Fifty Years

Working for Health in the Lao People’s Democratic Republic

1962–2012
### Contents

**Foreword**

Who’s Who in WHO

Acknowledgements

Introduction

The Foundation of the World Health Organization

The Lao People’s Democratic Republic joins the World Health Organization

About the Lao People’s Democratic Republic

   - Context
   - The Work of WHO in Laos
   - Case Study: Yaws Control in Savannakhet Province, as told by Dr Edmond J. Douvier

2. Basic Health Services in Difficult Times (1962–1975)
   - Context
   - The Work of WHO in Laos
   - Case Study: Smallpox Vaccination Campaign in Sayabouly Province
   - Case Study: Malaria control in Vientiane Province

   - Context
   - Alma Ata
   - The Work of WHO in the Lao People’s Democratic Republic
   - Case Study: Traditional Medicine (Then and Now)

   - Health Trends during this period
   - Context
   - The Work of WHO in the Lao People’s Democratic Republic
   - Case Study: Model Healthy Villages in Vientiane Capital
   - Case Study: The Expanded Programme on Immunization in the Lao People’s Democratic Republic
   - Case Study: The Fight Against Schistosomiasis on Khong Island

5. Into the New Millennium (2000–2012)
   - Context
   - Global Health Issues and their Impact on the Lao People’s Democratic Republic
   - Case Study: Strengthening Surveillance and Response
   - Case Study: Managing Emerging Infectious Disease Threats through Field Epidemiology Training
   - Aid Effectiveness
   - The Vientiane Agreement
   - Meeting the Challenge of Maternal and Child Health
   - Case Study: Great Expectations
   - Case Study: Kinoy’s Story
   - Looking to the Future

Abbreviations

Bibliography
It is my great honour to be associated with the celebration of the 50th anniversary of the World Health Organization’s presence in the Lao People’s Democratic Republic. The WHO Country Liaison Office was first established in Laos in 1962, and it was later expanded into a WHO Representative Office in 1968.

Over the last 50 years, WHO has worked with Lao authorities, health professionals, communities and development partners at many levels. We have built a strong partnership based on mutual trust with the Government of the Lao People’s Democratic Republic. WHO is proud to be a part of the Lao People’s Democratic Republic’s health development through an historically challenging period, and the Organization will continue its commitment to support the Government in the implementation of its Health Sector Development Plan, in the achievement of the health-related Millennium Development Goals and the attainment of universal health coverage.

WHO has witnessed impressive improvements in the health of the Lao people over the past five decades. The population has grown from 2 million people to just over 6 million in that time, and the life expectancy at birth has increased from 55 years in 1995 to 64 years for males and 67 years for females in 2010. The number of health centres has increased from 664 in 2000 to 862 in 2010, making basic health-care services more accessible to all.

WHO has worked with the Government of the Lao People’s Democratic Republic on the global eradication of smallpox, and its certification in 1979 represents a key achievement in the history of WHO. The Lao People’s Democratic Republic has
remained polio free since the last case of the disease was confirmed in 1996, and the number of measles cases has decreased from 295 in 2005 to 153 in 2010.

The International Conference on Primary Health Care in Alma Ata in 1978 set the framework for WHO’s successful collaboration and facilitation of health sector policies, strategies and plans and resulted in sector-wide coordination and knowledge exchanges in the Lao People’s Democratic Republic. Since that time, the Expanded Programme on Immunization has worked to improve under-5 morbidity and mortality rates. Safe Motherhood initiatives in the 1990s brought declines in the maternal and infant mortality ratio. And more than 40 areas of joint development on national policies, strategies and plans, as well as the recent health-sector reform plan, reflect the close collaboration between WHO, the Government and other health-sector development partners.

The International Health Regulations (2005) entered into force on 15 June 2007, and the Lao People’s Democratic Republic is committed to meet the core capacities required under IHR (2005). During the H1N1 pandemic in 2009, the Lao People’s Democratic Republic demonstrated its improved public health capacity to respond to public health emergencies of international concern and contributed to global information sharing.

Various challenges continue to confront the Lao People’s Democratic Republic, including globalization, urbanization, migration, mobile populations, ageing, the increasing burden of noncommunicable diseases, emerging disease outbreaks, epidemics and pandemics, and natural disasters. WHO remains committed to supporting and collaborating with the Government and the health sector in their efforts to achieve better health for the people of the Lao People’s Democratic Republic.

WHO looks forward to a brighter future with our partners in Government, other United Nations agencies, nongovernmental organizations, civil society and the people of the Lao People’s Democratic Republic.

Shin Young-soo, MD, Ph.D.
WHO Regional Director for the Western Pacific
Dr. H. Nakajima
Japan
1988–1998

Dr. Ziaul Islam
India
1986–1992

Dr. Gro H. Bruntland
Norway
1998–2003

Dr. Francois Canonne
France
1993–1994

Dr. Imrich Geizer
Czechoslovakia
1995–1997

Dr. Yves Renault
Belgium
1997–1998

Dr. Giovani Deodato
Italy
1998–2004

Dr. Dean Shuey
USA
2005–2006

Dr. Dong II Ahn
Republic of Korea
2006–2011

Dr. Margaret Chan
China
2006–2011

Dr. Yunguo Liu
China
2011–

Dr. A. Nordström*
Sweden
2006–

Dr. H. Nakajima
Japan
1988–1998

Dr. Ziaul Islam
India
1986–1992

Dr. Gro H. Bruntland
Norway
1998–2003

Dr. Francois Canonne
France
1993–1994

Dr. Imrich Geizer
Czechoslovakia
1995–1997

Dr. Yves Renault
Belgium
1997–1998

Dr. Giovani Deodato
Italy
1998–2004

Dr. Dean Shuey
USA
2005–2006

Dr. Dong II Ahn
Republic of Korea
2006–2011

Dr. Margaret Chan
China
2006–2011

Dr. Yunguo Liu
China
2011–

Dr. A. Nordström*
Sweden
2006–

* From 23 May 2006 until 3 January 2007, Dr Nordström of Sweden was appointed by the Executive Board to serve as acting Director-General, following the untimely death of Dr. LEE Jong-wook on 22 May 2006.
We would like to acknowledge the Government of the Lao People’s Democratic Republic, particularly the Ministry of Health, for its kind assistance in the sharing and verification of data. The government provided important contacts and advice during the research stage.

The staff at the WHO Representative Office in the Lao People’s Democratic Republic have generously shared their experiences in the field of health and have provided valuable input and assistance in reviewing the book for technical accuracy.

Finally, we also would like to acknowledge the staff at Khaosan Pathet Lao (Lao News Agency) for retrieving the historical photographs and transcribing labels and captions.

Research and writing by Ruth Foster and Irene Tan.

Editing by Marc Lerner.

WHO Regional Director for the Western Pacific Dr Shin Young-soo and the staff of WHO Representative Office, Vientiane, 2011.
Introduction

2012 marks the 50th anniversary of the work of the World Health Organization in the Lao People’s Democratic Republic, which began in 1962 when a Country Liaison Office was established in the capital city of Vientiane. The anniversary also celebrates 50 years of partnership and collaboration between WHO and the Government of the Lao People’s Democratic Republic.

Over the last 50 years, the scale of WHO support and the scope of partnerships in the health sector have increased exponentially. In 1962, there were only a handful of staff members at the new Country Liaison Office. In 2012, there were nearly 60 international and national staff members, both on fixed-term and temporary contracts.

This anniversary also provides an excellent opportunity to review key events, highlight achievements and successes, and consider some of the challenges that have faced WHO in the Lao People’s Democratic Republic over those 50 eventful years.

Those who worked with WHO in the country in the 1960s and 1970s might seem to have lived and worked in an entirely different context. In fact, in December 1975 the country embarked on a new political course and adopted a new name—the Lao People’s Democratic Republic. Yet there is continuity and there has been an uninterrupted WHO presence and involvement through times of great change.

Over five decades, the spirit of commitment and partnership between WHO and the Lao People’s Democratic Republic has flourished and grown. The huge increase in the number of key health-sector partners has made it necessary for WHO to frequently assume the role of coordinator. Development partners include other United Nations agencies, bilateral organizations, international nongovernmental organizations and civil society.
The Foundation of the World Health Organization

Globally, WHO has been at the centre of international health cooperation for more than 60 years. As the United Nations specialized agency for health, WHO formally came into existence on 7 April 1948 when its constitution was ratified by its 26th Member States.

Since then, 7 April has been celebrated each year as World Health Day. The work of the Organization is governed by the World Health Assembly and the Executive Board and is carried out by the Secretariat.

The Constitution of the World Health Organization defines health as its first principle:

*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

The objective of the World Health Organization was stated succinctly:

*The attainment of all peoples of the highest possible level of health.*
Laos joined WHO on 17 May 1950. The first session of the Regional Committee for the Western Pacific, the WHO governing body in Western Pacific, took place at the fourth World Health Assembly in Geneva, Switzerland, on 18 May 1951, with attendance by eight countries from the Region and four countries responsible for areas in the Region.

The three office bearers at that first session of the Regional Committee represented Laos, the Philippines and Viet Nam. Dr Oudom Souvannavong, the first Western-trained doctor in Laos, was the rapporteur, a clear indication of the active participation of Laos from those early days.

Initially, WHO interventions in Laos were directed from the Regional Office for the Western Pacific in Manila. WHO did not have an official representative based in Indochina, although the senior adviser in Viet Nam was increasingly taking on that role. On 1 March 1956, the WHO Representative Office opened in Saigon, now known as Ho Chi Minh City. For the next few years, the office also covered Cambodia and Laos.

Dr Arthur E. Brown, a British doctor with a background in public health, assumed the post of WHO Area Representative from 1956 to 1962, a title that later changed to WHO Representative, with responsibility for Cambodia, Laos and Viet Nam.
In the early 1950s, Laos was comprised of 11 provinces, with a population of less than 2 million people. While the population continues to be predominantly rural, there has been a significant rise in urban migration since the mid-1990s. The proportion of the population in rural areas decreased from 83% in 1995 to about 68% in 2011. In 2012, there are 17 provinces, including Vientiane Capital, and a population of more than 6 million people.

The country has a population density of just 26 people per square kilometre, with large interprovincial variations, creating challenges in the delivery of health-care services. The Government has strengthened its policy on resettlement of villagers from the highlands to the lowlands so they can be closer to roads and essential public amenities. The people of the highlands have traditionally practised slash- and-burn agriculture and in the past were often migratory.

All of the provinces have international borders, and the geographical proximity generates significant movement of people that can sometimes result in cross-border disease transmission. As globalization becomes inevitable with Lao People’s Democratic Republic’s opening up and embracing a more market-driven economic model in recent years, new challenges soon emerged in international health.

Accelerated development in recent years is leading to rapid change that impacts the health status of the population in both positive and negative ways. The story of health in the Lao People’s Democratic Republic and the involvement of WHO run parallel to the many challenges the country has faced and will continue to face.
Chapter 1

The Early Days of 
WHO in Laos

1950–1962
Context

In 1958, the School of Medicine for Assistant Medical Doctors was founded in Laos. In 1970, it became a full medical school training doctors. Dr Roger Leclercq was transferred from the WHO Rural Health Development Programme to oversee its contribution to medical education. Dr Leclercq was later appointed WHO Representative in the Lao People’s Democratic Republic, serving from 1975 to 1980.

The School of Medicine was a key achievement—for the first time it was possible for Lao doctors to receive full medical training at home. WHO invested heavily in promoting medical education in the Region, and the physician–population ratio increased significantly during that period. The number of doctors in the Lao People’s Democratic Republic increased from 49 in 1962 to 945 in 1990.

The first hospital in Laos was built in July 1960. In later years, this became the Setthathirath Hospital.
Who collaborated with Laos on public health from the early 1950s. WHO programmes were directed from Manila or Saigon, with two doctors working in Laos beginning in 1958. In April 1961, a series of health surveys was undertaken to prepare long-range national health plans. A concerted approach to accelerated rural development, including its health component, was initiated in a pilot area close to Vientiane in 1961. WHO provided assistance in setting up the rural health service and also worked closely with other development agencies towards common goals—an early example of integrated development planning with other development partners. Until 1959, there were virtually no maternal and child health services in Laos. An ambitious 10-year plan was developed with support from WHO and in partnership with the United Nations Children’s Fund (UNICEF), and other health partners. Once the principal maternal and child health (MCH) needs in Laos were ascertained, training programmes were set up. In this Region, international nurses were assigned as team members on special projects, such as MCH, tuberculosis control, public health demonstration and training programmes, treponematoses control, and rural health services development. In several MCH programmes and general public health programmes, two or more WHO nurses were assigned and project activities focused mainly on the preparation of nursing and midwifery staff and services. Laos, along with Cambodia and Viet Nam, was among the countries that requested this kind of assistance.
Over the years, WHO has cooperated in many activities that have helped strengthen the organization and management of nursing services in Laos. Potential nurse leaders have been awarded overseas fellowship to study nursing administration, and leadership training activities were conducted to strengthen leadership and management skills.

WHO education and training activities in the Region included a substantial focus on providing fellowships to assist countries in the production of well-trained health personnel—essential to the development of health services. However, the fellowship programme was intended to supplement rather than supplant local educational facilities.

A regional adviser in education and training was appointed by WHO in 1953 and a significant number of intercountry meetings were organized. The most common topics considered were malaria, public health administration, communicable diseases, environmental sanitation, vital and health statistics and dental health. Surveys were carried out to assess the status of medical education and to determine the training needs for physicians. Malaria was the most popular field of study, taking up 16% of fellowships awarded, followed by public health administration at 15% and nursing 9%.

The work of WHO in Laos was predominantly needs based. In 1959, malaria remained the most significant health problem in most of Laos. Other major health problems included colds, measles, pneumonia, tuberculosis, dysentery, worms, skin diseases and malnutrition.
In addition, enlarged or infected thyroids, cholera, smallpox, yaws, eye infections (trachoma), typhoid, typhus, rabies, leprosy, venereal diseases, traumatic wounds (from hunting and warfare), opium addiction and dental caries were some of the other problems identified during that period.

There were occasional cholera epidemics, and typhoid was endemic. There was a relatively high incidence of leprosy. Thyroid problems were common among mountain people and opium addiction was significant among Hmong and Mien ethnic groups. Rabies was an increasing problem in towns.

The yaws control project was established in Laos in 1953, the second such programme in the Western Pacific Region. When WHO was established, some 50 million people globally were inflicted by the disease, which is spread by poor hygiene. Yaws is prevalent in rural, warm, humid tropical areas in the Region, characterized by poor sanitation, poverty and inadequate health facilities.

Yaws (endemic treponematosis) is a chronic infection that affects mainly skin, bone and cartilage. It is caused by a bacterium related to the one that causes venereal syphilis. However, yaws is a non-venereal infection transmitted mainly through skin contact with an infected person. Although rarely fatal, the disease could and does lead to chronic disfigurement and disability.

The global campaign against yaws was one of the early successes of WHO. The main approach of yaws control projects focused on training national personnel in clinical and laboratory diagnosis and in modern treatment methods. A single dose of penicillin could treat yaws effectively. The treatment of yaws is often carried out with Bacillus Calmette-Guerin (BCG) and smallpox vaccinations and other rural health-care activities.

Dr Edmond J. Douvier, a WHO medical officer, was based in Laos from 1953–1954. When he made his final report on the WHO-and UNICEF-assisted-Yaws Control Campaign of Laos in November 1954, he also included an account of his experiences in the Savannakhet Province.
In point of fact, no one knew the prevalence of yaws in Laos, nor its geographical distribution. Indeed, it was not common in Laos for a medical worker to leave the main towns or the dispensaries to visit the villages to provide medical consultation or to establish statistics. Moreover, the state of war did not encourage workers to go into the villages.

In April 1953, a WHO expert together with one medical officer and six young men left for the Kengkok district during the rainy season. In theory the work was exceedingly simple: assemble the population, and examine and treat yaws patients and contacts in their families. Arriving early in the morning in the village, we settled down in the pagoda until evening when the population came along to be examined.

Everybody, however, wanted to be given a shot—the people suffering from yaws, from rheumatism, those who had scabies and even those who were well. It was very difficult to explain that only yaws patients and family contacts could be given treatment.

After two months, we found that despite administrative help and the eagerness of people to be treated, we had only covered about 70% of the population. We were forced to change our methods. I decided that going forward we would stay in every village and remain there until we had examined practically the whole population. The approach worked if we started examining our first “customers” at first light in the morning and the last with the light of a kerosene lamp, obtaining results we wanted and reaching 90% of the people.

Operations organized in this way continued, and in June 1953 we reached the district of Phalane and in July, Dong Hen. In August and September, work was carried out in the Savannakhet district and towards the end of the year in the Lahanam-Songkhone district.

Despite the critical situation, 691 villages were visited between April 1953 and November 1954. We examined 132,000 people, including 64,000 children and 7,607 yaws patients and 1,348 contacts were treated. The total rate of contagious yaws was 0.36%, and the rate of non-contagious yaws was 5.3%. Thus, the treatment of patients and their contacts was deemed adequate.

Carried out with limited resources in a country at war, this campaign nevertheless enabled us to estimate precisely the rate of yaws endemicity in Savannakhet Province, to treat patients even in the most remote villages, and to educate and train health workers who were able to continue the work.
Basic Health Services
In Difficult Times
1962–1975
In the 1960s and up until the mid-1970s, the burden of disease was little changed from that of the 1950s. Communicable diseases remained a significant public health issue. The small urban population continued to be ravaged by malaria, diarrhoea, parasitic diseases and tuberculosis.

During the early 1960s, the WHO Western Pacific Region experienced a major epidemic of El Tor cholera. Initially it was centred in the Philippines and then Viet Nam, but 13 countries in the Region reported cases and deaths from 1961–1965. Laos suffered another serious cholera epidemic in 1969, with 484 cases and 35 deaths.

The infant mortality rate varied in different areas and circumstances from 180–500 deaths per 1000 live births. In addition to the scourges of malaria, diarrhoea and malnutrition, children died of measles, polio, whooping cough (pertussis) and diphtheria. In 1963 and 1964, there was a serious polio epidemic in the country. The childhood diseases that could so easily be controlled by immunization in richer, more developed countries were rampant in Laos.

Vaccination campaigns against smallpox, which lead to its global eradication, were initiated in the Region. Lessons learnt from the smallpox activities were used in the development of other vaccines for major childhood diseases, with the development of a national vaccination programme for children.

In surveying the work of WHO in the Region, there was a growing realization that success in one area—reducing the infant mortality rate—would count for little if children faced a high probability of suffering from another preventable condition, malnutrition. In this period, many seeds were sown, new programmes were launched and the health status of the Region saw steady improvements.
A WHO Country Liaison Office was established in Laos in April 1962. Dr Shammas was the first Country Liaison Officer (CLO) and during his tenure WHO presence in Laos expanded and administrative systems were established. The office was located the Mahosot Hospital complex, close to the Mekong River.

The next Country Liaison Officer, Dr Antonio Brown, served from 1964 to 1967, a particularly challenging period. In 1968, full WHO presence was established with a WHO Representative (WR). The first WR was Dr Wolfgang H. Huehne, a German malarialogist who had been actively involved with high-level interventions in the Region since 1959. Dr Huehne had been WHO Permanent Secretary for the Anti-Malarial Coordination Board.

In 1969, WHO staff in Vientiane numbered about 20. Each WHO team reported to a different adviser in Manila and there was little opportunity for the different teams to collaborate in country. Dr Huehne was succeeded in 1971 by Dr G. J. A. Ferrand of France who continued in the post until 1975.

During this period, the work of WHO was often conducted in a fairly restricted area. Despite ongoing war, some WHO staff members did manage to visit an impressive number of provinces: Luang Namtha, Luang Prabang, Sayaboury and Vientiane provinces to the north, and Khammouane, Savannakhet and Pakse to the south.

One example of a WHO intervention outside the area was a smallpox vaccination campaign conducted in Sayabouly Province, northwest of Vientiane and to the west of Luang Prabang Province. This was the first time that such a team had been to remote settlements away from the towns and villages close to the Mekong River.
A resolution proposing a global campaign against smallpox was approved by the World Health Assembly (WHA) in 1956, three years after it had been first put forward. By then, a successful national smallpox eradication campaign in the Union of Soviet Socialist Republics (USSR) had demonstrated that eradication was feasible. Once the political will was established, resources had to be mobilized.

Initially, progress was slow as the programme had to compete with the far more costly Malaria Eradication Programme, which begun in 1955 and enjoyed a greater level of support. However, in 1966, the WHA voted to undertake a special, intensified smallpox eradication campaign.

When the campaign was launched in 1967, the disease still threatened 60% of the world’s population, killed every fourth victim and scarred most survivors. While only 131,000 cases were reported in 1967, it was estimated there were actually 10 million to 15 million cases in 44 countries at that time.

Smallpox vaccination became feasible worldwide—and in remote and hot climates—due to the development of vaccines that would remain stable and potent for a limited time, even at high temperatures. As the programme accelerated, two other innovations took place: the invention of the bifurcated vaccination needle and the development of a strong search and containment strategy.

Smallpox endemicity in South-East Asia was never particularly high; the greatest number of cases occurred in Africa and India. In 1966, Dr Joseph Westermeyer, an American psychiatrist and anthropologist, was involved in the WHO smallpox vaccination campaigns in Laos, as was Dr Victor Guetzel, a WHO paediatrician from Moldavia.

Dr Westermeyer trained health workers in the routine of smallpox inoculations. Local nurses and other team members did much of the work. The doctors were there primarily to screen cases that should not be vaccinated and to run a general “sick call” for people coming for vaccinations and be available in the event of adverse effects following immunization. Dr Westermeyer recalls that the turnout was overwhelming.

The last transmission of smallpox was recorded in Laos in 1953. However, eradication necessitated continuing efforts to inoculate and to conduct surveillance. The certification process began in 1973. Countries in the Western Pacific Region had to provide to WHO information from reports of visits by independent experts and other country reports, supported by data from the Regional Office. Smallpox was the first disease in history to be eradicated. The complete global eradication of smallpox was achieved in 1979 and remains one WHO’s greatest achievements.
Malaria control was an important area of activity for WHO in Laos from the earliest days. All accounts of the health situation mentioned the gravity of the problem. Between 1969 and 1975, limited DDT spraying took place in Vientiane Province, together with mass drug administrations of chloroquine, supported by WHO.

Spraying was carried out in part of the northern Vientiane Prefecture and Saithany and Phon Hong districts from 1969 to 1972, and in Naisaithong district from 1973 to 1975. In 1975, there were malaria outbreaks in Vang Vieng, Vientiane and Xieng Khouang provinces, according to WHO malaria adviser Dr C.T Ch’en. Massive influxes of people from non-malarious highland areas made them very vulnerable to the disease.

Although malaria remains a public health problem in the Lao People’s Democratic Republic, mortality has been greatly reduced due to intensified control measures applied to countries with a high incidence. Drug supply and treatment methods are usually adequate, but many people with severe malaria die because they arrive at the hospital too late.

The construction of the first major dam in the country in the late 1960s prompted real concerns that a significant new malarial zone might have been established relatively close to the capital city. The following account provides the background of the global malaria eradication programme and the early interventions in Laos and deals with the important work conducted in Vientiane Province from 1969.
Malaria Control in Vientiane Province

The Eighth World Health Assembly in 1955 launched the Global Malaria Eradication Programme. The following year, Laos set up the National Malaria Service (NMS). Initially based in Savannakhet, the NMS moved to Vientiane in 1958, with additional stations in Luang Prabang and Pakse.

By 1960, the NMS claimed to have protected 900,000 people through DDT residual spraying in households, and there was a curative programme using chloroquine. However, by this time, the increasingly insecure political situation and the intensification of the war made it impossible to continue the malaria programme. Spraying ceased in 1961.

In 1969, Laos and WHO agreed to collaborate on a malaria control project in Vientiane Province.

The project began in 1969 with the arrival of Dr M. Di Iorio as WHO malaria adviser for Laos. The work centred on the construction site for the Nam Ngum hydroelectric dam to the north of Vientiane.

Due for completion in 1970, this major engineering project had been undertaken with Japanese funding and technical advice. The dam site had two labour camps surrounded by 16 villages. Blood slides were collected from people attending the Japanese clinic and dispensary at Thalat between 30 May and 17 June. Of 144 patients, 104 tested positive for malaria (72%).

Workers at the site also had been severely affected by malaria. There were 11 cases of malaria among the workers from March to July. Some of the Plasmodium falciparum parasites were found to be chloroquine-resistant.

DDT household spraying resumed, mostly around the Nam Ngum site and the surrounding villages. Mass drug administrations with chloroquine were also carried out in the sprayed villages.

By 1970, the malaria situation at the Nam Ngum dam was well under control, but the completion of the project had been very significantly delayed and there were fears that the area would become highly malarious following the completion of the dam and the increase in size of the enclosed lake.

One of the most serious concerns—that Nam Ngum lake would become the epicentre of a highly endemic area—was never realized. As the lake filled, the breeding places for the major vector Anopheles maculates disappeared and the lake perimeter became virtually malaria free through this ecological change.
Primary Health Care Era of “Health for All”
1975–1986
On 2 December 1975, Laos embarked upon a new political path and was renamed the Lao People’s Democratic Republic. It was also a time of great change within WHO. The big “vertical” programmes that had enabled the eradication of smallpox and had attempted to eradicate malaria had also helped develop urgently needed public health infrastructure. The Organization’s thrust began to move towards “horizontal” programming and primary health care (PHC).

In 1975, the World Health Assembly defined and expounded a radical new approach that contrasted dramatically with the conventional health-care delivery systems of the past. The Thirtieth World Health Assembly in 1977 adopted the concept of “Health for All by the Year 2000”, a goal to be attained on the basis of primary health care. Health for All was defined as:

The main social target of governments and WHO is the attainment of all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

Soon after, WHO and UNICEF organized the International Conference on Primary Health Care in Alma Ata, where the PHC approach was resoundingly endorsed.
Alma Ata

The period from the mid-1950s up until the Alma Ata Conference in 1978 is now considered an era of basic health services. The International Conference on Primary Health Care at Alma Ata in Kazakhstan in 1978 was a defining moment in the history of WHO.

In the words of Dr Halfdan Mahler, the WHO Director-General at that time:

Primary health care is taken to mean a health approach which integrates at the community level all the elements necessary to make an impact upon the health status of the people. Such an approach should be an integral part of the national health care system.

It is an expression or response to the fundamental human needs of how can a person know of, and be assisted in, the actions required to live a healthy life and where can a person go if he/she needs relief from pain or suffering.

A response to such needs must be a series of simple and effective measures in terms of cost, technique and organization, which are easily accessible to the people in need and which assist in improving the living conditions of individuals, families and communities. These include preventative, promotive, curative and rehabilitative health measures and community development activities.

Dr Keo Phimphachanh, head of Cabinet for the Ministry of Health of the Lao People’s Democratic Republic, attended the International Conference with Dr Khamlieng Pholsena, Vice-Minister of Health. In fact, Dr Pholsena had an important role at Alma Ata as he was one of the five vice-presidents elected by acclamation. Looking back on this historic occasion, Dr Phimphachanh stressed that both the philosophy and practice of primary health care were already well established in the Lao People’s Democratic Republic.

After the establishment of the Lao People’s Democratic Republic, primary health care was enshrined in the policy of the new Government. While this was definitely in line with the international move towards primary health care, it was particularly relevant and necessary in the Lao People’s Democratic Republic given the extreme penury of funding for health and all other areas of development at this time.

The Alma Ata Declaration reaffirmed the original definition of health, which was the first principle of the WHO Constitution and went on to say that health was:

A fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

The following year at the Thirty-second World Health Assembly in 1979 the Global Strategy for Health for All was launched. The goal was commonly known as “Health for All by the Year 2000”. This was explained in the 10th and final clause of the Alma Ata Declaration:

Health for all does not mean that in the year 2000 doctors and nurses will provide medical care for everyone in the world for all their existing ailments and that nobody will be sick or disabled. It does mean that health begins and is fostered at home, in school and in factories, where people live and work. People will use better approaches than they do now for preventing disease and alleviating unavoidable illness and disability, and have better ways of growing up, growing old and dying in dignity.
Essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement. There will be an even distribution among the population of whatever resources for health are available and people will realize that they themselves have the power to shape their lives and the lives of their families, free from the avoidable burden of disease and aware that ill health is not inevitable.

Following the Alma Ata Declaration, the Government of the Lao People’s Democratic Republic took on the following commitments in order to implement primary health care on a wider scale:

- to increase the training of additional medical personnel to be assigned to rural areas with a mission to enrol and train voluntary village health workers;
- to give priority to preventative and promotional activities which would meet the basic health needs of the rural communities. This would be achieved by concentrating on a few vertical programmes with a view to eradicating endemic diseases such as malaria, diarrhoea and tuberculosis; and
- to launch self-help campaigns so that the villages could participate in the building and financing of their own community health delivery systems.

Convened by WHO and UNICEF, the International Conference on Primary Health Care met in 1978 in Alma-Ata, which is now Almaty in the Republic of Kazakhstan.
The Work of WHO in the Lao People’s Democratic Republic

During these years, WHO provided important continuity in the Lao People’s Democratic Republic. The WHO Representative in the Lao People’s Democratic Republic was Dr Roger Leclercq from Belgium who served from 1975–1980. He had been in the country for a number of years, was well connected and knew the country well.

In 1976, the Government of the Lao People’s Democratic Republic submitted a request for US$ 2 046 000 broken into basic health-care services (US$ 416 317), hospital services (US$ 344 451), health laboratory services (US$ 36 264), health education (US$ 12 821), human resources for health development (US$ 16 161), immunization (US$ 21 768) and drug production (US$ 1 198 218). Some of these obligations were met by the 1976 regular budget and others from bilateral donations.

Dr Leclercq was succeeded by Dr Ravi Ramdoyal from Mauritius who was Programme Coordinator from 1982–1983 and then WHO Representative from 1983–1985. The next WHO Representative, who also served as Programme Coordinator, was Dr Ziaul Islam from India who took up his post in 1986.

WHO initiated a major series of programmes in the Lao People’s Democratic Republic during this period. One of the area was traditional medicine which can be incorporated into primary health care.

Scientific research projects on traditional medicine funded by WHO included a survey on medicinal plants in the Lao People’s Democratic Republic. WHO fellowships have been awarded to researchers from the Lao People’s Democratic Republic to learn research methods and new techniques from abroad.

In many developing countries, traditional healers are essential human resources for health care in rural communities, but most have had no formal training in primary health care. WHO provided training to the traditional healers with the objective of using trained traditional healers as public health educators or primary health-care providers.

In addition, technical support has been provided for the development of national policies and programmes, the regulation of the practice of traditional medicine and the registration of herbal medicines.

Over the centuries, an herbal medicine tradition based both on local knowledge and Ayurvedic principles derived from India was practised in the Lao People’s Democratic Republic. People gathered plant material from the abundant forests, but also cultivated both native and exotic plants for this purpose. Herbalist healers included Buddhist monks and nuns who learnt the healing arts at the wat (temple) and villagers who grew medicinal plants or gathered them from the forest. Animal parts were also be used in small quantities. Different ethnic groups had their own indigenous herbal pharmacopoeia.

Between 1954 and 1975, in the provinces of Sam Neua and Phongsaly, the herbal aspects of traditional medicine were widely used and encouraged. The Lao People’s Democratic Republic over the years had been influenced by China and Viet Nam, which were close both geographically and ideologically and had very strong cultures of traditional medicine.

In 1976, one of the first health initiatives for the new Government of the Lao People’s Democratic Republic was to organize extensive training in the use of traditional medicine. Some 520 people
from all provinces received training on the promotion of the use of traditional medicine. The training sessions lasted three or five days. Trainers were senior healers, pharmacists and doctors, and the course participants were young healers, herbalists, village health volunteers and the heads of provincial traditional medicine stations.

That same year, the Institute of Traditional Medicine was created. In 1989, it was reorganized as the Research Institute of Medicinal Plants. In time, it became the Institute of Research on Traditional Medicine, before reverting to the title of Institute of Traditional Medicine.

There was renewed focus on traditional medicine between 1995 and 1999. A draft national policy on traditional medicine in the Lao People’s Democratic Republic was discussed at the national workshop held in December 1995 and submitted to the Ministry of Health.

A community-based traditional medicine programme was developed and expanded in several provinces of the Lao People’s Democratic Republic. This focused on providing locally available, affordable and simple remedies by setting up herbal gardens in districts and villages and on training village health workers on the safe use of plants.

An inventory and survey of medicinal plants was initiated in collaboration with the Research Institute of Medicinal Plants, Ministry of Health. Thirty commonly used plants were selected and a booklet entitled The Medicines in Your Garden was published in the Lao language. This provided information on the identification, collection, use and scientific basis of these plants.

In 1997, a six-acre model medicinal plant garden was set up in Vientiane, and since 2000 more than 700 acres of medicinal plant preserves for in situ conservation have been established throughout the country. Research projects funded by WHO included research on dihydro-artemisinin, an antimalarial drug used for multidrug-resistant cases.
Opening Up: New Directions and New Partners

1986–2000
**Health Trends during this Period**

HIV/AIDS was perhaps the greatest new global challenge during this period. The first cases of HIV in the Western Pacific Region were recorded in 1983. By 1986, the seriousness of the epidemic was becoming apparent. WHO established a Special Programme on AIDS in 1987, and the following year it was renamed the WHO Global Programme on AIDS (GPA). The programme had three main objectives: to prevent HIV infections, to reduce the personal and social impact of HIV, and to mobilize and unify national and international efforts. The GPA continued until December 1995.


In 1993, another disease that was seen disappearing in some countries was recording significant numbers of new cases in other countries. Tuberculosis was declared a global emergency as a result of the high number of deaths each year—3 million worldwide—and also because it affects so many people of working age. The number of tuberculosis cases of all types in Lao People’s Democratic Republic increased from 2083 in 1990 to 2234 in 2000, where overall the number of newly notified cases in the Western Pacific Region almost doubled from 186,522 to 353,138 over the same period.

The National Tuberculosis Programme (NTP) started directly observed treatment, short course (DOTS) in 1995 with the support of WHO and the Damien Foundation Belgium. NTP implemented DOTS in all 140 districts of the country and in 2005 reached the targets of identifying 70% of smear-positive cases and successfully treating 85% of those cases.

Tuberculosis was an example of a disease that was thought to have been declining, but that now was seen to be re-emerging. Other examples of re-emerging diseases were cholera, dengue fever and dengue haemorrhagic fever, and diphtheria. Up until 1995, WHO had coped with public health problems associated with emerging and re-emerging diseases through disease-specific programmes.

A cholera outbreak in the Lao People’s Democratic Republic in 1995 reported 1261 cases, with 161 deaths. The regional Outbreak Response Task Force responded with stockpiles of cholera kits from Cambodia. In the following year, a diphtheria outbreak saw 73 cases, with five deaths.
CHAPTER 4: Opening Up: New Directions and New Partners

From 1986, as part of the New Economic Mechanism, the Government of the Lao People’s Democratic Republic decided to reduce public spending for the health sector, which since 1975 had, together with education, accounted for a large part of the budget. In 1987, health budget responsibilities were decentralized to provincial authorities. However in 1992, it was decided that this decision should be reversed, with the health budget and public expenditures again falling under the central Government.

The combination of recentralization and limited resources for primary health care and health promotion, plus the poor economic situation in rural areas, led to a reorientation towards the economically stronger urban areas. Higher-level medical and paramedical health workers in particular were not keen to take up postings in rural and remote areas.

Between 1979 and 1989, the number of health centres in the Lao People’s Democratic Republic had increased from 294 to 1190. From 1986, the budgetary constraints that followed the New Economic Mechanism had resulted in a reduction in available funds, and by 1993 the number of health centres had decreased to 723.

A girl being examined at a paediatrics ward, 1999.
Before the 1990s, when very few donors were present in the country, WHO’s strategy was twofold: capacity-building through international training and support for the development of all key institutions in the Ministry of Health. Collaborative activities were expanded to cover a large number of projects, many of them receiving donor funding through WHO. These collaborative activities were demand oriented and responsive to the country’s changing needs based on jointly agreed plans.

This is a period when the Lao People’s Democratic Republic gradually opened up and actively sought the engagement of more development partners. In addition to bilateral aid, multilateral aid became a major factor.

The most substantial areas for WHO involvement in this period were development of human resources for health, malaria, acute respiratory illness, diarrhoeal diseases, immunization and environmental health. In addition to whatever support that was being provided in country, each of these health areas had over 20 separate missions from WHO experts who visited the Lao People’s Democratic Republic between 1986 and 2000.

Other areas that were accorded a significant level of attention included: community water and sanitation, AIDS prevention and control, leprosy, maternal and child health, nutrition, blindness and deafness, disease vector control, epidemiologic surveillance, essential drugs and vaccines, health systems development, and communicable diseases.

In addition, there was also focus on financial management planning, oral health, primary health care, clinical
laboratory techniques, management for national health development, tuberculosis, parasitic diseases, drug and vaccine safety, health sector reform, public information, and health education.

Traditional medicine, cancer, health of the elderly, hospital services development, mental health, emerging and re-emerging diseases, food safety, health statistics, laboratory development, cardiovascular diseases, other noncommunicable diseases, health situation trend assessments, research promotion and development, alcohol and drug abuse, external relations, health biomedical information and informatics complete the list of health priorities.

Malaria remained the most serious health problem during the 1980s, with prevention techniques focusing mainly on community engagement and bednet usage. By 1995, the gravity of the problem resulted in the Government seeking additional resources by taking a World Bank loan of US$ 5.9 million to implement a malaria control programme covering 24 districts in eight provinces.

The national malaria control programme was supported by several partners and in particular, the European Commission (EC), which made good progress in protecting the population at risk with insecticide-treated bednets. Pregnant women and children were identified as most vulnerable. All types of malaria can lead to severe problems during pregnancy and have severe ill effects on mothers and infants.

The Centre of Malariology, Parasitology and Entomology (CMPE) instituted public health programmes and measures to evaluate and modify procedures on net impregnation, treatment protocols and adequate supplies of chemicals at reasonable prices, along with some operational, diagnostic and treatment capacities.

Towards the end of this period, the Lao People’s Democratic Republic remained one of the nine countries in the Western Pacific Region where malaria was still an important health problem. The Roll-Back Malaria (RBM) Initiative was launched in the Mekong countries in March 1999. This brought the six Mekong countries—Cambodia, China (Yunnan Province), the Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam—together with various partners.

The number of malaria cases has decreased from 40,666 in 2000 to 22,800 in 2010. Community participation has helped address the malaria problem from the grassroots level. The Ministry of Health, Vientiane Capital Health Department, and WHO work with district and village community representatives on the Model Healthy Villages programme, which mobilizes community participation to maintain a clean environment and integrate basic health services, which positively impact the health of the population by adopting better hygiene practices.
Many years ago, health workers in the Lao People’s Democratic Republic came up with a catchy slogan they refer to as the “three cleans”: Gin Sa’at, Deum Sa’at, Yu Sa’at. These can be loosely translated as “clean or safe food, clean drinking-water, clean or hygienic home”.

One setting where the “three cleans” have been central is in the designation of “Healthy Villages” and “Model Healthy Villages” (MHV). The Lao People’s Democratic Republic has few big cities and even the main centres of population such as Vientiane Capital, Luang Prabang, Savannakhet and Pakse are not truly urban settlements. The basic administration unit in the Lao People’s Democratic Republic is the ban or village. Several villages are clustered together into a village group and the next unit is the district. The average province in the Lao People’s Democratic Republic has about nine districts.

The idea behind Healthy Villages was to establish a local community where primary health care was implemented in terms of health education, nutrition, environmental health and sanitation, vaccination, mother and child health, control of communicable diseases, essential drugs, and an improved health network. It focused on a clean environment, enough clean water and latrines, and a very low rate of communicable diseases. If a village was particularly successful in improving sanitation and standards of cleanliness and health, then it could be designated as a Model Healthy Village.

In Vientiane Capital, the Model Healthy Village programme started in Sisattanack District in 1991. By 1995, six villages had been declared Model Healthy Villages and the scheme was later extended to all nine districts in the Vientiane Capital.

Villages are inspected and scores are awarded to households. Coloured flags are handed out to the households after the evaluation (red for best, yellow for moderate households and blue for households in need of improvement). Award ceremonies are held to recognize the Model Healthy Villages.

The criteria that had to be met included the “three cleans”, namely clean food, clean water and a clean household environment, as well as access to a latrine, the destruction of mosquito larvae, necessary vaccinations for pregnant women and children, the absence of epidemic diseases such as dengue fever in the village, a good drainage system, animal cages kept away from homes, and clean and tidy areas around homes.

Village health committees continue to organize and hold meetings for villagers about MHV activities. Villages are inspected and scores are awarded to households. Coloured flags are handed out to the households after the evaluation (red for best, yellow for moderate households and blue for households in need of improvement). Award ceremonies are held to recognize the Model Healthy Villages.
Another project that achieved success by working closely through schools is the Expanded Programme for Immunization, which targets six diseases: diphtheria, pertussis, tetanus, polio, measles and tuberculosis. The five-year acceleration plans resulted in rapid geographic expansion, even to remote areas. This was achieved through the mobilization of a cross-section of society: political and religious leaders, women’s and youth groups, schools, and governmental and nongovernmental organizations, and the media.

In 1996, the Report of the Regional Director on the Work of WHO in the Western Pacific Region noted that one of the contributing factors to the remarkable improvements in the health status in children in the Region was the expanded coverage for immunizations, including tetanus toxoid given to mothers during pregnancy.

Comprehensive reviews enabled national plans to be revised and targets were met. However, work was still needed to extend cold-chain management so that vaccines could retain their potency even after being transported to remote districts. WHO’s collaboration with UNICEF resulted in the development of a new generation of cold-chain equipment.

Neglected tropical diseases, namely soil-transmitted helminthiasis (STH), foodborne trematode infection due to *Opisthorchis viverrini*, schistosomiasis and lymphatic filariasis are important public health problems in the Lao People’s Democratic Republic. The schistosomiasis control project on Khong Island was a major WHO-supported initiative. Schistosomiasis control began in October 1989, with active participation from the Institute of Malariology, Parasitology and Entomology in Vientiane.
The Expanded Programme on Immunization (EPI) was established in 1977 by WHO to help developing countries create national vaccination programmes for children. At the end of the Smallpox Eradication Programme, it was decided to use the expertise and lessons learnt from smallpox activities to provide other vaccines for major childhood illnesses to children in underserved regions of the world.

Initially, the antigens provided through EPI were for diphteria, pertussis and tetanus vaccine (DPT), oral polio vaccine, measles and BCG. In recent years, new vaccines have become available providing protection against hepatitis B, Haemophilus influenza type B, rubella, Japanese encephalitis and pneumonia (pneumococcal vaccine).

In the Lao People’s Democratic Republic, the National EPI was established in the early 1980s. Prior to 1991, immunization services were limited to selected parts of the country, mainly in provincial and some district towns. Outreach to villages came later. Since 1991, programme activities were expanded to cover the entire country. Steady increases occurred, with coverage for all antigens at about 70%.

Monitoring the impact of vaccinations on target disease incidence requires reliable surveillance for the diseases. With its successful polio eradication effort in the 1990s, the Lao People’s Democratic Republic’s National Immunization Programme (NIP) was able to establish good surveillance, which helped guide programme efforts and document the elimination of wild poliovirus from the country. The last polio case in the Lao People’s Democratic Republic was in October 1996.

The Lao People’s Democratic Republic and other countries of the Western Pacific Region were officially certified as polio-free in October 2000.

The main challenge for EPI in the Lao People’s Democratic Republic, and indeed for most of the communicable disease interventions supported by WHO, has been resources and access to target populations. Resource constraints have been both financial and human. Some 30% of the national population lives in areas that are very difficult to access so they must be covered by mobile teams.

Some of these difficult areas can be reached for only four to five months of the year, assuming there are resources for outreach. Recent economic developments in the country have resulted in an improvement in both roads and health system infrastructure. This trend will continue so gradual extension of the regular programme through access to previously hard-to-reach areas should result in increased immunity levels.
CHAPTER 4: Opening Up: New Directions and New Partners

Schistosomiasis, also known as bilharziasis or snail fever, is a significant zoonotic disease. It is a waterborne infectious disease that affects both humans and a variety of animals. It is caused by blood flukes or trematode flatworms of the genus Schistosoma. The intermediate host for the parasite is a freshwater snail that releases the larvae form of the parasites into the water. They then penetrate the skin of people while they are swimming, wading or fishing.

The symptoms of schistosomiasis are caused by the body’s reaction to the worms’ eggs, not by the worms themselves. Intestinal schistosomiasis can result in abdominal pain, diarrhoea and blood in the stool. Liver enlargement is common in advanced cases and is frequently associated with an accumulation of fluid in the peritoneal cavity and hypertension of the abdominal blood vessels. In such cases there may also be enlargement of the spleen.

The economic and health effects of schistosomiasis are considerable. In children, schistosomiasis can cause anaemia, stunting and a reduced ability to learn, although the effects are usually reversible with treatment. Chronic schistosomiasis may affect people’s ability to work and in some cases can result in death.

In 2010, schistosomiasis was endemic in 74 countries affecting more than 207 million people worldwide, mostly living in poor communities without access to safe drinking-water and adequate sanitation. An estimated 700 million people worldwide may be at risk of infection as their agricultural, domestic and recreational activities expose them to infested water. There are three major strains of schistosomiasis that affect humans: Schistosomiasis haematobium, S. mansoni and S. japonicum, none of these occur in the Lao People’s Democratic Republic.

In 1950, a specific schistosomiasis, similar to S. japonicum, was discovered when a Lao student studying in Paris was admitted to a hospital there. The student originally came from Khong Island to the south of Pakse in Champassack province. Khong district has a population of approximately 65,000 distributed among 13 communes and 131 villages that depend on rice cultivation, fishing and tourism.

The Mekong flows through the district, which contains a large number of islands of which Khong Island is the largest. For generations, every island community had its “fat-bellied people”, but the inhabitants were unaware of the parasites that caused the condition. Between 1963 and 1967, a number of other Lao students in France were found to have the same parasite. WHO recruited a number of parasitologists and epidemiologists and sent them to the Khong Island on two occasions.

It was not until a third mission in 1966–1967 by Toshihico Iijima and Rolando G. Garcia that a survey among school children on Khong Island found a high prevalence of the disease. At this point the parasite was also recognized as a new species, given name S. mekongi.
Many years went by before a major programme was undertaken to control the disease in the Lao People’s Democratic Republic. The intervention supported by WHO began in November 1988, 30 years after the discovery. The intervention included a mass drug administration (MDA) of praziquantel and health education in Khong district, which continued until December 1990.

The MDA of praziquantel, with a single dose administered at the rate of 40 mg/kg body weight, was conducted in April 1989 and continued until the end of the programme. The MDA excluded children under 2 years old, pregnant and breastfeeding women, people with neural diseases, and those living inland, more than 6 kilometres from the Mekong River.

From August 1991, the MDA targeted everyone above 4 years of age, and the programme was conducted at least four times in more than 100 villages in all the communes. In 1994, an evaluation supported by WHO showed the prevalence had fallen to below 0.4%.

A survey conducted of 100 families living in Chomthong in Khong Island found that almost everyone was aware of the disease, but they knew very little about the intermittent host, *S. mekongi*. The survey found that 100% of the people interviewed bathed in the Mekong River: 97% of them bathed exclusively in the river, while 3% occasionally used well-water. All the families used the river water for domestic purposes; about 2% used well-water.

All of the families fished in the Mekong and this inevitably involved wading in the Mekong, whatever fishing method was used. Some 40% of the families said they had never used latrines, and of those who had 8% said that they also defecated outdoors occasionally. In addition, 38% of the families said that their children defecated in the Mekong.

None of the families had any idea of a link between the disease and water snails, hence their lack of concern about the health risk of contact with the Mekong. Clearly, health education would be of paramount importance. Therefore, the Lao government and WHO created a new name, Phayadhoy Muang Khong (snail transmitting the disease in Khong), to assist in health education by explaining how the disease was transmitted through the river.

This strategy was very effective in raising awareness, but the campaign was limited to Khong Island. Health education took the form of workshops, training sessions and the distribution of illustrated posters and calendars. The programme to control schistosomiasis due to *S. mekongi* in Khong district lasted from 1989 to 1999.

Despite limited resources, the programme was successful. The coverage of the population by MDAs was excellent and the campaign was considered a major achievement. Prevalence in 21 sentinel villages declined dramatically: in 1989, in 21 villages surveyed, prevalence was estimated to be more than 50%; in 1993, in 17 villages surveyed, prevalence had decreased to 1.5%; and by 1999, in 21 villages surveyed, prevalence was estimated to be 0.8%.

After the end of the intervention, limited monitoring was carried out. In May 2003, the Lao government and WHO conducted a survey in 65 villages in Khong district and 24 villages in Mounlapamok district and found that the prevalence was 1%–47%, with an average of 11% in Khong district. The re-emergence of *S. mekongi* was confirmed and WHO immediately provided drugs for the treatment of the disease. Follow-up surveys conducted in 2004 and 2011 showed that the prevalence is low and well under control.
Into the New Millennium
2000–2012
For much of the 20th century, people looked towards the year 2000 as a hugely significant threshold. The turn of the century also marked nearly 25 years since the proclamation by the World Health Assembly of “Health for All by the Year 2000”. But as the new century dawned, the majority of the world’s population was still a long way off in terms of enjoying the good health that was now considered as a fundamental human right.

In his Millennium Report, Kofi Annan, the United Nations Secretary-General, signalled the progress made since the founding of the organization, but also highlighted many intolerable inequalities: “There is much to be grateful for. There are also many things to deplore and correct.”

Most people could expect to live longer; they were better nourished and enjoyed better health. At the same time, grinding poverty and striking inequalities persisted within and among countries, even amid unprecedented wealth. Diseases old and new still threatened to undo progress.

On 8 September 2000, following a three-day Millennium Summit of world leaders at the United Nations, the General Assembly adopted the United Nations Millennium Declaration. All 189 world leaders present at the summit committed to combat poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women.

The eight Millennium Development Goals (MDGs) are derived from the declaration and all have specific targets and indicators.

**Millennium Development Goals (MDGs)**

MDG 1: Eradicate poverty and hunger
MDG 2: Achieve universal primary education
MDG 3: Promote gender equality and empower women
MDG 4: Reduce child mortality
MDG 5: Improve maternal health
MDG 6: Combat HIV/AIDS, malaria and other diseases
MDG 7: Ensure environmental sustainability
MDG 8: Develop a global partnership for development

In 2010, the Lao People’s Democratic Republic introduced a localized goal—MDG 9—to reduce the impact of unexploded ordnance (UXO). With 41 out of 46 of the poorest districts facing the threat, the correlation between UXO and poverty is clear. The Lao People’s Democratic Republic has been the most heavily bombed country, per capita, in history. Today, cluster sub-munitions and other UXO continue to kill and injure 300 people a year. The presence of UXO negatively impacts socioeconomic development, preventing access to development land.

While some of the MDGs are clearly health-specific, they are all interdependent. All of the MDGs influence health, and health will indirectly affect all of the MDGs. For example, better health enables children to learn and adults to earn. Gender equality is essential to the achievement of better health. Reducing poverty, hunger and environmental degradation positively influences—but also depends on—better health.

The nine MDGs are made up of 21 quantifiable targets. Sixty indicators measure progress towards those targets. The Millennium Summit was followed by another summit and report in 2008, and another in 2010. In addition, regular reviews have measured the overall progress of individual countries and their likelihood of achieving each MDG by 2015.
Globalization had become an increasingly important issue in the 1990s. The interconnectedness of nations and communities was evident in the way disease outbreaks spread alarmingly across borders. While the attention of the development community was focused to a large extent on working towards the achievement of the MDGs, new challenges were soon to emerge in international health.

The process of opening up and embracing a more market-driven economic model continued and accelerated after 2000. Over the last 10 years, the economy of the Lao People’s Democratic Republic has been growing steadily with annual growth of gross domestic product (GDP) at around 8%. The changes have had a positive impact on the health status of the population and on health developments.

In 2003, there was an outbreak of a new and highly virulent virus, known as the severe acute respiratory syndrome, or SARS. The outbreak originated in China and came to international attention in February 2003. Over the next few months, the SARS epidemic caused an enormous amount of fear and social disruption, crippling international trade and travel and massively impacting economies.
This health emergency loomed large and extraordinary measures were taken both in countries where cases were recorded and internationally. WHO coordinated the international response and was able to help countries to contain transmission, seal off opportunities for the spread of SARS and prevent this new disease from becoming endemic.

One feature of SARS was that it had a very high level of transmission within health facilities. A large proportion of the people contracting the disease were health workers who came into contact with people already infected. Of over 8000 cases globally, 95% occurred in the Western Pacific Region and 12 countries were affected. About 10% of the cases proved fatal. Two of the most seriously affected countries were China and Viet Nam, both sharing borders with the Lao People’s Democratic Republic.

Three WHO consultants were hastily posted to the Lao People’s Democratic Republic to provide support to the Ministry of Health for SARS preparedness and response.

During the critical period of April to July 2003, integrated training was delivered to front-line staff in hospitals and to border and checkpoint staff at the central and provincial level. The training included epidemiology, clinical management, infection control and laboratories. Health workers in the Lao People’s Democratic Republic were highly motivated to improve their skills and knowledge, as they were aware of the enormity of the risk.

At that time, the only isolation unit was at the Mittaphab (Friendship) Hospital in Vientiane Capital. Personal protective equipment was distributed to the main hospitals and border checkpoints. A manual for preparedness and response was drafted and it served as the basis for training of trainers for other provincial hospitals later in the year. In 2004, a variety of training materials for infection control and for information, education and communication was developed for the Lao People’s Democratic Republic.

Fortunately, the SARS outbreak did not spread to the Lao People’s Democratic Republic. The prevailing hospital facilities and limited human resources would have made it very difficult to contain. However, it did give rise to much-enhanced surveillance and improvements in infection control.

The SARS epidemic was halted within a few months and the crisis led to a 2005 revision of the International Health Regulations (IHR). This marked the first time IHR had been fully revised since 1969, when it added six quarantine diseases. The 2005 revision embodied a major paradigm shift: from control at borders to achieving containment at the source, from a list of diseases to all public health threats, and from preset measures to adapted response.

The legal requirements became far more wide ranging and had implications for building capacity to “detect, assess, notify and report events in accordance with the regulations” and to “respond promptly to what was discovered”. Instead of covering a list of specific diseases, it broadened the range and definition of health threats.

Epidemic-prone diseases are still at the forefront in the battle against emerging and re-emerging diseases. But IHR (2005) covers foodborne diseases, accidental and deliberate outbreaks, toxic chemical accidents, radiological and nuclear
accidents, and environmental disasters. Control at borders is important but so is containment at the source.

Soon after SARS, another serious threat emerged in the Western Pacific Region when eight Asian nations reported outbreaks in poultry of a highly pathogenic avian influenza A (H5N1). Huge numbers of domestic birds were culled in order to halt the disease, with serious economic and social consequences, especially in the poorer communities. The pathogen could and did transmit to humans and proved fatal.

In March 2009, another significant new strain of influenza originated in Mexico, known by the popular name “swine flu” because it was initially thought to have links with pigs. As it started to spread internationally, WHO progressively raised the level of alert until it reached level 6 and was declared a pandemic. The first case in the Lao People’s Democratic Republic was detected in 16 June 2009, raising the level of surveillance.

A quick multisectoral approach was initiated with stakeholders from the various ministries and the Department of Immigration. Risk communications training was organized and was attended by high-level officials, demonstrating its priority for the Government.

The Lao People’s Democratic Republic is generally not affected as severely by natural disasters as some of the other countries in the Western Pacific Region. However in 2009, several of the provinces in the south of the country were seriously affected by Typhoon Ketsana, which caused extensive flooding and damage to infrastructure. Five district hospitals were affected or destroyed, and hundreds of houses were destroyed. Nine people died.

In the following months, there was a need to support relief and reconstruction efforts and health interventions. A subsequent nutritional survey conducted by the National Institute of Public Health (NIPH) found critical or serious rates of malnutrition in 13 districts of Attapeu, Salavan and Savannakhet provinces. As a result, there was a joint United Nations response in support of the Government in these districts. WHO, along with other United Nations agencies, provided emergency relief.

On 24–25 June 2011, Typhoon Haima hit the northern and central parts of the Lao People’s Democratic Republic causing heavy rain, widespread flooding and serious erosion in the provinces of Bolikhamxay, Vientiane, Xayaboury and Xieng Khouang provinces. The typhoon caused severe damage and losses to basic infrastructure. A joint damage, losses and needs assessment was undertaken by the Government of the Lao People’s Democratic Republic, United Nations agencies and nongovernmental organizations.

The Office of the WHO Representative in the Lao People’s Democratic Republic led the “health cluster” in the assessment. Health facilities in three out of four Haima-affected provinces were damaged by flooding. Flood damage affected buildings, equipment, furniture, medicine and medical supplies among other resources. Substantial funding was required to cover the cost of conducting disease-prevention activities, including health education, distribution of insecticide-treated bednets, the use of abates to control mosquitoes, and better treatment and enhanced disease surveillance activities.
An effective surveillance, risk assessment and response system is an important part of any country’s defence against emerging infectious diseases. The first steps towards establishing a surveillance system in the Lao People’s Democratic Republic were taken in 1989 when an indicator-based surveillance (IBS) system was introduced called the National Surveillance System for Notifiable Selected Diseases (NSSNSD).

The system involves cases and deaths associated with priority diseases and conditions seen at health facilities nationwide, with the data collected by health offices in a systematic way and routinely reported to the next level within the public health system. Data are then analysed, interpreted and fed back to users in a timely way to allow for a rapid local response and to inform timely policy decisions.

In 2008, a computerized system was developed by WHO and introduced as part of the NSSNSD Lao Early Warning and Response Network (Lao EWARN). It was implemented using the existing surveillance structure at provincial health offices and centrally at the National Centre for Laboratory and Epidemiology (NCLE). The benefit of this system is a computerized data entry form and timely electronic transmission of data that can be implemented easily at the provincial level once staff had received basic training. It includes clear indicators and automatically generates trend graphs that are easy to interpret and alerts that signal when action needs to be taken.

Another recent surveillance development involves the allocation of provincial sentinel hospitals for sending of samples from patients with suspected influenza-like illness and severe acute respiratory infections to the NCLE on a weekly basis for influenza testing. The results are fed back on a weekly basis to help public health decision-making at the local and national levels. Also, samples are sent to international reference laboratories for typing. In the future, routine testing of samples from other priority diseases, such as dengue, could be referred in this way.

While indicator-based surveillance (IBS) ensures that patterns of diseases and syndromes in health facilities are monitored on a weekly basis, a different approach needs to be taken for immediate reporting of unusual events, especially in the community. This is where event-based surveillance (EBS) is important.

Hotlines are the main mechanism for encouraging reporting by the general public, with a “166” hotline for the public and a hotline at the NCLE for health-care workers. The lines are staffed day and night, answering calls, recording reports and passing on information to NCLE or the National Animal Health Centre if action is required.

Another initiative piloted in 2010 involved issuing guidelines and training on the prevention and control of communicable diseases to school teachers in Vientiane Capital, including reporting of outbreaks or high absenteeism to the nearest health facility or office. The successful programme is now being extended to other provinces.

As the main objective of emerging disease surveillance in the Lao People’s Democratic Republic is to enable timely recognition of and response to outbreaks, these early warning surveillance systems have had a significant impact on the ability of national and provincial health office staff to identify and respond to outbreaks. At the same time, multidisciplinary rapid response teams have been set up in all provinces, including staff members who have been trained in the one-year, in-country field epidemiology training programme. In fact, the Lao People’s Democratic Republic was recognized throughout the Western Pacific Region for the progress made in surveillance and response over the last few years.
CHAPTER 5: Into the New Millennium

Managing Emerging Infectious Disease Threats through Field Epidemiology Training

Against the backdrop of pandemic influenza threats, including highly pathogenic avian influenza, the Lao People’s Democratic Republic recognized the need to strengthen and decentralize national epidemiological capabilities. This was accomplished by establishing an adapted Field Epidemiology Training (FET) programme with support from Influenza Division of the United States Centers for Disease Control and Prevention and WHO.

With critical pressure on human resources for health, the Lao Ministry of Health developed an innovative one-year FET tailored to the Lao context. Eight trainees from the national and provincial levels are selected annually from both the human (six) and animal (two) health sectors, thereby facilitating the “One Health” concept.

Each of three modules consists of one-month practical classroom instruction and three months of applied field experience. Each FET trainee is assigned an operational research project tailored to meet national public health needs. Applied activities are linked to supporting essential surveillance and response activities at the National Centre for Laboratory and Epidemiology (NCLE).

In February 2009, the first eight Lao FET trainees gathered at NCLE in Vientiane Capital to start the training course. They came from six strategically located provinces (Champassack, Luang Namtha, Luang Prabang, Oudomxay, Savannakhet and Vientiane Capital), as well as from NCLE and the National Animal Health Centre (NAHC).

After three years, the Lao FET alumni network boasts 23 graduates, covering 16 of 17 provinces, who have since returned to work after completing the training. FET has proven to be a critical resource in the rapid identification and response to outbreaks and in providing more accurate and timely surveillance data. Furthermore, the network of graduates, armed with new skills, now comprises the core human training resources for undertaking training at the local level.

FET has played a major role in developing core surveillance and response capacity in the Lao People’s Democratic Republic. The applied nature of the training has equipped graduates with the ability to readily and effectively employ their newly gained knowledge. In addition, the impact of the trainees’ field work findings and recommendations has translated into Ministry of Health policies for the control of communicable diseases. These include, for example, the starting of new vaccine initiatives for rubella and Japanese encephalitis. In the near future, the Lao FET is to be further strengthened through development of the alumni network and a focus on training for trainers, supervisors and mentors.
**Aid Effectiveness**

Since the late 1990s, there has been increasing concern about aid effectiveness—the extent to which aid achieved demonstrable results in overcoming poverty and increasing the quality of people’s lives. Critics have said aid was too often donor led, reflecting the priorities of the richer nations rather than empowering the developing countries they intended to help. Too often, aid was uncoordinated, unpredictable and lacking in transparency.

In 2005, the international community gathered in Paris for a High-Level Forum on Aid Effectiveness, hosted by the French Government and the Organisation of Economic Co-operation and Development (OECD). Representatives from donor-and developing-country governments, multilateral donor agencies, regional development banks and international nongovernmental organizations endorsed the Paris Declaration on Aid Effectiveness.

The declaration highlighted five fundamental principles for making aid more effective:

- **Ownership:** Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.

- **Alignment:** Donor countries align behind these objectives and use local systems.

- **Harmonization:** Donor countries coordinate activities, simplify procedures and share information to avoid duplication.

- **Results:** Developing countries and donors shift their focus to development results and measure those results.

- **Mutual accountability:** Donors and partners are accountable for development results.

At its heart was the commitment to help governments in developing countries formulate and implement their own national development plans, according to their own national priorities, using wherever possible, their own planning and implementation systems.

In February 2007, the Government of the Lao People’s Democratic Republic and its partners in development adopted the Vientiane Declaration of Aid Effectiveness. This localized version of the Paris Declaration and added specific details to fit the circumstances of the Lao People’s Democratic Republic. In addition to the MDGs, it also looked to the long-term development goal of exiting from the least-developed country status by the year 2020.

**The Vientiane Agreement**

The number of United Nations agencies and international nongovernmental organizations partnering with the Lao People’s Democratic Republic has been increasing steadily over the years. To better coordinate the efforts of the Government and development partners, a new coordination mechanism was established in 2006. The first round-table meeting was held in 1998.

Eight sector working groups addressing different areas of social and economic activity began meeting regularly. The health-sector working group soon became one of the most active, with a reputation for best practices and attention to aid effectiveness. A national census was conducted in 2005. At the same time, a nationwide reproductive health survey was carried out.

In 2009, the Government of the Lao People’s Democratic Republic enacted a decree for the regulation and operation of Lao non-profit associations. This marked a significant step towards a more enabling environment for civil society in the country. There is now a mechanism for civil society organizations to become registered and recognized as legal entities, with the possibility of accessing funds and contributing to the development process within the country.
CHAPTER 5: Into the New Millennium

Meeting the Challenge of Maternal and Child Health

Maternal and child health, in particular that of infant and children up to 5 years, has always been a huge challenge in the Lao People’s Democratic Republic. In 2005, the maternal mortality rate (MMR) was 405 per 100,000 live births, the under-5 mortality rate was 97 per 1000 live births, and the infant mortality rate was 70 per 1000 live births according to 2005 census data.

There was progress noted in the recent Lao Social Indicator Survey (LSIS) 2011 data, with MMR at 357 per 100,000 live births, the under-5 mortality ratio was 79 per 1000 live births and the infant mortality rate at 68 per 1000 live births. Thus, target for MDG 4, which calls for a reduction in child mortality, is relatively on track.

Many factors continue to contribute to these high mortality rates including the remoteness of communities and transport difficulties, the tendency of many ethnic groups to marry and start child-bearing at a young age, a relatively high birth rate and lack of birth spacing, a paucity of services, and difficulty in accessing those services when needed due to financial or personal reasons.

Maternal mortality suffers from considerable under-reporting, as maternal deaths are difficult to measure owing to many factors, including their relative comparative rarity and context-specific factors such as reluctance to report abortion-related deaths, problems with memory recall or lack of medical attribution.

Social and cultural barriers often prevent women from exercising their freedom of reproductive choices. Limited choice or poor availability of contraceptives makes the adoption of fertility-regulating methods difficult.

A wide range of traditional practices and beliefs, such as food taboos or restrictions for women during pregnancy or in the days or weeks following childbirth, need to be addressed. A balance needs to be struck between respecting traditional practices, such as how the umbilical cord is cut and that of a new mother lying over a hot bed of coals.

According to the Lao Reproductive Health Survey of 2005, almost 85% of births took place at home, and trained health personnel assisted with only about 18% of births. This means that complications in pregnancy or during childbirth may not be recognized in time and potentially life-saving actions to address minor complications may be delayed, resulting in the high maternal mortality ratio.

The 2011 LSIS data show 37.5% of childbirths taking place in health facilities and 42% were assisted by trained health personnel, marking progress since 2005. However, most maternal deaths occur in rural, hard-to-reach areas where access to a health centre may be difficult.
Improved data collection and analysis also show that the low status of women and a lack of education may directly or indirectly influence a woman’s choice in terms of the number of pregnancies, access to health care and better nutrition, among other issues.

Maternal education can enhance the chance of a child’s survival as measured by nutritional status, infant mortality and child mortality. A child whose mother has not been to school is 2.5 times more likely to die than one whose mother has had seven years or more of education.

A technical working group bringing together groups involved in maternal and child health and EPI covering government sectors, United Nations agencies, bilateral donors and nongovernmental organizations was established in 2007, and assisted in the development of the Strategy and Planning Framework of Implementation of Maternal, Neonatal and Child Health Services in the Lao People’s Democratic Republic (2009–2015), which was launched in September 2009.

The national Maternal, Newborn and Child Health Strategy defined an MNCH integrated package of care and a service-delivery mechanism. It outlined three strategic objectives: to improve leadership, governance and management capacity for programme implementation; to strengthen the efficiency and quality of health-service provision; and to mobilize individuals, families and communities for maternal, neonatal and child health.

The current challenge is to implement this package of services at the district, health-centre and community levels. While WHO supports the nationwide implementation of the MNCH strategy, it has simultaneously supported and MNCH initiative in two districts, one in the north and the other in the south to gain practical experience of MNCH service-package delivery.

The MNCH initiative is an integral part of the Government’s efforts in the nationwide implementation of the MNCH strategy. The role of WHO is to support the Government to obtain practical experience through the initiative in delivering the integrated MNCH package, through timely updates on the implementation process elsewhere, and to speed up the progress in achieving MDGs 4 and 5.

Many data collection tools, forms and guidelines were formulated as a result of the initiative, such as health-centre micro-plans, village data collection forms, and operational guidelines and reporting forms for district planning.

In May 2010, with financial and human resource support from the Korea Foundation for International Healthcare, US$ 1 million was mobilized and one staff member was provided on secondment for WHO to scale up the initiative in 10 districts of two provinces, Xieng Khouang and Huaphan. This in turn led to further scale up of the initiative to support five additional districts in Huaphan in May 2011, thereby supporting all districts in the two provinces with this coverage.
The original initiative and the scaled-up programme focus on three strategic objectives: to build the capacity of Government staff at the provincial, district and health-centre levels to make their own annual plans; to organize simultaneous training and collection of data at the village level; and to make regular supervision visits.

Clinical skill capacity-building was made possible through support to short training courses for health centre staff and the provision of basic medical equipment, such as delivery beds and delivery kits to health facilities in district hospitals and health centres.

Mobilizing community human resources, especially village health volunteers, involves setting up terms of reference for the focal MNCH person in the village to collect data, to provide health education to villagers, and to encourage pregnant women to visit a health facility for delivery. It also includes a scale-up phase with a voucher system in support of free delivery service for pregnant women.

All of these activities were conducted in close cooperation with the Ministry of Health through joint visits, training and supervision and resulted in strengthening capacity at the central level and a spirit of ownership and mutual respect between collaborating partners.

In early 2011, a joint United Nations project involving four United Nations agencies (WHO, UNFPA, UNICEF and the World Food Programme) successfully signed a Memorandum of Understanding securing a US$ 10 million fund from the Luxembourg Government to support the Ministry of Health in implementing the Integrated MNCH service package to reduce maternal, newborn and child mortality and morbidity, as well as the high levels of malnutrition in women and children under 5 years of age.

Through this joint programme, the United Nations agencies supported the Government in its implementation of the Integrated MNCH Services Package in four provinces (Luang Namtha, Oudomxay, Phonsaly and Savannakhet). WHO also supports the nationwide school deworming programme and weekly iron/folate supplementation programme for women of reproductive age.

MNCH is improving in the Lao People’s Democratic Republic given the priority set in recent years. The coverage of antenatal care with at least one visit has increased from 35.1% in 2006 to 71% in 2009. For the same period, the proportion of births assisted by skilled birth attendants has increased from 20.3% to 37%.

The Lao People’s Democratic Republic remains a relatively low-prevalence country for HIV/AIDS. There have been concerted efforts to ensure that information and prevention measures reach at-risk populations. Half of all new HIV infections are among people aged 15–24. As the Lao People’s Democratic Republic is surrounded by countries with high prevalence rates and mobility is increasing rapidly both within the country and across borders, there is still a real threat of an expanding HIV epidemic.
Great Expectations

A 27-year-old mother from the Lao People’s Democratic Republic was among six women highlighted in a one-of-a-kind WHO website feature on pregnancy and childbirth. The feature followed the daily life of Bounlid from Vientiane Province, from the time she was five months pregnant until her child was 1 year old.

Bounlid’s story was part of a global effort to ensure that women give birth safely to healthy children and to publicize the fact that over half a million women die in pregnancy and childbirth annually and nearly 11 million children do not reach their fifth birthday.

The feature, Great Expectations, continued in the months leading up to the World Health Day on 7 April 2005, which highlighted issues of maternal and child health, with the slogan “Make every mother count”.

The other mothers came from Bolivia, Egypt, Ethiopia, India and the United Kingdom (each country representing a different WHO region). It showed both the universal aspects of the experience of pregnancy, childbirth and caring for a young baby, but also the differences in the lives of the six women. While the initial project ran for a shorter time span, the team in the Lao People’s Democratic Republic continued to record the lives of Bounlid and Lang until the little girl was 5 years old.

At the time, the choice of a woman from a rural village in the Lao People’s Democratic Republic was a bold one as the country had one of the worst records in the Western Pacific Region regarding maternal, neonatal and child health. The series of photographs taken of Bounlid and her new baby girl, Lang, were intimate, poignant and representative of many families in the country.

The Lao mother and child did not have access to the recommended postnatal care and Lang did not have the childhood immunizations that should have been completed before turning 1. Their family did not have access to clean drinking-water and sanitation, though that has improved over time.
Kinoy’s story

Kinoy, who lives in Savannakhet Province, has known his HIV positive status since 2000. At that time, there was no antiretroviral therapy (ART) in the Lao People’s Democratic Republic. In 2001, he joined a group of HIV-infected people in Savannakhet and began to volunteer helping provide counselling to HIV-infected people who came to the provincial hospital. Many HIV patients had the wrong information about HIV/AIDS, and they needed some kind of psychological support as well as medical care.

In 2001, he joined a study visit to Thailand where he met other people living with HIV and heard about antiretroviral (ARV) drugs for the first time. They explained how the drugs worked and how important it was to be committed to taking them properly: to get into a routine and to keep taking them regularly. It was important to take the correct dose at the right time. They explained the advantages of these drugs and also the possible side effects.

When he returned from the study visit, he joined others in advocating for ARV drugs to be brought to the Lao People’s Democratic Republic. In September 2003, ARV drugs became available at Savannakhet Hospital. He was the second HIV-infected patient to have access to this treatment in the country.

Since then, the number of people with access to these drugs has increased dramatically. People who need ART do not have to pay for it. There are several centres in the country where treatment is free. The therapy allows HIV-infected people to lead a normal life. Kinoy became the head of self-help group for people living with HIV and a full member of the national HIV group involved in the development and review of HIV national strategies and laws.

People living with HIV should have a say in how policy and services are developed. But it is a long road because many people who may be at risk still do not know their HIV status and do not have access to HIV information. A lot has been accomplished, but there is still a way to go before the entire country is properly covered. Kinoy would like to continue working to help others to have a better quality of life and fair access to prevention and treatment.
Looking to the Future

WHO works with other development partners in a continuing commitment to support the Government of the Lao People’s Democratic Republic to implement its 7th National Socio-Economic Development Plan (2011–2015). The first Country Cooperation Strategy (CCS) signed between WHO and the Lao People’s Democratic Republic covered the period of 2009–2011. It was followed by a second CCS covering 2012–2015. The CCS is aligned with the other major development frameworks for the Lao People’s Democratic Republic, as set out by the Government and other development partners. This framework aligns the work of all cooperation partners and is crucial to the overall development of health policy development and capacity-building over the long term.

The health system relies heavily on donor support. The very low level of Government health expenditures poses an enormous challenge for the country in its goal to achieve the MDGs by 2015 or universal coverage by 2020. Global partnership for development, stronger policies, good governance and a real sense of shared responsibilities are crucial, and development partners need to recognize the changing development priorities of the country in order to address them effectively.

As a member of the United Nations, WHO operates within the United Nations Development Assistance Framework (UNDAF) for 2012–2015 and works with other international agencies to support the Government to achieve the country’s development goals.

The first Country Cooperation Strategy signed between the Minister of Health, Dr Ponmek Dalaloy, and WHO Regional Director for the Western Pacific, Dr Shin Young-soo, 2010.
The WHO Country Cooperation Strategy has four strategic priorities, each with its own main focus areas. Strategic Priority 1 calls for an increase in the access to primary health care and a reduction in health inequities by strengthening the health system and improving aid effectiveness. Focus areas include improving national health policy, strategy and planning processes and supporting implementation of the National Socio-Economic Development Plan (2011–2015).

Other areas include providing support for implementation of the National Health Financing Strategy (2011–2015), advocating and providing technical support for the implementation of the Health Personnel Development Strategy by 2020, and promoting evidence-based decision-making, planning and policy-making by strengthening the implementation of the Health Information System Strategy (2009–2015). The shortage of qualified health staff, especially in rural areas, needs to be addressed so that the gap in access to health care for people in those areas can be bridged.

Strategic Priority 2 focuses on WHO’s contribution to the achievement of the health-related MDGs. An integrated MNCH and nutrition services package has been developed to achieve MDGs 1, 4 and 5. Continual efforts to control HIV/AIDS, tuberculosis and malaria as part of MDG 6 are under way and are contributing to efforts to reduce environmental risks to health as part of safe water and sanitation initiatives for MDG 7.

Since 2003, the National Tuberculosis Program (NTP), which had implemented DOTS in 140 districts, has decentralized and moved responsibility for TB control and DOTS to 808 out of 869 (93%) health centres and it will be further extended to cover the entire network of health centres. The programme increased its capacity to
examine patients by microscopy from 15,617 in 2004 to 35,980 in 2011 and almost doubled the notification of new and relapse tuberculosis cases from 2,227 in 2000 to 4,306 in 2011. The treatment success rate of new smear-positive tuberculosis cases increased from 77% in 2000 to 91.9% in 2011.

Environmental risks to health can be reduced with a focus on safe water and proper sanitation. Achievements have been made in this area with regards to the enforcement of the Water Law, revision of National Drinking-Water Standards and the establishment of the Environmental Health Impact Assessment Unit within the Ministry of Health.

Strategic Priority 3 targets the prevention and control of emerging infectious diseases and public health events. There is a need to strengthen the capacity of key players, such as Government agencies, to prevent and control health security risks of emerging and re-emerging diseases, neglected tropical diseases, food safety events and other health hazards. Preparedness and response to health security risks following natural and man-made disasters have to be strengthened through capacity-building.

Strategic Priority 4 addresses health risk factors to reduce noncommunicable diseases, mental health and disabilities. There is a need to advocate for and support noncommunicable disease control, especially in the areas of promotive and preventive services by recognizing the modifiable causative factors.

This final strategic priority also involves the scale up of care for mental, neurological and substance use disorders and support for disabilities prevention and rehabilitation, with focus on the effects of UXO, road safety, violence, blindness and visual impairment. Most countries in the Western Pacific Region report a shortage of mental health staff and underdeveloped mental health facilities.

Stigmatization and marginalization of the mentally ill continues around the world, and mental health care is given low priority in general health care in most countries. Lack or insufficient mental health legislation, inadequate services and the lack of specialist services result in people with serious mental illness or disorders and those with other mental health problems not receiving proper care.

The Millennium Development Goals have provided clear directives for the United Nations agencies to work towards common goals. Better integration of efforts from Government sectors, United Nations agencies, bilateral and multilateral donors, civil society and nongovernmental organizations must be achieved to maximize the efforts of those working to contribute to the development process within the country.

More cooperation with non-health sector development partners must be forged to provide analysis of the health impacts of Government policies and large-scale development programmes (mining, hydropower, agricultural land use changes, and rail and road construction) and the impact of climate change on health service provision.

To achieve these strategic priorities, WHO will continue to provide technical support for the implementation of various health programmes. WHO will continue to work with its main partner, the Ministry of Health, and other key development organizations and partners, including other United Nations agencies and nongovernmental organizations, and civil society to achieve the MDGs by 2015.
The work of WHO has moved from a needs-based approach to one in which it supports the Government of the Lao People’s Democratic Republic to develop better primary health care and implement health reforms. More planning and implementation are possible with data collected that address areas where health services can be improved.

For WHO in the Lao People’s Democratic Republic, strengthening the country health system, building national health capacities, developing and implementing more pro-poor health policies and providing equitable access to good quality health services for all are important priorities. There is a lot that needs to be done and can be done to improve the provision of health services. Universal health coverage is a goal that we are working towards, a step at a time.

Throughout the world, the mission of WHO is to attain the highest possible level of health for all people. Until the day “health for all” becomes a reality and everyone enjoys good health as a fundamental human right, the work of WHO in the Lao People’s Democratic Republic will go on.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guerin</td>
</tr>
<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
</tr>
<tr>
<td>CHAS</td>
<td>Centre for HIV/AIDS and STIs</td>
</tr>
<tr>
<td>CMPE</td>
<td>Centre of Malariology, Parasitology and Entomology</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment, Short Course</td>
</tr>
<tr>
<td>DDT</td>
<td>Dichlorodiphenyltrichloroethane (Organochlorine insecticide)</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria</td>
</tr>
<tr>
<td>EBS</td>
<td>Event-based Surveillance</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>EWARN</td>
<td>Early Warning and Response Network</td>
</tr>
<tr>
<td>FET</td>
<td>Field Epidemiology Training</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GMEP</td>
<td>Global Malaria Eradication Programme</td>
</tr>
<tr>
<td>GPA</td>
<td>Global Programme on AIDS</td>
</tr>
<tr>
<td>IBS</td>
<td>Indicator-based Surveillance</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations</td>
</tr>
<tr>
<td>LSIS</td>
<td>Lao Social Indicator Survey</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDA</td>
<td>Mass Drug Administration</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MHV</td>
<td>Model Healthy Village</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Neonatal and Child Health</td>
</tr>
<tr>
<td>MSF</td>
<td>Medecins Sans Frontieres</td>
</tr>
<tr>
<td>NAHC</td>
<td>National Animal Health Centre</td>
</tr>
<tr>
<td>NCLE</td>
<td>National Centre for Laboratory and Epidemiology</td>
</tr>
<tr>
<td>NIPH</td>
<td>National Institute of Public Health</td>
</tr>
<tr>
<td>NMS</td>
<td>National Malaria Service</td>
</tr>
<tr>
<td>NSSNSD</td>
<td>National Surveillance System for Notifiable Selected Diseases</td>
</tr>
<tr>
<td>NTP</td>
<td>National Tuberculosis Program</td>
</tr>
<tr>
<td>OB</td>
<td>Operation Brotherhood</td>
</tr>
<tr>
<td>ODA</td>
<td>Overseas Development Agency</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation of Economic Co-operation and Development Primary Health Care</td>
</tr>
<tr>
<td>PHC</td>
<td>Roll-Back Malaria</td>
</tr>
<tr>
<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USCDC</td>
<td>United States Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>USSR</td>
<td>Union of Soviet Socialist Republics</td>
</tr>
<tr>
<td>UXO</td>
<td>Unexploded Ordnance</td>
</tr>
<tr>
<td>WHA</td>
<td>World Health Assembly</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>


Holloway AP. Basic data for planning a public health program in the Kingdom of Laos. Vientiane, USOM, 1957.


Watson L. Lao malaria review, 2.9 Traditional medicines, 1999.


