Health Service Delivery Profile

Lao PDR

2012

Compiled in collaboration between
WHO and Ministry of Health, Lao PDR

Lao PDR health service delivery profile

Demographics and health situation

In 2011, Lao People's Democratic Republic had an estimated population of 6.4 million with 37.3% under 15 years of age and 3.7% above 65 years.[i] It is a predominantly natural resource-based, landlocked country with an estimated 66.8% of the population dispersed and living in rural areas in 2010. Many places are difficult to access due to the highly mountainous landscape and up to 21% of the population live in areas with no roads. There are 49 officially recognized ethnic groups. Ethnic Lao people comprise 52.5% of the total population and inhabit the lowlands predominantly, while ethnic minorities mostly live in the highlands. The three broad ethnic groups (the Lao Loum, Lao Theung, and the Lao Soung) have smaller ethnic subgroups which exhibit some differences in dialect, customs, and beliefs, including health seeking behaviour and use of traditional or herbal medicine.

In the 1950s, 1960s and early 1970s, Lao has been ravaged by several wars and political instability until, in 1975, the communist party took over the reins of the country. In the last ten years, Lao PDR has enjoyed average GDP growth of 8% and the country has just become a low-middle income country. This growth is fully driven by foreign direct investment in natural resource extraction industries (such as mining, deforestation/industrial plantations) and hydro-electric power. Despite this economic growth and national efforts, the proportion of the population living under the poverty line was 27.6% in 2010 (UNDP). The poverty gap is getting wider, as are the gaps in access to school, food, and health care, especially among women and girls.[ii]. Most of the poor live in rural areas. Recently, Lao PDR has become more 'land-linked' with better road access within the country as well as with neighbouring countries, especially in the development context of regional economic corridors.

Table 1. Key development indicators in Lao PDR

Key development indicators	Measure	Year
Human development index (UNDP)	0.524	2011
Human development index ranking (UNDP)	138	2011
GNI per capita (World Bank website, databank)	1,010	2011
GDP per capita (US$) (Lao Statistic Centre)	1281	2011
Total health expenditure (% of GDP) (MOH)	4.1	2010
Population living below US$1/day poverty line (%)	25.6	2010
Literacy rate (male/female) (%)	83/63	2005
Life expectancy at birth (MOH)	67.5	2011
Maternal mortality ratio (per 100,000 live births) (LSIS)	357	2012
Proportion of population using an improved drinking water source (%) (MOH NamSaat)	78	2012

Several measures have been taken to promote Primary Health Care (PHC) and "Health for All" and some key health indicators have improved, especially in maternal and child health (see Table 3). However, health-related outcomes remain among the poorest in South-East Asia and progress in expanding coverage of priority health interventions has been inconsistent. Non-communicable diseases (NCDs) accounted for 48% of all deaths in Lao in 2008;[iii] communicable diseases, maternal and perinatal as well as nutritional conditions accounted for 41% of deaths. Malnutrition remains a challenge with 26.6% of children under 5 year of age being underweight, and 44% being stunted.[iv]

Health legislation, strategies, and objectives

The health sector is governed by a series of laws, decrees, regulations and policies: Decree on Health Care Services (1995), Decree on Establishment of Private Hospitals (1998) Decree on Social Security System for Enterprise Employees (1999), The Environmental Protection Law (1999), Law on Drugs and Medical Products (2000), Law on Hygiene, Disease Prevention and Health Promotion (2001), Decree on Drug National (2003), Law on Food (2004), Regulation on the Promotion of Maternal and Child health (2004), Law on Health Care (2005), Regulation for Community Based Health Insurance (2005) Law on Tobacco Control (2009), Health Personal Development Strategy by 2020 (2010), Decree on incentives for civil servants posted to rural areas (2011).

The Law on Health Care (2005) provides for administration of the health sector, national health financing and social health insurance, including in Article 50 the establishment of a 'social security fund' (or health equity fund). It also gives administrative authority to provincial and district health authorities, including the right for public facilities to implement user fees and exemptions and to nominate legitimate service charges. The Prime Ministerial Decree No. 52 in 1995 authorized the collection of official user fees at facilities and also provided for fee-exemptions for the poor. The Prime Ministerial Decree 381 in 2006 on Technical Revenues was intended to regulate user fee collection across the public service generally.

As a signatory of the Alma Ata Declaration of 1978, Lao PDR has developed a comprehensive *Primary Health Care Policy (2000)*. Two key components to the PHC policy are maternal and child health care and nutrition, and these are addressed in the *Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services (2009-2015)* and the *National Nutrition Strategy and Plan of Action (2010-2015).* Integration of MCH and Expanded Programme of Immunisations (EPI) services has also been recognized as a key strategy to further expand coverage of the services, especially in rural areas.

The Ministry of Health's (MOH) *Seventh 5-Year National Health Sector Development Plan (2011-2015) (NHSDP)* goals are: i) create basic material and technological health infrastructure, including sustainable health financing, in order to bring the country out of the Least Developed Country status by 2020; ii) expand and strengthen the health system in order to meet the needs of the people, especially the poor and vulnerable; and iii) contribute to eradicating poverty to improve the Lao people's quality of life, aiming to achieve the five health-related MDGs. Accompanying this overall plan, a series of sub-sectoral plans and strategies have been developed or are currently in the development process (e.g. Health Information Systems; Human Resources for Health; Health Financing Strategy; Reproductive Health Strategy). Many have been developed for the first time.

Service delivery model

The *Law on Health Care (2005)* provides that all citizens regardless of sex, age, ethnic origin, race, religion or socioeconomic condition have the right to receive health-care services, and requires delivery of health care in an equitable manner. However, out-of-pocket payments are charged in public and private facilities and make up 63% of total health expenditure, and safety nets for the poor are not strong. The state-provided public health system is underutilised, especially in peripheral areas, but nowadays utilization is increasing. Private facilities are mostly located in urban areas. The public health system has three arms: 1) health care, 2) prevention, promotion and disease control, and 3) health management and administration. Vertical approach has been long time practised.

The government has made all issues related to maternal and child health a priority area in policy and strategy development. This is due to lack of health care services reaching all communities, especially women and children in remote areas. The National Commission for Mothers and Children has an advisory, monitoring and advocacy role for the MNCH strategy.

The *Integrated Maternal, Neonatal and Child Health Services Package* is outlined in the MNCH Strategy, and is being implemented (since 2009) in a phased approach by the MOH in close collaboration with several development partners. The aim is to reach coverage of the entire country district by district through a uniform approach. Though the comprehensive package is required to be delivered in the identified prioritised districts, all levels of health facilities and all staff members are required to provide the complete package of MNCH interventions as defined for that level of facility. The MNCH package includes an essential set of services and an additional optional set. Services are planned to be person-centred and delivered along the continuum of care from pre-conception, through pregnancy and up to child health care. An outreach package of interventions has also been developed that responds to the need of remote communities and increases coverage.

Laotian traditional medicine dates back to at least the 12th century, and is influenced by Buddhist and Indian traditional medical systems. It remains an important element in the prevention and treatment of disease. The main type of traditional medicine practised is the Laotian traditional medicine. Other introduced forms of complementary and alternative medicine, including acupuncture, Ayurvedic medicine, herbal medicine, and Chinese traditional medicine, are also popular. Traditional treatments include coin rubbing, cupping, steaming, acupuncture, acupressure, massage, herbology, and the use of amulets, etc.

Table 2. Levels of service delivery and types of services in Lao PDR, 2012

Facility	Number	Characteristics
Public sector services *(MOH, 2010)*		
Community level Village drug kits	5,000	MCNH package of essential services: health information including family planning, supplementation
Outreach services		Outreach package of MNCH interventions includes immunization, de-worming, Vitamin A supplementation and health promotion particularly for nutrition. Also skilled birthing care.
Health centres	894	Each health centre covers about 7,000 but many serve 1,000 people Implement MNCH services. Provide community and outreach services.
District Hospitals (A and B)	130	Health promotion, disease prevention, diagnosis and treatment
Provincial Hospitals	12	Treatment and rehabilitation services
Regional Hospitals	4	Provide curative health care services at the provincial level in the representative province of the region, as well as provide health care for the entire population of the region.
Central Hospitals	4	Tertiary curative care
Special treatment centres	3	Provide dermatology, ophthalmology, and rehabilitation
Private sector services *(MOH, 2010)*		
Clinics	222	Mainly in urban areas. There are 647 applications waiting for approval
Pharmacies	1993	Mainly in urban areas
Hospital	0	No private hospitals, but recently, a number of private clinics and private wards in some major hospitals have been set up
Selected development partners' programs and activities that support the MNCH strategy*		
Asian Development Bank		Health sector development program, support MNCH, Health Equity Fund, free delivery and under 5 treatment in eight provinces ,64 districts in the North Strengthening MOH capacity
GAVI HSS		Integrated MNCH services package (five districts in two provinces)
Japanese Government: JICA		Strengthening Integrated MNCH services project in four provinces
Luxembourg Government: Lux-Dev		Health Sector Support Programme including MNCH services (three provinces) Funds the Joint UN project for MNCH and Nutrition in four provinces
Safe the Children Fund (Australia)		Health Sector Development Project districts in Luang Phrabang and before, in Xaiabury
UNFPA		Development of the Skilled Birth Attendance Development Plan to address acute shortages of staff. The delivery of the MCNH package is dependent of these staff Supports strengthening of the drug logistic system in order to ensure quality drugs and supplies are always available. Working to strengthen the Family Planning (FP) component of the MNCH package
UNICEF		Technical support to deliver MNCH outreach services to three poor districts in Savannakhet province Development of the MNCH core package.
WHO		Assists in policy and capacity building Development and implementation of the MNCH integrated package
WHO and Korea Foundation for International Healthcare		Supports expansion of MNCH integrated package to 17 provinces.
World Bank		Health System Improvement Project in five provinces

* Note: many development partners work in collaboration with other country and partner organizations to fund and deliver these programs

A 2005 study showed that 77% of the population had used traditional medicine at some point in their lifetime. This study also showed that traditional medicine is equally popular in lowland districts as in mountainous districts, as between urban and rural areas. This goes against the notion that a lack of trained medical personnel leads to greater utilisation of traditional medicine in remote areas. Women and men were shown to have similar levels of knowledge regarding traditional medicine. Traditional medicine is commonly used at childbirth and to treat sick family members. Reasons for the use of traditional medicine include its perceived efficacy, accessibility, and lower cost compared to modern medicines.

The provider network

The public sector delivers most health services in Lao PDR through government owned and operated health centres and district, provincial and central hospitals. Although it is predominant, a private alternative is growing. Development partners have agreed to work in different geographical locations of the country and focus on areas of specific expertise of the relevant organizations (Table 2).

Hospitals are mandated to give priority attention to maternal, neonatal and paediatric wards; provide emergency obstetric and neonatal care (basic or comprehensive); provide emergency, triage assessment and treatment of children; manage sick children using standard treatment guidelines; ensure adequate hospital policies; material resources, drugs and commodities for care of mothers and children; give priority to staff training for care of mothers and children, ensure supervision, and monitoring and evaluation. Yet due to weaknesses in the system, hospitals often face difficulties to fully comply with these instructions.

Traditional medicine service delivery operates at three levels in Lao PDR: national, provincial, and local community level. Traditional medicine practitioners play a very important role in primary health care (Table 3).

Table 3. Traditional medicine service types and providers in Lao PDR

Facility	Number	Characteristics
Community traditional medicine practitioners/healers (with different skills/knowledge)	18,226	Every village has one or two traditional practitioners. Estimated 3,370,002 patient visits to traditional practitioners so far. Estimated cost per visit (cash and In-kind) is around 100,150 (kips) almost equal to USD 12
Provincial traditional medicine units		Under control of provincial food and drug offices/provincial health offices. Each with 1-3 staff, mostly pharmacists and healers
Provincial traditional medicine stations/sections	7	Under control of the provincial health offices. Each with 3 - 6 staff, mostly pharmacists and healers TM stations provide different services, including acupuncture (Champasak & Sayabouly), and sauna (Xiengkhouang & Sayabouly) Champasak TM station also has the capacity to processing TM products (e.g. capsules), and provides them to the provincial hospital for treatment
Institute of Traditional Medicine (Former Name: Traditional Medicine Research Centre)	1	Provides treatment with herbal remedies, acupuncture, and massage 43 staff (34 permanent and 9 non-permanent) Treated more than 4,200 people from 2004 to 2009
Private traditional medicine healers		Also provide treatment with traditional medicine at the local community level. Besides, there are Chinese private traditional medicine clinics.

Health financing

As it is shown in Table 4, funding for health is heavily reliant on out-of-pocket payments and development partners. User fees were introduced to public health services in 1995. Fees are charged for patient registration and ancillary services, but not for consultations with health care professionals. Although total health expenditures have increased significantly in recent years, this is almost entirely accounted for by a rise in private, primarily out-of-pocket spending, predominantly for medicines at both public and private facilities. User fees for drugs are set at cost plus 25% to cover costs. There are fee exemptions for the poor, although these have proved difficult to implement. 63% of the total health care expenditure comes from household expenditure.[v]

Table 4. Key health financing indicators

Indicators	Value
Government Health Expenditure as % of General Government Expenditure *(MOH-WHO NHA 2009/2010)*	5.9%
Out-of-pocket expenditure as % of Total Health Expenditure *(WHO, 2011)*	63%
External funding as % of Total Health Expenditure *(MOH-WHO NHA, 2009/2010)*	15.1%
Coverage of Social Health Protection (all schemes) *(MOH, 2011)*	18.5%

Lao PDR has four social health protection schemes, all of which seek to increase utilisation of health care services and provide financial protection to families. These include the State Authority for Social Security (SASS) which provides coverage for civil servants, the Social Security Office (SSO), Community-based Health Insurance (CBHI), and Health Equity Funds (HEF). At presence, these four schemes cover only 18.5% of the population, of which the SASS covers the highest at 79% of its target population, followed by SSO at 27%, HEFs at 11%, and CBHI at 4.7% of its target populations, respectively. Despite great efforts made to increase coverage from 13% in 2009, these schemes have not contributed significantly to greater financial protection of the population.

The Government of Lao has expressed commitment to enhance the efforts to reform for better social health protection coverage, including increase in domestic funding for health.

Human Resources

There are about 14,189 public sector health workers. MOH (Lao) staff and other health staff from the ministries of National Security and National Defence take up about 30% of total health work force in the country. With the average 2.17 health workers per 1,000 population, Lao PDR health system is classified as facing a critical shortage of staff. [vi] Low salaries and low levels of basic training inhibit health system efficiency. Staffing is urban-biased; there is often low motivation, conflict of interests and a lack of training and career development opportunities. However, as the MOH progresses with implementation of its first National Health Personnel Development Strategy 2009-2020, a number of these deficiencies begin to be addressed. For instance, the decree on incentives for civil servants posted to rural areas, approved in 2011, will contribute to reduce the urban-rural imbalances of health workers. The National Health Statistic Report in 2011 shows evidence of progress in health professional staff distribution of 2.4 doctors and 7.5 nurses per 10,000 populations compared to 1.9 and 7.9 respectively in 2010.

Under the MNCH package of services, increased capacity of the health centres and district hospitals is required to ensure improved access. Staffs are also required to optimize each opportunity of contact, to deliver multiple interventions to mothers and children. There has been no report on how this is implemented.

Traditional practitioners in Lao PDR include Buddhist monks, herbalists, shaman soul callers, magic healers, and massage therapists. It is estimated about 600 traditional medicine practitioners listed in the database of Traditional Medicine in the country. There are no licensing requirements for practitioners of traditional medicine or complementary and alternative medicine in Lao PDR. However, the government fully supports the use traditional medicine or complementary and alternative medicine and medical plants in the health care system and encourages both public and private sectors to contribute to the development of traditional medicine practice.

Pharmacists practising in traditional medicine stations and units possess only general and basic knowledge on traditional medicine that they received while undertaking their pharmaceutical study. Traditional healers mostly have had no formal education, but possess knowledge passed down from generation to generation.

The Traditional Medicine Research Centre and provincial traditional medicine units/stations conduct training courses for healers using a standard training package. Basic knowledge on the use of traditional medicine and simple medicinal plants is disseminated though publications including, *Medicinal Plants in Your Garden* (1993), and *Simple Plants for Self-medication* (2001).

Medicines and therapeutic goods

Dispensaries are public and group of village-based. The user fees system has generated a situation where providers over-prescribe, and weak regulations mean that drugs are often charged at cost plus 40% instead of plus 25%. As a result, expenditure on drugs accounted for 36.2% of out-of-pocket (out-of-pocket) expenditure on health by household.[vii] Since 2009, the implementation of the ministerial decree No.594/MOH to integrate logistic systems into one system to harmonise the national drug supply system, together with the decree on drug management, quality drugs are more accessible. The MOH issues an essential medicine list. Drug kits are distributed to all villages situated 2 hours of walk to a dispensary. In 2010, there were about 5,700 drug kits distributed in the country.

Additionally, traditional medicine also plays a significant role, especially in rural areas. The *Law on Drugs and Medical Products (2000)* covers traditional and herbal medicine products. Traditional and herbal products are sold in pharmacies or other outlets as non-prescription self-medication or over-the-counter. There are an estimated 5,000 pharmacies nationwide, and some of them sell imported and local traditional medicine products. Traditional medicine products are allowed to make medical or health claims. The regulations governing *Drug Registration* were issued in 2003.

Lao PDR has no national pharmacopoeia for traditional medicine. Other countries' pharmacopoeias are used, including those of China, Japan, Vietnam, but these are not legally binding. WHO monographs Volume 1 (1999), 2 (2002), and Volume 3 (2007) are also used. There are no Good Manufacturing Practice requirements for traditional medicine manufacturing in Lao PDR. However, manufacturers are required to provide reference to safety data in documented scientific research on similar products. Traditional medicines are produced by both public and private sector manufacturers. The public sector includes the State Pharmaceutical Factories and the Institute of traditional medicine. The private sector includes joint venture factories, home-based factories, and healers at grass roots level.

Manufacturers are required to provide relevant pharmacopoeia information or necessary references and samples for the drug regulatory authority to approve for registration. In 2010, 184 traditional and herbal products have been registered, with 102 imported and 82 domestic products; 18 of these have been adopted into the national essential medicines list. There is no post-market surveillance system for safety of traditional medicines.

Implementation of the service delivery model and package

Lao PDR is a single party socialist country and is governed through decrees. This contributes to a strong policy and strategy environment. The MOH provides leadership and plays a central role as a technical advisor to the Provincial Health Offices (PHO) and the District Health Offices (DHO). The DHOs are the key actors for activities implementation at health facilities and community level. A Sector Wide Coordination (SWC) mechanism for health is used to align and direct the contribution and activities of the Development Partners in achieving the Government of Lao and MOH health objectives. This mechanism involves high-level membership from government, health, labour, social welfare and finance ministries, and development partners and operates at three levels: the policy, operational, and the technical level. It is steered by a MOH Steering Committee that also coordinates activities between MOH programs, including GAVI HSS and on-going monitoring and evaluation activities. Large government organizations, especially the Lao Women's Union and the Lao Red Cross, are involved in specific health activities, especially in promotion and prevention at the grass-roots level. Health care volunteers are also used at the community level.

The Centre for Mother and Child Health manages the nationwide implementation of the MNCH strategy through a number of specialized programmes via the provincial and district maternal and child health sections. Development partners contributing to MNCH interventions are coordinated through a technical working group. Provinces implement components of the strategy in slightly different ways.

Traditional medicine utilisation is officially supported and strongly promoted in Lao PDR. This is in keeping with a strong cultural heritage but also reflects the recognition that traditional medicine has a role in addressing the problem of access to, and cost of, modern medicines.

In 1976 a national office for TM was established in the Institute of Traditional Medicine under the MOH. The Traditional Medicine Research Centre was also established by the MOH in 1976. Since April 2010, this Centre has been named the Institute of Traditional Medicine. A national policy on the promotion of TM was issued in 1996, and the Prime Minister Decree on the *Promotion of the use of Natural Medical Resources* was issued in September 2003. The National Strategy for TM 2012-2015 was endorsed by the Ministry of Health in April 2012. Within the Food and Drug Department there is a Division of Traditional Medicine, which is responsible for regulating traditional/herbal medicine products. There is no national expert committee for TM in Lao PDR.

Referrals and linkages through the provider network

The health centres provide referrals and are the liaison with community services. However, public facilities, especially district and health centres, are poorly utilized, with bed occupation rate averaging 44.6% nationwide (range 15% - 80%) at provincial level in 2011.[viii] Coverage for preventive health services is also low. The ability to pay is a major barrier to utilization. Subsequently, the purchase of drugs in official or unofficial pharmacies and / or the use of traditional healers are often the first health-seeking behaviour.

The MNCH package requires a functional referral system to be established at all levels of care and incentives to encourage providers and users to follow the referral protocols. These have not yet been fully developed.

Quality

The MOH approved in 2009, the 10 Minimum Requirements which is a tool for assuring basic quality services at district hospitals and district health offices. Each of the ten minimum requirements is related to a set of specific activities; each one of them receives a standardized score which is provided monthly, quarterly or annually. The means of verification are checklist, reports and health facility records including a self-evaluation to which is added a bi-yearly external evaluation. The 10 minimum requirements and related activities are used to assess quality improvement of the health facilities with focus to a large extent on MNCH, EPI and the overall facility management. The bi-yearly external evaluation is applied mostly in the case of externally funded projects. Other quality assurance measures have been introduced to the health system spasmodically over the last few years.

The MNCH package has been planned in a manner that promotes attaining national defined standards of care. In order to increase the impact of appropriate primary care interventions and referrals on maternal, neonatal and child survival, the primary focus is on good quality hospital care. Health workers are being trained in the use of evidence based standard treatment guidelines for mothers and children, and are required to adhere to these guidelines at all levels of health facilities. The package also provides certification for those facilities that meet the minimum standard, and certification of MNCH health workers once they have received appropriate MNCH training and are found to be proficient. However, there is no documented evidence of these activities being implemented.

Equity

The Government of Lao has made progress in efforts to achieve the universal coverage aims to achieve it by 2020. Together with the free MNCH policy (maternal and children under 5 services) approved in 2011, a Prime Minister's Decree has been approved and guidelines have been drafted for the implementation. More specific emphasis is made on the Government's funding for free MNCH services in 10 of the 56 prioritised districts, plus other development partners have covered the service in number of other districts.

The health network claims to cover 93% of the population at an average walk of 90 minutes to a health facility. There are, however, major differences in access to services across geographical, social, political, economic, and ethnic and gender factors. User fees and high out-of-pocket payments have also led patients to delay care until illness is severe. High costs coupled with poor services lead to low utilization of services. A recent study commissioned by WHO titledthe burden of out of pocket expenditure and health service utilisation in Lao PDR (2011) found that those who mentioned financial barriers as a reason for not seeking care were mostly among the poor and the poorest households. The poor households are more vulnerable to catastrophic status, especially among family with children under 5 years old and elderly with long-term illness. Inequities in access to services are greatest in rural areas, where households in the highest income quintile have an in-patient admission rate of 42.4 per 1,000 populations, nearly 3 times the rate of 15.9 for households in the lowest income quintile. Similarly,

households located further from services than those in urban areas have less access to health services; only one quarter of the poor live in villages with a medical practitioner compared to one half of the non-poor who have closer access to doctors.

The Government has committed to support reform to strengthen efforts to increase social protection coverage through progressive legislation, restructure and funding for health insurance, in order to reach out to more vulnerable and excluded groups, of which will contribute to reducing inequities.

Demands and constraints on the service delivery model

Country factor demands, including the presence of 49 ethnic groups with different cultures, traditions and livelihood systems that heavily influence health seeking behaviours and practices, a dispersed, rural population, and travel logistics, all influence the health care situation in Lao PDR. The National Health Sector Development Plan (NHSDP) identifies infrastructure for a stronger disease prevention system, modern equipment, private social investment in country and abroad, and a focus on the four health-related MDGs, as key health objectives.

Other demands and constraints on health service delivery in Lao PDR include:

- Out-of-pockets continue to add to the economic burden and make access to services low, particularly MNCH services. The government aims to merge the various financing schemes into one single National Health Insurance Scheme, with a target to cover 50-60% of the population by 2015 and achieve universal coverage by 2020.
- A strong vertical approach to service delivery, with different development partners supporting specific interventions which are at different stages of implementation, influences coordination of health services delivery.
- There is demand for an increased focus on prevention of communicable diseases. While prevention of new HIV infections will remain a priority in Lao PDR, care and support services, including antiretroviral treatment, need to be scaled up. The full package of services needs to be expanded and sustained among appropriate target populations. Combating malaria and TB on a sustained basis requires new drugs to fight resistant malarial parasites and multi-drug-resistant strains of tuberculosis, often associated with HIV infection. All existing strategies, such as use of insecticide treated bed nets etc… needs to be extended and sustained.

The focus of health services in Lao is skewed towards maternal, neonatal and child health issues due to a profound under-utilization of services. Despite the development of the MNCH package and the start of implementation, several constraints remain:

- A lack of health providers, particularly in rural areas, and a frequently inadequate service delivery system (access, coordination, communication, referral, monitoring and evaluation).
- The availability and capability of skilled and adequately trained staff in several areas of MNCH still remains an area of concern, and village health volunteers and traditional birth attendants still need to be trained and their skills upgraded.
- The quality of services continues to be poor with standards yet to be established for routine MNCH services and inadequate capacity of facilities to manage pregnancy-related complications, including a lack of capacity in management and manuals and guidelines that have yet to be developed.

Indicators of progress

Lao PDR is committed to achieving its MDGs. If the current trend of health care continues, the country is on-track to reach the target of reducing the under-five mortality rate by two-thirds. Malnutrition is a serious issue and it is off-track – unlikely to achieve the targets of reducing underweight and stunted children, as well as reducing hunger by half. Similarly, having among the lowest full immunization rates in the region, despite great efforts to reach coverage of immunization against measles (69% in 2011 – WHO UNICEF), Lao PDR might still be off-track for reaching the target of 90% coverage. Progress on maternal health, including mortality rate and births attended by a trained birth attendant, is also off-track and not likely to be achieved. (see Table 5)

Table 5. Health MDGs targets and current status in Lao PDR

	2005[v]	2011	2015 Targets
MDG 1: Eradicate Extreme Poverty and Hunger			
Target 1: Halve between 1090-2015 the proportion of people suffer from hunger			
Prevalence of underweight in children under 5 years of age (%)	37	26.6 [i]	**22**
Prevalence of stunting children under-5 years of age (%)	40	44 [i]	**34**
MDG 4: Reduced Child Mortality			
Target 4A: Reduce by two-third between 1990-2015, the under–5 mortality rate			
Under-five mortality rate (per 1,000 live births)	98	89 [i] 73 (LSIS/MOH)	**80**
Infant mortality rate (per 1,000 live births)	70	76 [i] 68 (LSIS/MOH)	**49**
MDG 5: Improve Maternal Health			
Target 5A: Reduce by three quarters, between 1990-2015 the maternal mortality ratio			
Maternal Mortality Ratio (per 100,000 live births)	405	357 [i]	**260**
Proportion of births attended by trained health personnel (%)	23	41.5 [i]	**50**
Target 5B: Achieve, by 2015, universal access to reproductive health			
Contraceptive prevalence rate (%)	38	49 [i]	**55**
Antenatal Coverage (%)	28.5	54 [i]	**60**
MDG 6: Combat HIV/AIDS, Malaria and Other Diseases			
Target 7: Have halted by 2015, and begun to reverse the spread of HIV/AIDS			
HIV prevalence among general population (estimated) (%)	0.1	0.2 [ii]	**<1**
Percentage of sex workers who are HIV infected (%)		1 [ii]	**<5**
Percentage of men who have sex with men who are HIV infected (%)		4.2 [ii]	**<5**
Target 6B: Achieve, by 2015, universal access to treatment for HIV/AIDS for all who need			
Percentage of adults and children with advanced HIV infection receiving ARV (%)		52.3 [ii]	**70**
***T**arget 8: Have halted by 2015 & begun to reverse, the incidence of malaria & other major diseases*			
Death rate associated with malaria (per 100,000)	0.4	0.26 [iii]	**0.2**
Proportion of children under 5 sleeping under bed nets (%)	87	81.2 [iii]	**95**
Prevalence of tuberculosis (per 100,000)	700	540 [iv] (353-767)	**750**

Sources:
[i] Lao Social Indicator Survey (LSIS) 2011-2012 (draft, preliminary data Aug. 2012)
[ii] MOH, CHAS 2012
[iii] MOH, CMPE 2012
[iv] MOH, TBC. Data in WHO Stop TB, LAO PDR country profile, to be published in next WHO report 2012, Global Tuberculosis Control in October 2012
[v] Joint MDG Progress Report 2008. Lao Government and the United Nations

Lao PDR has made considerable progress on the control of communicable diseases, and is on-track to achieve the MDG targets to halt and reverse the spread of malaria and TB. Until recently, the country is on track to achieve targets for HIV/AIDS, but the latest surveillance and estimation results showed increase in prevalence among populations at higher risks, consequently, it might go off track. The estimated HIV prevalence among adult (aged 15-49) though has remained low at 0.2% in 2011. The *NSEDP* includes health targets in three main areas: mother and child health, clean water and sanitation, and halting the spread of AIDS, fever due to mosquito-bites (malaria/dengue), and other contagious disease.

The MNCH strategy includes targets and outlines standard impact and outcome indicators for national, provincial and district levels, and by development partners. The impact indicators include maternal mortality ratio, under five mortality rate, infant mortality rate and prevalence of malnourished under-five children. The outcome indicators are in the areas of family planning services use, antenatal, birth and postnatal care services used, and child health care services used. As the MNCH package has only recently been implemented in different stages in different parts of the country, the progress on indicators still needs to be ascertained. In addition, process indicators from each program are collected and collated at a central level. There is no uniform data as each program has its own reporting mechanism.

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End notes

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