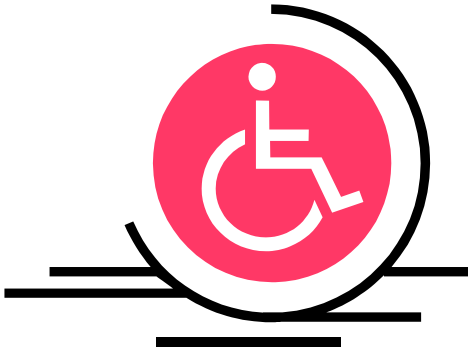

Country Report

to the 7th ASEAN & Japan High level Officials Meeting on Caring Societies:

"Toward an Inclusive Society ".

31 August Œ 3 September 2009, Tokyo , Japan.

Country name: Lao People's Democratic Republic

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On behalf of the Participants for the health sector and myself , I am very happy and honorable to be attending and reporting to 7th ASEAN & Japan High level Officials Meeting on Caring Societies : " Toward an inclusive Society ".

I . General information of Lao PDR .

According to UNDP classification Lao P.D.R, belong to the Least Developing country) LDC country group. The data collection systems themselves are being worked on. Therefore, the crude data must be taken with a certain caution.

1.1. Demographics

The Lao PDR has a population of 5.6 million (2005) a population growth rate of 2 % , a space population density (23.7 per square Kilometer) with a large interprovincial variations, and an average household size of 5.9 persons .The topography breaks into low land area along the Mekong River that depend predominantly on paddy rice, and highland areas that depend on upland rice and gathering of nonŒtimer forest product for livelihoods. The population os young but there are signs of changes in demography structure; the percentage of population is unfer 15 years decreased from 43.6% to 39% between 1995 to 2005. The nation is rural , with the beginnings of a rural to urban shift, as indicated by the increase on urban ares; the percentage of the population living in rural areas decreased from 83% to 72.9% from 1995 to 2005.

The latest census identified 47 district ethnic groups. The ethnic :ao comprise 52.5% of the total population and predominate to the lowland

Laos is a Land locked country neighboring Thailand, Cambodia, Vietnam, China and Myanmar. It is organized in 18 provinces with Vientiane as a capital 5.6 mil Laotians are living

in their 236,000-skm country, 20% of them in urban settings, the others rural. The low
population density of 19.4 persons/skm is willing increase if the annual growth remains at 2.4% (average over the last ten years). As close to 50% of the population is below age 54 they are likely to contribute to this development.

1.2 Political situation

The Lao People's Democratic Republic was founded in 1975. The organs of government are the President, the Prime Minister and the National Assembly. The Government operates under the guidance of the Lao Peoples' Revolutionary Party (LPRP) through five-yearly Party Congresses,the Politburo and the Central Committee. The VIIIth Party Congress was held in early 2006. A National Assembly (NA) election was held in April 2006, with competition among a group ofLPRP-approved candidates and outstanding participation by the population. The NationalAssembly as the main legislative organ is composed of 115 members, of which 29 are women;113 members are LPRP members. The NA elected a new President, Lt. Gen. ChoummalySayasone, in June 2006. At the same time, a new Prime Minister, Mr Bouasone Bouphavanh, wasappointed by the President for a five-year term, with the approval of the NA. The rule of law hascontinuously been strengthened by new laws, including several health sector laws in respect ofpublic health, curative services, food safety, drugs and medical devices. The Government reportsto the NA on the implementation of its 6th National Social and Economic Development Plan2006-10 (NSEDP), which includes national strategies on poverty eradication. The last report to the NA was made in June 2007. During this session, the participation of NA members was dynamic and a request was made to the Government to report regularly on the implementation and achievements of the NSEDP.
Until January 2006, the country comprised 17 provinces . The security in the country is considered stable.

1.3.Socioeconomic Situation

Lao People's Democratic Republic ranks 130th out of 177 nations on the Human DevelopmentIndex in 2005. Literacy has improved in the last decade, attaining 73% in the population above15 years of age in 2005, compared with 60% in 1995. Schooling has

improved for children from
6 to 16 years of age, but boys still have higher attendance than girls: 75% for boys and 68% forgirls in 2005 compared with 66% for boys and 56% for girls in 1995.
The official poverty rate fell from 39% in 1997 to 33.5% in 2002. Poverty is higher in remote andhighland areas and inversely correlates with road or river access. Compared with internationalstandards in 2006, 71% of the population lives on less than PPP US$ 2 a day and 23% live onless than US$ 1 a day. Inequalities remain important, with the share of the national economyof the lowest and the highest quintile being 7.6% and 45%, respectively. Proxy indicators ofpoverty, such as access to sanitation and electricity, also point to the vulnerability of the Population. The latest Lao Reproductive Health Survey found that, in 2005, 50% of House holds had no toilets and over 40% had no electricity. Disparities between urban and rural areas are stillpronounced. For example, 96% of urban households have access to electricity, compared with only 33.3% in rural areas without road access.
The World Bank estimated that per capita gross national income was US$ 823 in 2008, with 7.5% economic growth. Agriculture makes up 42% of the gross domestic product (GDP), industry(mainly hydropower, mining and textiles) 32.5%, and services 26%. Revenue collection has beenabove national targets for the last two years but remains very low, estimated at 14.3% of 2008 GDP. The budget deficit has therefore declined and fiscal space has widened. Major publicmanagement reforms are ongoing, but implementation is still below desirable targets. One persisting major issue is the management of customs and taxes. In 2007, collection of taxes and revenues was recentralized by Prime Ministerial decree. New budget and state audit laws stillneed to be fully implemented.

1.4 Vulnerabilities and hazards

Locked between Thailand, Viet Nam, China and Myanmar, the Lao People's DemocraticRepublic is facing major challenges as the country opens up to external influences. Despite itslow level of prevalence, the HIV/AIDS epidemic is gaining attention. The latest round ofsurveillance (2004) showed an accelerated rate of transmission

among sex workers in two of the17 provinces. With the recent trend in opening of offshore trade zones with China and VietNam, the important investment in casinos throughout the country and the ease of migrationformalities, the country faces important challenges with regards to spread of HIV/AIDS andother communicable diseases.

Until early 2007, there were only limited reported outbreaks of avian influenza in poultry and nohuman cases of infection with the H5N1 virus in the country. However, in early 2007, thecountry faced a series of outbreaks in poultry and its first two human cases in the

capital,Vientiane.

The economy continues to rely heavily on natural resources (hydropower, timber and minerals)and concern has been raised by international environmental agencies that biodiversity andresources are being overexploited, particularly timber.In 1998, the Lao People's Democratic Republic ranked as the third largest illicit opium producerin the world,
after Afghanistan and Myanmar, and had one of the highest opium addiction rates.

Through its high-level commitment to fighting drug production and abuse, the Government managed, in less than a decade, from 1998 to 2005, to reduced opium cultivation by 93% and opium addiction by 68%. These changes, however, have brought new challenges for the authorities as there is a need for sustainable economic alternatives for highland former opium farmers. New synthetic drugs have emerged, however, raising concern for public health andamphetamine-type stimulants pose the most serious and fastest-growing drug threat in the country. In the mid-1990s, the Government, with assistance from its partners, started prevention and treatment programmes for drug abusers.

The country ranks among the least-developed in the world and, despite a steadily increasingGDP, growth is still slow and inequalities serious. The country is also facing major challenges inaddressing transparency and corruption issues; in 2007, it was classified by TransparencyInternational, as 168th on the Corruption Perception Index of 179 countries. As a comparison, in2005, it ranked 77th of 158 countries.

2. HEALTH SITUATION AND TREND

2.1 Communicable and noncommunicable diseases, healthrisk factors and transition

Health indicators from the routine health information system are not robust or universal.

Therefore, many of the most reliable indicators are from national surveys, most of which were

conducted in 2000 and reported in 2001. A national census was conducted in 2005 and official

results were published in 2006 that showed important improvements in the maternal mortality

ratio, the crude death rate, the total fertility rate, the crude birth rate and other macro-indicators.The methodologies used in the calculations of these indicators have, however, been criticized byinternational development partners, particularly those concerning maternal mortality; the actualnumbers may be underestimated. A multiple-indicator cluster survey was conducted in early 2006 and it is expected that results will be published in 2008. The results of these last two exercises,

when available, will update many health indicators. There is a general perception that there will befurther improvement in many areas.

The Lao People's Democratic Republic is a low-HIV-prevalence country, with an estimated adultseroprevalence rate of 0.1%. At the end of 2007, the official cumulative number of peopleidentified with HIV since 1993 was 2630, of whom 1675 were known to be living with AIDS. Of the reported HIV cases, 55% were male. Based on cumulative HIV case reports, the majority of those infected are between the ages of 20 and 39 years. Of those whose mode of transmission was known, 85% had been transmitted through heterosexual sexual contact, 3.5% transmittedfrom mother to child, 0.7% through homosexual sexual contact, 0.3% through blood productsand 0.2% through use of unsterilized needles (the remainder unknown). Preliminary results froma second round of second generation surveillance have shown the HIV-positive seroprevalencerate in female sex workers increasing from 0.9% in 2001 to 2% in 2005. Chlamydial infection andgonorrhoea are common in sex workers, with an estimated combined infection rate of 37.6%. Atotal of 375 individuals are currently receiving antiretroviral treatment at a single treatment site.

2.2 Outbreaks of communicable diseases

Dengue fever incidence seems to have increased in recent years, with 96.9 cases per 100 000inhabitants in 2006. In the same year, outbreaks of dengue accounted for a total 6356 cases (5556cases of dengue fever and 800 cases of dengue hemorrhagic fever/shock syndrome), and sixresultant deaths were reported. This represents an increase to an incidence of 110.6 cases per100 000 inhabitants using the Census 2005 population projections at mid-year. Dengue appears to be moving peripherally, with cases recorded in smaller population centers in recent years. In 2007, 5648 cases were estimated, although this may be an underestimation.

Until early 2007, there were only limited reported outbreaks of avian influenza in poultry and no human cases of infection with the H5N1 virus in the country. However, in February 2007, the Ministry of Agriculture confirmed an outbreak of avian influenza, H5N1, in commercial poultry farms and backyard poultry in the capital city, Vientiane. Since then, other outbreaks in poultry have been reported and confirmed from four other provinces in the north, centre and south of the country. Control activities targeted at poultry have been conducted successfully and passive surveillance has been reinforced. In early 2008, several new outbreaks in poultry were reported in the northern region bordering China and Myanmar. The

first two human cases were confirmed in early 2007, both resulting in death. The first reported case was a 15-year-old girl from Vientiane city. She developed symptoms and died after a long period of hospitalization. The second case was a 42-year-old woman from Vientiane province. Both cases had recent histories of poultry exposure. Public health activities targeting avian influenza have intensified since the first case was confirmed. There is now a health-care-facility- and avian-influenza-surveillance system in place. At the national level, as well as in several provinces, there are alert telephone numbers for reporting of suspected human avian influenza cases. The National Influenza Laboratory (NIL), based at the National Centre for Laboratory and Epidemiology (NCLE) has been operational since the beginning of January 2007.

In December 2007, a cholera outbreak was reported in the south of the country, in Sekong province, with more then 350 cases and three fatalities.There was a substantial number of measles outbreaks in 2007, accounting for 1678 cases, mostly in the north of the country. A national measles immunization campaign was conducted in November 2007 for

children aged nine months to 15 years and this activity vaccinated more than2 million children, achieving 96% coverage. The campaign was carried out with the support ofWHO and other international partners. Although it is expected that the campaign will lower the
incidence of measles for the next two to three years, large outbreaks will occur again unless
routine immunization coverage improves or a follow-up campaign is conducted.

2.3 Leading causes of mortality and morbidity

Malaria is considered the leading cause of morbidity and mortality, with 70% of the population atrisk. This assumption is still made despite the availability of recent data on other major sources ofmorbidity. In 2006, the total number of reported malaria cases fell to 18 058, corresponding to an incidence rate of 319 cases per 100 000 population. Programme data showed 75.5% of those at risk using preventive measures in 2006. A total of2 702 339 people (population at risk 3.6 million) were being protected with bednets as of the endof 2005. The number of probable and confirmed malaria deaths in hospitals decreased from 187(2001) to 21 (2006), while the annual incidence of confirmed malaria cases per 1000 populationdecreased from 5.5 in 2003 to 3.19 in 2006. Artemesinin-based combination treatment was introduced in 2004 following increasing malaria-drug resistance.

2.4 Maternal, child and infant diseases

The maternal mortality ratio (MMR) fell from 656 to 405 deaths per 100 000 live births from
1995 to 2005, the infant mortality rate (IMR) from 104 to 56 deaths per 1000 live births, and the under-five mortality rate (U5MR) from 170 to 97.6 (est. census 2005) deaths per 1000 live births. However, these numbers are probably underestimates. The IMR varies a great deal between provinces, with the lowest rate in Vientiane Capital (18) and the highest in Sekong (122). Whilethe mortality rate in Vientiane Capital is only 26% of the national rate, Sekong has a mortalityrate that is 183% higher than the average for the country. The latest National
Health Survey shows that children have a two-week fever incidence rate of 2.9%, an ARI incidence rate of 3%,and a diarrhea incidence rate of 6.2%. The Lao Reproductive Health Survey 2005 revealed that only 18.5% of deliveries take place with the participation of a trained birth attendant,

only 11%of deliveries are in a health facility, and only 32% of children aged 12 to 23 months are fully immunized.

The preliminary results of the Lao Reproductive Health Survey, conducted in 2005, were disseminated in late 2007. The survey shows a slow but significant improvement in intermediary health outcomes related to reproductive health. Progress was observed in usage of modern contraceptive methods (28.9% in 2000, to 36.6% in 2005, for married women). The total fertility rate has declined (4.88 between 1995 and 1999, to 4.07 between 2002 and 2005). This highlights the improvements in family planning observed over the period. Progress in antenatal care and skilled birth attendance has not been significant in the general population, despite some improvement in younger women. In 2005, the percentage of women not seeking antenatal carewas 71.5, compared with 75.8 in 2000; 86% of women still deliver at home, compared with 89%in 2000; and only 18.5% were receiving assistance from skilled health workers, compared with17.4 in 2000.

2.5 Burden of disease

Tuberculosis prevalence was estimated at 71 smear-positive cases per 100 000 population in2003. A total of 3041 smear-positive cases were reported in 2006, an increase from 2806 in 2005.The directly observed treatment, short-course (DOTS) programme reaches 100% of districts.The estimated smear-positive case-detection rate was 77% in 2006 and the treatment success ratewas 85% in 2005.The most recent data show an intestinal helminth prevalence rate of 62% (2002) among school children. De-worming for children aged 12-59 months has now been established, with child- health days and a national measles campaign, reaching more than 500 000 children (>80%)

In 2007. There is evidence to show that schistosomiasis has been re-emerging in southern partsof the country since control programmes have ended.Road accidents are a growing problem as traffic and the speed of vehicles due to road improvements increase. Mental health issues, particularly drug abuse, are also a growing concern.Other mental health and neurological diseases issues include management of seizure disorders and psychoses.Nutrition is a neglected area, with 40% of children stunted and 48.2% of children and 31.3% offemales with haemoglobin levels below 11 g/dl. Universal salt iodization misses at least 7% ofchildren, and vitamin A supplementation in the past has been

far from universal. A new biannual child- health-day approach has been used recently, however, achieving >80% of the target600 000+ children aged six to 59 months, for both rounds, in 2007. The rate of exclusive breastfeeding at three months of age is only 28.1%.Food insecurity has also been pointed out as alarming by international partners like the World Food Programme (WFP). In 2006, WFP conducted a comprehensive food security andvulnerability study. The initial conclusions of the study pointed out that …''the chronic
malnutrition in the Lao People's Democratic Republic is at an alarmingly high level. Every
second child in the rural areas is chronically malnourished, affecting, not only their physical
development, but also their cognitive capacity''…''. ''Chronic malnutrition is as high today as it
was 10 years ago. 30% of the rural households have either poor or borderline food
consumption.'' ''Sino-Tibetan ethnic groups are the most disadvantaged and food insecure,
followed by the Hmong -Mien and the Austro-Asiatic.''There are no official national data available on risk factors for non communicable diseases(NCD). The national authorities are planning to conduct a STEP-wise approach survey (STEPS)for the assessment of national NCD risk factors in 2008, with WHO support. Tobacco and alcohol consumption remains a concern, although no actual figures on consumption and effects on public health are available. However, the Government has taken note of the risks related to their abuse and has made important efforts regarding prevention and control of alcohol and tobacco consumption. In 2006, major legal steps towards tobacco consumption control were taken, the country ratified the International Framework Conventionon Tobacco Control, and a series of regulations was passed concerning health warnings oncigarette packs, importation of tobacco and smoke-free areas in the national University. In 2007,a law was drafted for national implementation of the Framework Convention.

3. HEALTH SYSTEM

3.1 Ministry of Health's mission, vision and objectives

The national health priorities are articulated in three documents: (1) the Health Strategy to

theYear 2020; (2) the Lao Health Master Planning Study; and (3) the National Growth and

Poverty Eradication Strategy (NGPES). The principles and visions of these documents have beenincluded in the Sixth National Socio and Economical Development Plan (2006-10) (see

paragraph 3.3)The Health Strategy to the Year 2020 was promulgated by the VIIth Party Congress in 2001 andhas four basic concepts: full health care service coverage and health care service equity;development of early integrated health care services; demand-based health care services; and self reliant health services. This then leads to six health-development policies: strengthening the ability of providers; community-based health promotion and disease prevention; hospital improvement and expansion at all levels, including remote areas; promotion of traditional medicine, integration of modern and traditional care, rational use of quality and safe food and drugs, and national pharmaceutical product promotion;· operational health research; and effective health administration and management, self-sufficient financial

systems, and health insurance.The health sector is extremely project- and donor-dependent, which has often led to competing and overlapping donor demands. The Minister of Health has called for more integrated approaches, particularly for maternal and child health and immunization, decentralized service delivery methods, improved methods of health care financing, a unified and simplified health inforrmation system, and an emphasis on quality improvement in the next five years, rather than quantity improvement, which was emphasized over the past five years.

3.2 Organization of health services and delivery systems

The public health system is predominant, although a private alternative is growing. There are no private hospitals, but there are around 1865 private pharmacies and 254 private clinics, mainly in urban areas. The state system is underutilized, especially in the peripheral areas. In its efforts to increase access through village volunteers and village revolving drug funds, the Government has managed to reach 5226 villages.There are four administrative strata in the health system: central (ministry, college of health technology and reference/specialized centres), provincial (provincial health office, provincial and regional hospitals, and auxiliary nursing schools), district (district health offices and district

hospitals) and village (health centres) levels.

The main network for health care services provision remains the public system. In 2005, its health facilities consisted of four central teaching and referral hospitals; five regional hospitals, including one teaching hospital; 13 provincial hospitals; 127 district hospitals; and about 746health centres. District hospitals are further classified as category A or B, category A meaning that the facilities have surgery capacities, unlike category B. A total of 5081 hospital beds were available in 2008, 0.9 beds per 1000 inhabitants.

The Government has announced future autonomy for public health facilities. In 2007, the LaoHealth Maintenance Organisation was created, which foresees the opening of the first fully private hospital in the country by 2009.

3.3 Health policy, planning and regulatory framework

In 2001/2002, the Ministry of Health, with support from the Japan International
Cooperation Agency (JICA), conducted the Lao Health Master Planning Study. The study identified seven'precedent programmes' to be implemented and 31 'very high priority' programmes in the fields of planning and management, human resource development, health financing, health education,infectious disease control, primary health care, maternal and child health, nutrition, hospitalservices, medical laboratory technology, and essential drugs. The need for sectorwidecoordination is emphasized in the study report and initial steps toward such coordination havebeen taken since 2005 with the support of the sectorwide coordination process financed by the Japanese Government in close collaboration with major donors, WHO and other United Nations agencies working in the health sector.A third major policy document is the National Growth and Poverty Eradication Strategy(NGPES). The NGPES focuses on poverty and the poorest districts, of which 72 poor,47 poorest, and 10 for initial activities have been identified. The health priorities in the NGPESare: information, education and communication for health; expansion of the service network for the health promotion of people in rural areas;· improving and upgrading the capacity of health workers from village to post-graduate level, with an emphasis on ethnic minorities, gender balance, and incentives for retaining health workers in areas of shortage; maternal and child health (MCH) promotion;

· immunization; water supply and environmental health; communicable disease control; control of sexually transmitted infections, including HIV/AIDS;· village revolving drug fund development; food and drug safety; promotion of traditional medicine integrated with modern medical treatment; and

· strengthened sustainability, including financing, management, quality assurance and legal framework.

To a large extent, all documents are superseded by the Sixth National Socio-Economical Development Plan (2006-10) (NSEDP), which was promulgated by the VIIIth Party Congressand the National Assembly in 2006. The NGPES has been fully integrated into the draft 6thNSEDP and serves as its core. The NSEDP was presented to and discussed widely with both internal and external partners, but there remains a large funding gap for implementation in all sectors, including health. Despite the constant fall in the share of health expenditure in the public budget and as a percentage of GDP, the Government has pledged to increase health spending within the framework of it policy dialogue with the Bretton-Woods institutions (World Bank and International Monetary Fund).

A new constitutional article (2004) obligates the Government to improve and extend the health network; improve disease prevention; create conditions so all people receive health care, especially mothers, children and the poor; and legalize private investment in health services. In August 2007, the 6th National Health Conference (NHC) reviewed the achievements and implementation of the 2001-2005 National Health Plan and provided recommendations for the 2006Œ-2010 five-year national plan. The actual strategy of the Ministry of Health is based on a" healthy village model" that will include the eight components of primary health care (PHC), as expressed in national PHC policy, and will provide health for all. It is aimed at enabling development from the grassroots level up. The 6th NHC calls for: (1) a general increase in funding for health; (2) establishment of the University of Health Sciences under the direct supervision of the Ministry of Health; (3) implementation of the Complex of Hospital -Institutional - Project -University (CHIPU); (4) creation of new posts; and (5) increased incentives for health workers in rural areas.

3.4 Health care financing

Current estimated per capita health expenditure is US$ 19, about 80% coming from households,10% from donors, and 10% from the Government. Hospitals are highly dependent on user fees for recurrent expenditure. There are nascent health insurances systems for both the formal and non-formal sectors and a civil service scheme is being reformed. Equity funds are under discussion and limited piloting has occurred.Health expenditure made up 3.3% of total government spending in 2006, and donor spending is
estimated to have made up 52% of total public sector health spending in the same year. Salaries account for the bulk of domestic public expenditure on health (75.3%).

The Lao People's Democratic Republic faces similar challenges to all low-income countries as regards issues of human resources for health (HRH): under-funding of salaries and wages, mal distribution of qualified staff among geographic and health system levels, limited number of qualified health workers, and low staff productivity.

The country faces a general shortage of qualified health workers. The total health workforce in2005 numbered 18 017 workers, corresponding to a ratio per 1000 inhabitants of 3.21. This
included regular staff (civil servants) under the Ministry of Public Health, as well as contractual staff. It also included the health workers under the two other Ministries that manage non -public health facilities: the Ministry of Defence and the Ministry of Public Security. Around 70% of all health workers are under the Ministry of Health. High- and mid-level medical staff under the Ministry of Health, defined as physicians, nursing staff and midwives with more than two years of formal training, account only for 23% (4123, i.e. 0.74 workers per 1000 inhabitants).Less then 50% of all health workers are in public health facilities managed by the Ministry of Health. The 8942 regular health workers under the Ministry work in hospitals, health centres and district health offices/hospitals, with district-level facilities accounting for the majority. However, the bulk of the staff at district level are mid- and low-level (88%) health workers. Physicians represent only 6% of district-level staff. Health centres are almost totally served by low- and midlevel staff, at respectively 81% and 18%. There are only eight doctors working in health centres. Mal distribution of staff, both geographically and by level of facility,

accentuates the crisis. There are only 2992 regular high- and mid-level medical staff at health-facility level, corresponding to0.53 workers per 1000 inhabitants, far below the recommended WHO target of 2.5. These workers tend to be concentrated in socioŒeconomically better-off regions to cope with the limitations of their salaries and wages. Rural areas, where living conditions are difficult, are not attractive to newly trained, competent workers. Compared with international standards, the productivity of health workers in the Lao People's Democratic Republic could be considered low. This is mainly due to the lack of financial and material incentives available to them (In 2005, the average annual salary for health workers was estimated to be US$ 405.). This forces health workers to rely on coping strategies and secondary occupations to ensure their livelihood. This situation, combined with the limited number of new posts created in recent years (The workforce has grown more slowly than the population in the last decade.), limits the development of the health system and its response
to the needs of the population. In 2007, with WHO support, a national HRH database was designed and tested. A national conference on HRH was held and the drafting of a framework for the development of HRH in the Lao People's Democratic Republic was initiated.

3.6 Partnerships

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has been a major
contributor in the country, with more then US$ 45.5 million in grants allocated between 2003
and 2006. The majority of this funding was allocated to reducing the malaria disease burden
(US$ 27.2 million). In total, at the actual approved state of proposals, the Global Fund will have made available more than US$ 62 million of the US$ 95 million requested. In 2007, the country applied for grants as part of Round 7 of the Global Fund call for proposals, and two of its proposals were assessed positively by the Fund's Technical Review Panel. The requested funds amount to US$ 25.6 million to fight malaria and US$ 10.9 million to fight tuberculosis.
Since 2002, the Global Alliance for Vaccination and Immunization (GAVI) has supported the

Lao People's Democratic Republic in immunization services and introduction of new vaccines.This support included the rolling out of DTP-HepB tetravalent vaccine to all districts
(2004)along with injection-safety improvements. GAVI's five-year estimated commitment to the
country (2002-2007) currently stands at US$ 7.1 million. Other major health sector development partners and donors include: the Asian Development Bank, the World Bank, and the governments of Japan, Luxembourg and France. Avian influenza preparation has also beneficiated from the important support of Australia, the European Union and the United States of America. Most of the United Nations funds and specialized agencies are represented in the country. In2006, the United Nations Country Team finalized with the national authorities the 2007-2011United Nations Development Assistance Framework (UNDAF), based on the Common Country Assessment conducted in 2005. WHO led the health working group for the preparation of these documents. The UNDAF will be the leading guideline for actions carried out by the United Nations Country Team in future years.

II. The Health Care services for Children with Disabilities

Following the health system services in Lao PDR composes in 5 levels as follows:

1) In central level compose of 4 Faculties and 3 specialist Hospital.
2) In 4 Regional general Hospital .
3) In 12 provincial general hospital
4) In 67 Districts hospital
5) In 746 health centers

And 254 private clinics

The early detection for children with disabilities was performed by the pediatrist or Physician at the faculty , Regional and provincial general Hospital .

Through this early detection performing the referring system for children with disabilities such as the cerebral palsy, DownŒSyndrom and malformation congenital like the club foots & back deformity can refer to the physical medicine Division for early physical rehabilitation. The place can serve only at the faculty and 4 Regional general Hospital . The others provincial or practical MD need to improve their knowledge in qualifying their post graduate in neuropediatric medical doctor.

The structure of the physical medicine rehabilitation in Lao PDR consist of 3 levels:

1. In Central level has two services like : The National rehabilitation center, the physical medicine Division at the 3 Faculty hospitals.
2. The Sub regional rehabilitation center on 4 Regions and physical medicine rehabilitation at the 4 Regional general Hospital .
3. The physiotherapy Section at the 12 general Hospital .

The Human Resources for the physical medicine service sector in Lao PDR.

1. In Central level has two services such as: The National rehabilitation center, the physical medicine Division at the 3 Faculty hospitals.
    - The National rehabilitation center has 3 Divisions for providing the physical and orthopedic services consist of : The physical medicine rehabilitation Œ the orthopedic surgical, the prosthetic & orthotic and wheelchair workshop and the community Based rehabilitation services consist of the rehabilitation technical team as follows:
        a) The orthopedic surgeons team
        b) The physical medicine rehabilitation team
        c) The prosthetic & orthotic Œ wheelchair technicians team.
        d) The community Based rehabilitation supervisor team ..
    - The 3 faculty Hospital in the capital Vientiane has 1 physiotherapy Division consist of 1 physician and 5 physiotherapists.
2. The 4 Sub regional rehabilitation Center and 4 Regional general hospital has two level of providing the services like : the Sub regional rehabilitation center provide for institutional level and community level by providing the community Based rehabilitation service consist of 1 physician , 10 physiotherapists who are also working the CBR trainer and the Regional general Hospital consist of 5 physiotherapists.
3. The 12 provincial general Hospital has 1 physiotherapy Division consist of 4 physiotherapist s

III. The Disabled

According to the Lao Social indicator survey, overall, 2.4% of the population surveyed was reported as" Disabled by the household heads " .There was significant variant by residence (Urban, semi-urban or rural). The National estimation based on this survey are reported the National statistic in 2005 as follow:

- Deafness 22,504
- Lamess / paralysis 30.194
- Blindness 10.831
- Amputation/ loss of limb 14,000
- Mentally 5200
- Psychosis (strange Behavior) 6450
- Leprosies impairment 5213
- Others physical disabilities 65.240.
- The Victims of the war and UXO Lao 50.230 (data collection in 2008 by the Cooperation between MoH and National Regulatory Authority UXO's Lao by using the health network every districts of Lao PDR.) is going put in Data based of Victim assistant .

The detail of data based for the others group of disabilities is needed the resources and fund to finish.

- To improve the sectorwidecoordination body within the Government agencies of Lao PDR follows of the ESCAP Proclamation on the full participation and equality of PWD'S in Asia and Pacific Region ; the Government of Lao PDR has signed official this paper on 14 December 1995 . then taking account to this action .
- The structure of the National committee for Disabled now the Lao Government is now improving which consist of the Deputy Prime Minister as a Chairman and the Minister of Labour and Social welfare and Vice Minister of Health as Vice of the Chair and also the Director general of the Different ministries concerned as a committee. Ministry of Labour and Social { Welfare is the office of the permanent secretary the participants from SocialŒ welfare – will report in detail for this .

IV. The action plan of the National Committee for the Disabled has follow:

In the past the action plan of this committee based on the ESCAP proclamation on the full Participation and Equality of People with disabilities in Asia and Pacific Region and now based on the International Convention for the right of PWD's that signed by the Government of Lao PDR in New York in December 2008. Now this committee is arranging the Office permanent and strengthening within the Stakeholders in the Government agencies to work together for this action and now its runs some programme as follows:

4.1 A program on prevention, treatment and medical rehabilitation of disabilities.

- This program involves many other sectors, and the National Committee for the Disabled has instituted a number of measures and programs to cooperate with the sector involved, as infection can cause sickness and disability especially the successful of the eradication the poliomyelitis in the whole country. Congratulation to the Health Ministry in collaboration with the local government to get this goal.
- As treatment and medical rehabilitation is under the leadership of the health Ministry and Labor and Socio-welfare Ministry, the National Commission assigned the two sectors to cooperate closely to improve the National Rehabilitation Center, so that it may offer a high quality of service at the Central level and expand services to all provinces, to give the disabled access to these services.
- A traffic accident prevention program has been instituted, coordinated by National Commission for the Disabled, assigning duties to the traffic sector and the Police Department under the responsibility of the Interior Ministry.
- Accidents resulting from detonation of unexploded ordnance in the war prevention program are under the Labor and Socio-welfare Ministry locates fund and has set-up the National Regulatory Authority office to work with UNDP and others donor and the states parties who signed the International Convention of the Cluster munitions and now working with the stakholders to mange and solve this problem for the unexploded ordnance clearance program (UXO) and the victims of UXO in LaoPFR. This program is being implemented with the active cooperation of International Organizations.

4.2. Education of the disabled

- Under the Prime Minister Decree on compulsory education in primary schools, the National Commission for the Disabled supervises the National Rehabilitation Center, and in cooperation with the education sector encourages all disabled children to study at school in an integrated education program. This program is expanding to all parts of

the country, and is receiving interest from domestic and International organizations.

One of their basic rights is the general education and employment oriented vocational training. It is agreed that due to the particular communication needs, education for deaf and blind persons are more suitable provided in special classes. Nevertheless Laos plans, in cooperation with UNESCO, to integrate disabled student of secondary level in normal classes.

The NRC will have task to provide suitable teaching aids, training courses for special teachers at provincial level and support the ordinary teacher in facilitating the impaired students. It will continue to product primary classes for blind or deaf children, too.

Similar to the whole population there are 1,620 deaf and blind children aged 5-14 years living in the area of Vientiane alone or 8,910 in the whole country. Though the number of students at the NRC is fast growing they are still modest compared to the estimated needs.

	Deaf students	Blind students	Total	
Opening	11	6	17	
1992/93	38	10	48	
1995	43	17	60	
1996	62	+31	93	School at NRC VT
application 2008--09				
	24	4	28	School at the Sannakhet province
	37	0	37	School at Luangprabang province
application 2008--09		50		
application 2008--09				School at the Ophthalmology Center (MoH)
application 2008--09				

Unfortunately we don't have the capacities to accept the applicants all the target. The 38 teachers and the four assisting volunteers are fully absorbed by the progressive needs of the actual students. Among them they have to organize the new vocational training for the oldest. Another limitation is the precarious space situation. Some classes are already held in temporary rooms.

65 students live at the center. They sleep in the dormitory or their classroom. The quality of living condition is poor, too. One building, constructed in 1964, should be demolished as it is in danger of collapse. The five toilets and washing facilities are basic and have to be shared with staff and patients of the orthopedic department. Half of the students are living close enough to reach home every

evening and practice social integration. But some parents have no choice, even the weekly transport to and from the school is very expensive. Those parents, who prefer their child keeping daily contact to brother and sister, will keep their child at home without education at all.

Beside this in Savannaket province the special school for the deaf and the blind has been opened in 2005 and can accept 34 deaf students and 1 Blind students and in Luangprabang spcial school for the Deaf students opened in the beginning of 2009 and can accept 37 students and stay all in dormitories. The Ophthalmology Center (MoH) opened in 1998 and accepted 50 Blind students staying at dormitories and also join the inclusive education at the primary and secondary education.

4.2.1.The inclusive education between the normal and the disabled children

- The general policy and Background.

The inclusive Education program between the normal and disability children is one part of the responsibility to the Policy on the compulsory education, the treaty of the right of Children and the Salamanca statement about the education of the disabled children. This program is the inclusive education between the normal children and the disabled children project. Beside the implementation the policy for disadvantage children or poverty and female children.

The inclusive education is one program to support the disabled children to inclusive education with normal children in primary located in their hometown. They provide some facility in the school and class-room for the children with disability to receive a good result of the education.

The integrated education program is connected with the others improvement education projects such as: The improvement the curriculum and new metrology teaching in general education (kindergarten, primary and secondary school). The inclusive education is one benefit for children with disability and low mental retarded children because these group of disability can follow the education until they graduate this general education. We observe that when the teachers have a good think for the children in that area include the children with disability and they have been improving the new technology on how to teach these kind of disability children, especially a good result the class-room being increased, but the unsuccessful of the graduation the class-room and leaving the school will be down.

At the present the inclusive education is supporting the fund by the Save the Children fund of England UNESCO and more funding the second period, since the end of 2000 SIDA adding the fund.and a;so the Catholic Relieve Service(CRS) . The assistance for the project budgeting not official report until

2005---_2009 fiscal year is the total amount of : 900.000 US$. For next two fiscal years will have : 300.000 US$.

- Activities and the result

a. Pilot and extending project

- The special education for the blind and the deaf children established in 1992.
- Since 1993 starting the first pilot project inclusive education at Saphanthong Nova primary school and accepted 13 disabled children.
- In 1995 starting the expanding the project till 1999 in 65 primary schools (23 kindergarten, 39 primary schools, and 3 secondary schools) in 23 districts, 8 provinces. The total children with disability is : 505 persons.
- The begining of 2000 is expanding into 78 schools, in 28 districts and 12 provinces, accepted 600 disabled children.

b. Noming the team work of the project

- In 1993 nominated the team work of the project consist of : Director general of general education Department, Deputy Director general of the teachers training, and Deputy Director of National Rehabilitation Center. Include also the technical staff from different Department concerning being operation team.
- Every provinces implemented the project should be Deputy Director of provincial education Department as a supervisor this project, the operation team come from different organizations include district educational office and provincial rehabilitation unit.

c. The human resource training

The inclusive education project focus on the training the metrology and

the knowledge about teaching the children with low and moderate mental retarded children to the operation team at provincial level. When they understand this work, this program can implement by this team at provincial level. The training we use such as:

- Organizing the seminar for the team work in provincial level such: Director and teachers in every pilot primary school. All the documents needed for this training have been prepared.
- Exchange the experiences between the primary school, the district and the provinces and also study tour in abroad.
- Organizing the annual meeting to sharing the experiences and evaluation the done in this fiscal year. A good teachers and Director of the primary school and also the team operation of the project from the provinces being invited.

- The technical from Ministry concern going to the provinces to follow up and monitoring twice a year.
- Publishing the Bulletin about the activity of this program written by the members responsible of the project, teachers, Director of the primary school.

d. Others achievement of the project

- Strengthening multi-Sector for work plan and the implementation the program and extend the responsibility by practice and budgeting.
- Summarize the statistic of the project in every year.
- Strengthening participation of the community and their family.
- Close cooperation with others institution, especially the National Rehabilitation Center.

4.3.Vocational training program

For this, the Labor and Socio-welfare Ministry, the Health Ministry and the education Ministry have cooperated to establish a project for vocational school for persons with disabilities. Previously, the National Rehabilitation Center has a project cooperation with the Foundation for educational development of Sisters of Saint the Chartres to establish the Sikeud vocational school for physical disabled persons since 19/9/1999 and ln 2004 the 4 Self Œ enterprise for the -graduate from the vocational school in 4 provinces working at these Centers name (SIKEUDNET) . The total number of the students graduated is 336 persons and all are employ from private and companies sector .The National Committee for Disabled supported a vocational program for a number of persons with disabilities, so that they may acquire employment skills to earn a living for themselves.

4.4 .Socio-welfare support for persons with disability

- The National Committee for the disabled, under the Government policy assigns the Labor and Socio-welfare Ministry to provide suitable housing for persons with disability, and encourages government agencies to accept the disabled as employees. Presently the Commission is studying formulation of regulations for job security and adapting buildings for better access for disabled persons, getting ride of physical barriers.
- All of these follow documents resulting from the ESCAP Declaration on full participation and equality of persons with disability. The government is still faced with difficulties in implementing the program. Nevertheless, I believe that with continued effort on the part of the Lao Government, joined by cooperation and support from International organizations and friendly countries, we can achieve even better results in the future.

5.The Problems to be solved with children with Disabilities.

When we look at the figure of the number of children with disabilities in Lao PDR is quiet big ; however those who in the countryside especially in 47 poorest districts they don't know where the heath services are and cannot access to the services .Even the International convention for the right of Disabled People and the Government of Lao PDR has been signed in December 2008 in New York and now the Ministry of Labor and Social Welfare of the Government of Lao PDR in cooperation with others Stakeholders concerning with disabilities issue is preparing the legislation for the right of Lao PWD's.

Although we don't complete this legislation . the Lao Government put in the policy and established the National Committee for Disabled people within the Government agencies ; Especially the three Ministries such as the Ministry of Labor and Socio Welfare , Ministry of Health and Ministry of education . This Committee as I mention above has the programme for providing the service for Children with Disabilities. For the site of the health services we do the community based rehabilitation supported by International NGO's in 7 provinces but not covering all the target . especially those who live in the rural area.

The outreach progamme that we are starting now is becoming a large number of the poliomyelitis, the cerebral palsy and the club foot children come to the Regional rehabilitation center and to National rehabilitation center in the capital Vientiane . The services is free of charge for transportation, accommodation food and medical services like operation and physical medicine rehabilitation. This programme the INGO's support and also adding the local fund raising .

5. Lessons Learnt

Face to the causes of Children with disabilities are increasing not only from the birth also those who healthy ; because of the poverty and living in the area of the risk of UXO accident. The children l collected the UXO scrap metal to sale .Every year there are some 300 UXO accident, resulting on approximately 120 death and 180 injuries and become disabilities.

The programs for the action for opening the access of Children with Disabilities for the health service especially the skill of how to refer these group of Children to access the service and Strengthening the network of the Social welfare for the poor family who have the Children with disabilities .

6. Recommendations

Lao PDR is still young of the ASEAN member and has a limit National Budget to provide the improving the services both for health sector and social &

welfare sector and highly open door to cooperate with the ASEAN members , especially with JICA .

End of Lao PDR report for Health Sector