the subjects taught at the medical and nursing schools (in the 6th year for medical students and 2nd year for nursing students).

There are no official statistics of disability in the Lao PDR. In 1996, a survey of the major types of disability in the country was undertaken by piggy-backing a questionnaire to village chiefs on the EPI. 80% of all villages returned questionnaires, and the results were bulked up to reflect the national circumstances. In 1999, a limited survey of disability in 2 provinces was carried out and the figures multiplied up to suggest a national result. They represent the best available evidence to date.

Table 1.1 The Incidence of Disability in Laos

<table>
<thead>
<tr>
<th>Disability</th>
<th>1996</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>Amputation</td>
<td>3,987</td>
<td>11</td>
</tr>
<tr>
<td>Leprosy</td>
<td>400</td>
<td>1</td>
</tr>
<tr>
<td>Paralysis</td>
<td>5,600</td>
<td>14</td>
</tr>
<tr>
<td>Polio</td>
<td>5,200</td>
<td>13</td>
</tr>
<tr>
<td>Club foot</td>
<td>2,800</td>
<td>7</td>
</tr>
<tr>
<td>Lower limb deformity</td>
<td>9,945</td>
<td>26</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>2,400</td>
<td>6</td>
</tr>
<tr>
<td>Deaf</td>
<td>16,892</td>
<td>45</td>
</tr>
<tr>
<td>Moderate hearing loss</td>
<td>800</td>
<td></td>
</tr>
<tr>
<td>Blind</td>
<td>6,642</td>
<td>18</td>
</tr>
<tr>
<td>Poor vision</td>
<td>1,600</td>
<td>4</td>
</tr>
<tr>
<td>Learning difficulties</td>
<td>3,600</td>
<td>9</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>2,400</td>
<td>6</td>
</tr>
<tr>
<td>Cleft lip/palate</td>
<td>800</td>
<td>2</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----</td>
<td>---</td>
</tr>
<tr>
<td>Multiple disability</td>
<td>2,400</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>1,600</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40,000</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

These statistics are well below the WHO norm of about 10% of any population suffering some disability. In Laos, this would suggest about 550,000 people with disabilities, or well over ten times the total in the above table. It is thought that the figures in the table are likely to be below the true numbers, but that the population of disabled in Laos is substantially below the WHO norm.

All provinces except the special zone have a rehabilitation office, which constitutes a unit within the provincial health department. A few districts also provide for rehabilitation services within the district health office.

VIII. Framework for health and welfare services for people with disability

(1) Insufficient Statistics on Disability
There are no official statistics on disability in Lao PDR. The last population census (1995) contained no question on disability. Handicap International (an NGO) collected the only available nation-wide statistics on disability in 1997. However, this survey was limited to people suffering disabilities as a result of UXO accidents.

(2) Weak Organization of the Rehabilitation Programme
Rehabilitation services are currently organized only at the national and regional/provincial levels. The National Rehabilitation Centre of the Ministry of Health is responsible for the national rehabilitation programme. The Provincial Rehabilitation Office is located within the Provincial Health Department and is responsible for rehabilitation at provincial level. The programme has not yet been extended to the district level.

The services provided at NRC are limited to physiotherapy, prosthetics, orthopedic surgery, community-based rehabilitation, some diagnostic services for sensory disability and some occupational rehabilitation. Ideally, it should include services in the areas of psychological therapy, counseling and orientation, and systematic occupational rehabilitation.

At the provincial level, the rehabilitation office is often non-functional due to a lack of equipment and staff, qualified or not. At the regional centres, the services available are physiotherapy and prosthetics fitting. The only service provided at provincial level is physiotherapy.

(3) Lack of Rehabilitation services provided by Professional Staff in hospitals
In principle each provincial hospital has one rehabilitation unit to provide in-house rehabilitation services. The diagram below shows the operation of the rehabilitation unit in the hospital.
In practice, however, the hospital rehabilitation units do not function. Patients therefore do not receive appropriate rehabilitation services in hospital, nor do they have access to advice from professional rehabilitation personnel before being discharged.

**(4) Unavailability of Rehabilitation Services in Remote Areas**

There are no rehabilitation services available for people in remote areas. The services are available only at the provincial offices or regional centres. These offices are not frequently used by people from remote areas. This is due to several reasons:

- Irregular public transportation system and high transportation costs;
- Lack of information for villagers regarding available services, leading possibly to distrust in the rehabilitation services or reluctance to use the services; and
- Opportunity costs and other expenses related to the trip.

**IX. Inter-sector collaboration**

In 1995, Laos became a signatory to ESCAP *Proclamation on the Full Participation and Equality of People with Disability in the Asian and Pacific Region*. By its signature, the Lao government “proclaim and pledge our commitment… to enable people with disabilities to develop their full potential so that they may live as agents of their own destiny…” In that year, too, the Prime Minister of the Lao PDR issued a decree (No 18/PM of 27/01/95) on Appointing The National Commission for Disabled Persons (NCDP). The decree set out the membership and the roles and duties of the NCDP amongst which was to “form the association for disabled persons”.

Institutional responsibility for disability issues is shared, at governmental level, between the Ministry of Health and the Ministry of Labour and Social Welfare. There are some schemes for inclusive education of disabled children that fall within the purview of the Ministry of Education.

**A) Ministry of Health**

The Ministry of Health has significant responsibility for providing services to people with disabilities. In 1997, MoH set out its Development Policy for the Rehabilitation for the Handicapped Sector from 1996-2000 and beyond. This focuses on the role of the National Rehabilitation Centre (NRC), Vientiane, in providing services and leadership. Training has a key role in a variety of disciplines. In addition, rehabilitation in all provinces is to be improved.

The Ministry has established a vocational training school for the disabled at Sikeut, near to Vientiane, where rather more than 100 mobility disabled students, aged between 17 and 35, are trained in English language, electrical repair work, tailoring, computing, and accountancy.

The Ministry, through the NRC, is now engaged in preparing a Master Plan for the delivery of services to the Lao disabled.

**B) Ministry of Labour and Social Welfare**

In 2000, the Minister at the MLSW published a Strategic Plan on Rehabilitation and Development of Disabled Persons 2000-2003. The plan has 12 points, which are:
1. Coordination of planning at the national level
2. Law
3. Information for disabled persons
4. Public awareness about the Decade of Disabled Persons
5. Support for disabled persons among the ethnic minorities according to the resources of the state and party
6. Educational rehabilitation
7. Vocational rehabilitation and promotion of employment placement for disabled persons
8. Prevention of disability
9. Physical rehabilitation
10. Equipment and aid kits for disabled persons
11. Promote and encourage self-help activities for disabled persons
12. Strengthen regional cooperation in developing rehabilitation among the ethnic population.

MLSW is responsible for War Veterans and, more recently for the social welfare of all people with disabilities. The department for War Veterans and Social Welfare has responsibility for eleven villages specifically established for disabled war veterans. The P&O centre at Ban Keun, one of the eleven villages, falls within the purview of MLSW, but it has been unable to provide any P&O services for a number of years due to lack of funding. War veterans who would formerly have been treated at Ban Keun are now sent to NRC, by agreement with MoH.

MLSW is responsible for the NCDP. The Minister chairs it and the head of the Department of War veterans and Social Welfare is its Coordinator. The Ministry is required under the Prime Ministerial Decree, to provide a secretariat for the NCDP and to define its role.

C) National Commission for Disabled People.
The NCDP was established under the prime Ministerial Decree no 18 of January 27th 1995, and brought into being through Agreement no 732/NCDP of 9th May 1995.

It exists under the Presidency of the Minister at MLSW and with the Minister of MoH as Vice-President. Other members include the Deputy Minister at the Ministry of Foreign Affairs, a representative from the Ministry of Defence and the head of the Social Welfare Department at MLSW, who has the role of Secretary.

The role and duties of the NCDP are included such things as promoting benefits for the people with disabilities, awareness raising, gathering statistics, developing policy, establishing an association for disabled people and a provincial and district-level network, exchanging information with other countries, disability prevention, barrier-free access, and equal opportunities. The NCDP is charged with the job of producing a plan of action to cover these matters.

Following national consultations concluded through the medium of a Handicap International project to develop a coordinated SE Asian landmine victim assistance programme, an assistant is being appointed to the NCDP with the role to coordinate the
development of support to landmine victims and other disabled. This programme is mainly aimed at linking in to support that may be available for landmine and other UXO survivors under the Ottawa Landmine Ban Convention.

D) Lao Disabled People’s Association.
The LDPA is a self-help group of people with disabilities with a history going back to 1990, when 23 disabled people came together and set up Group Solidarity for Disabled People. In 1996 it became the Lao Disabled People’s Association and prepared a draft set of Bylaws which were submitted to MLSW for approval, granted in July 2001. The legal authority for the LDPA lies in the approval of the Bylaws.

LDPA’s mission is to promote the rights of people with disabilities, empowering them to personal achievement, assisting them to develop their livelihoods and interests and bringing about their full participation in society.

There are currently four provincial DPAs. The number of members of LDPA and the four branches is nearly 600 at the time of writing, and is scheduled to increase to 14,000, spread throughout all 18 provinces, by July 2007, under proposals contained in the LDPA Five Year Strategy (August 2002-July 2007). The Committee were replaced.

X. Partnership between government and non-government organizations
In 2001, a grant by the UK-based Diana, Princess of Wales Memorial Fund (DPWMF) allowed the start of a 32-month programme to strengthen the administrative and financial management capacity of LDPA, and the Association to move into offices independent of government. That grant has now been supplemented with a further grant which will support the development of the Association unit November 2005.

In September 2002, LDPA issued a Five-year Strategic Plan for the period August 2002-July 2007. This sets out a comprehensive development programme of self-help activities. The Plan is under review at the time of writing.

Lao Association for Disabled Women and Children. Established in 1998 with a mandate to promote the common rights and just benefits of Lao handicapped women and children. It has a training programme aimed at imparting occupational skills, such as paper-making, sewing and weaving, to disabled women and children. In common with LDPA, the LADWC comes within the purview of MLSW and NCDP.

International NGOs. Apart from COPE and its partners, other INGOs concerned with disability are Leprosy Mission International, Consortium, Handicap International, World Concern and Garneau (an offshoot of a Canadian University). Handicap International, World Concerned and Garneau, are involved with Community Based Rehabilitation (CBR), although on a modest scale compared to the country’s needs. Other programmes (e.g. SCF-UK) have focussed on vocational training and education for people with disabilities. COPE is the cooperative project between the MoH and four INGOs, is the main existing programme for the delivery of rehabilitation services to people with disabilities.
In conjunction with JICA, the Ministry produced a National Health Master Plan. It contains a section dealing with rehabilitation.

**XI. Perspective Actions**

To address the above-mentioned issues and thus allow equal access to health and rehabilitation services for all Lao people, the following major directions should be set:

1. Better understanding of disability in Lao PDR – number of disabled people, nature of disability and rehabilitation needs;
2. Systematic teaching on rehabilitation in medical and nursing schools and development of regulation for rehabilitation services;
3. Reinforcement of complete rehabilitation services at the national and provincial levels;
4. Availability of rehabilitation services at provincial and district-level hospitals.
5. Availability of community-based services.

**Possible Measures**

1. **Development of Database on People with Disabilities and Their Needs**
   A nation-wide survey on people with disability should be conducted. The survey will provide the Government of Laos (GOL) with basic socio-economic data on people with disabilities. In addition the survey will enable GOL to identify the real needs of disabled people and thus plan proper rehabilitation services.

   The development of a database should be developed from the national survey. It should be updated on a regular basis. The national census, which is conducted every 5 years, should include a section on disability.

   Regular registration of disability should be included in the government administrative structure. The village head should report new cases of disability as part of his or her regular report to the district. Based on hospital registration, new cases of disability should be reported on the hospital record form.

2. **Reinforcement of the teaching of rehabilitation** in the schools of medicine, nursing and other health professions and development of national protocols for providing services in rehabilitation. The current curriculum on rehabilitation should be revised, improved and printed. The existing curriculum was developed by the NRC and has been taught at the schools of medicine and nursing. It should be printed and distributed in class. The teaching of rehabilitation should be extended to other health professionals such as PHC workers or assistant nurses. There should be enough teachers on rehabilitation to cover teaching at all health/medical schools.

3. **Reinforcement of Hospital-Based Rehabilitation Units**
   Information sessions should be organised for the management of provincial health departments and provincial hospitals so that they understand the importance of rehabilitation services during the time the patients are in hospital. A better understanding will enable them to better allocate resources necessary for the establishment and operation of rehabilitation units within the hospitals.
(4) Reinforcement of complete services at the national and provincial levels and
extension of services to district level
Complete rehabilitation services should comprise the following units. These services
should be available at the national and provincial levels.

1) Physiotherapy
2) Prosthetic production and fitting
3) Community-based rehabilitation
4) Rehabilitation services in the hospitals
5) Occupational therapy
6) Psychological therapy
7) Counseling and orientation.

The NRC should be able to provide training and regular technical assistance to the
regional and provincial rehabilitation offices in all the areas listed above. In order to
achieve this, the staff of NRC should be trained in both necessary technical subjects and
training methodology. The necessary equipment should be provided in order to allow the
specialists to provide good rehabilitation services. A travel budget should also be planned
so that technical assistance and supervisory trips can be made to the provinces.

The regional/provincial offices should be adequately staffed, equipped and provided with
a sufficient operating budget to provide complete rehabilitation services. The staff of the
provincial rehabilitation office should be trained by the trainers from the NRC.

(5) Establishment of a Community-Based Rehabilitation Network
A basic district level rehabilitation office should be created. This office should be
equipped with qualified staff, appropriate equipment and an operational budget. District-
level rehabilitation services should be limited to physiotherapy and community-based
rehabilitation. It should serve as a referral centre for other types of rehabilitation needs.

The district rehabilitation office will be responsible for setting up a community-based
rehabilitation programme in the district. A team of qualified staff, means of transportation,
training materials and operating budgets should be provided.