No. 4

ラオス人民民主共和国保健医療分野
日本・WHO合同調査チーム報告書

平成3年6月

国際協力事業団
医療協力部

JICA
112
90.7
MCF
LIBRARY

医協
JR
91 - 24

ラオス人民民主共和国保健医療分野
日本・WHO合同調査チーム報告書

JICA LIBRARY

1096073(0)

23345

平成3年6月

国際協力事業団
医療協力部

国際協力事業団
23345

序　文

ラオス国に対する保健医療分野の協力はラオス革命以降一時停止していたが、ラオス国の開放政策の中で本格的な協力再開の気運が高まってきている。

他方、より効率的な国際協力を行うため国際機関との連携を進めるとの方針のもと、我が国は平成2年WHOとの定期協議を開始し、今後のお互いの協力の方向を検討した。

こうした背景のもと、国際協力事業団は平成3年3月、ラオス国に対する保健医療分野のニーズを把握し、今後の協力の可能性を探るため、母子愛育会日本総合愛育研究所所長平山宗宏氏を団長とする調査チームを派遣した。本調査チームは、我が国とWHOとの連携強化の足がかりとして日本・WHO合同調査チームとした。

本報告書はその調査結果を取り纏めたものである。

ここに、本調査にあたりご協力頂いた関係各位に深く感謝するとともに今後更なるご指導ご鞭撻を賜るようお願い申し上げる。

平成3年6月

国際協力事業団
理事　西野世界

目　　　　次

I.　調査の目的・日程

I-1.　調査の目的・内容 1

I-2.　調査団の構成 1

I-3.　調査日程 3

II.　調査内容

II-1.　調査時の留意点と対処方針 4

II-2.　調査・打合せの概要 5

II-3.　フィールド視察の概要 13

III.　調査結果

III-1. 調査先の状況の概要 14

III-2. 調査の所感 16

III-3. 今後の取り進めぶり等 17

III-4. Note for the Recordについて 18

III-5. ラオス地域保健向上計画（試案）概要と展望 21

IV.　参考資料

IV-1. 参考資料の内容について 23

IV-2. 主要面会者リスト 24

IV-3. "Health Systems Development in Lao PDR:
Major Problems and Current Issues" 26

IV-4. "Implementing Primary Health Care in Laos" 30

IV-5. "フランス・WHO対ラオス協力合同調査団報告書" 49

IV-6. Project Proposal (Draft) 52

I．調書の目的・日程

I-1. 調書の目的・内容

ラオス国に対する保健医療協力の拡大に資するため、そして当該分野のニーズを把握し、今後の協力の可能性をさぐるため、建築担当者、援助機関担当者との打ち合せ、保健医療施設の視察などを行うことを目的をして調査を実施した。

又、別途平成2年から、WHOを日本との協力を強化する観点から、定期協議を開始したが、この一環として、ラオス国をWHOと日本の合同調査の対象国として選択した。

I-2. 調査団の構成

(1) 平山　宗宏(63)　　母子愛育会日本総合愛育研究所所長
Dr. Munehiro Hirayama President,
Nippon Aiiku Research Institute for
Maternal-Child Health and Welfare,
Aiiku kai

(2) 伊藤　清臣(44)　　国立病院医療センター国際医療協力部派遣課課長
Dr. Kiyoomi Ito　　Director, Expert Dispatch Division,
Department of International Cooperation,
National Medical Center Hospital

(3) 佐藤　三郎(33)　　外務省経済協力局技術協力課
Mr. Saburo Sato　　Official, Technical Cooperation Division,
Economic Cooperation Bureau,
Ministry of Foreign Affairs

(4) 渡辺　正夫(42)　　国際協力事業団医療協力部管理課課長代理
Mr. Masao Watanabe　　Deputy Director, Administration Division,
Medical Cooperation Department,
Japan International Cooperation Agency

なお、WHOチームとして、下記の3名が全行程参加した。

(1) 麦谷　眞里

Dr. Masato Mugitani	External Relation Officer, WHO/Geneva

(2)

Dr. Katja Janovsky	Division of Strengthening Health Service, WHO/Geneva

(3) 尾身　茂

Dr. Shigeru Omi	EPI/CDD Programme, WHO/Manila

I-3 調査日程

3/9（土）	成田	→	バンコク (JL717)
10（日）	バンコク	→	ビエンチャン (TG690)
11（月）	8:30		WHOビエンチャン事務所訪問
	9:30		在ビエンチャン日本大使館表敬
	14:30		UNICEFビエンチャン事務所訪問
12（火）	8:30		UNDP事務所
	9:40		保健省大臣表敬
	10:00		保健省幹部職員との打合せ
	14:30		マホソット病院視察
			※平山団長合流
	16:00		母子保健研究所視察
13（水）	8:30		国立医科大学視察
	10:30		医療技術専門学校視察
	14:30		国立衛生研究所視察
14（木）	9:20		Phone Hong District Hospital 視察
	11:00		Thoura Khom 郡保健チーム事務所視察
	16:30		JICAチーム・WHOチーム調整会議
15（金）	8:30		対外経済関係省表敬
	10:30		SIDA打合せ
	14:00		団内協議
	16:00		保健省との最終協議
16（土）	9:00		製薬センター視察
17（日）			ビエンチャン→バンコク (TG690)
18（月）			バンコク→東京 (TG640)

II. 調査内容

II-1. 調査時の留意点と対処方針

II-1-1. 留意点

(1) 協力実績

ラオスに対する保健医療分野の協力は、昭和40年代のルアンプラバン病院、タゴン医療センターに対するプロジェクトがあった。

ラオス革命（昭和50年）以降、当該分野への協力も一時停止していたが、60年代に入り、製薬技術開発センター（無償、技協）、セタティラート病院（機材供与）感染症基礎調査等が実施され、本格的な協力再会の機運は高まっている。

(2) 社会・経済上の問題

本来ラオスは隣国「タイ」の社会・経済圏内にあったが、上記のラオス革命後、一時両国の関係は悪化した。

その後の「ラ」国の開放政策の中で状況は改善されているものの、依然「LLDC and社会主義の国」であり、かつかつての公用語であるフランス語もその地位を失っている。

従って、技術移転の基盤（インフラ、人材、そのための共通語）が弱いことが懸念される。

(3) 協力要請について

今回の調査については、「日本側からのオファー」であり、ラオス側がこれを受けて協力内容の特定を検討し、要請を越すことが期待されている。

(4) WHOとの関係について

WHO (HDQ/WPRO)から、合同ミッション派遣の提案がなされていたが［WHOとしての対処方針］あるいは［ラオスに対する特別プログラム］の内容等についての情報は調査団出発までに入手出来なかった。

II-1-2 対処方針

(1) 保健医療分野のプロファイ

平成元年度の同国に対して実施した「感染症基礎調査」を踏まえつつ、バイ（二国間協力）としての協力方向をさぐることとする。

※基本的には、セクターレビューを行い、サブセクターをさぐる。感染症対策（EPI、検査・レファレンス機能の強化等）が中心となるであろう。

(2) WHOとの関係

WHOの対ラオス保健政策があれば入手して、プロ形成時に留意する。

II-2 調査打合せの概要

a) WHO事務所

参加者　JICAチーム（除　平山団長）

WHOチーム

WHO Acting Representative

Dr. F. Amini

WHO EPI/POLIO Program

Dr. R. Nesbit

内容　WHOのラオスでの活動内容

人材養成（フェローでのタイでの研修）

保健活動のシステム構築

EPI活動（受容率の向上が難しい）

Re-Centralization政策

保健機関の末端でのIntegration

b) 大使表敬

参加者　上記a)

JOCV稲垣調整員

討議内容　マルチ／バイの今後の動き

その際の留意事項

c) UNICEF打合せ

参加者 UNICEF, Education Program

Ms. Anne Sutherland

Mission Members

WHO（２名）

討議内容 Res. Rep. と Health Program Officer BKKへ出張中

UNICEFの Health Sectorへの参加方法

←アセス、技術支援

・SIDAとの協力

Data Base作成について

Water Sanitationについて

d) UNDP事務局

参加者 JICAチーム

WHOチーム

大使館長嶋一等書記官

UNDP R. R.

Ms. Ameerah Hag-Perera

UNDP Program Officer

Ms. Takeko Iinuma

内容 UNDPの役割

他機関への技術支援

国際機関間の調整

保健セクターでの活動

マホソット病院改善計画

地方病院改善計画

ドナーミーティングの設定

今後ラオスで行われるべき内容

マラリア、PHC、MCH etc

e) 保健大臣表敬

参加者　JICAチーム

WHOチーム

大使館長嶋一等書記官

ラオス国保健大臣

内容　保健セクターへの協力をお願いする

担当副大臣と十分打合わせをして欲しい

現状では［ヒト、カネ、モノ］不足である

EPIの活動を活発化したい

十分な調査を行い、良い案件を発掘して欲しい

内容　［副大臣］

PHC、人材養成、保健教育etcの部門での協力が欲しい

都市部にしか外国援助が入っていない

［マホソット病院長］

医学生の教育病院となっているが施設が不足している

［NIHE副所長］

PHCのネットワーク化

EPI Programの拡大が必要

アクセス用の機材、人材

［大学医学部］

卒業研修の機会が欲しい

短期専門家

機材

スタッフトレーニング

モデル地区でのヘルスマネージメントの改善

［NIHE所長］

レファラル　ラボとしてのLab.の改善

Hb、デンギ、AIDS

スタッフトレーニング

機材

f) 保健症幹部との打合せ

参加者　JICAチーム

WHOチーム

大使館長嶋一等書記官

ラオス側出席者

Minister of Health	Mr. Khambou Sounixay
Vice Minister for Public Health	Prof. Vannareth Rajpho
Deputy Chief of the Cabinet responsible for Internat. Cooperation	Dr. Bovara Chounlamountry
Deputy Chief of the Cabinet responsible for Pranning and Finance	Dr. Philaysack Naphayvong
Cabinet of the Ministry Coodinator of Internat. cooperation	Dr. Ketsamay Rajphangthong
Cabinet of the Ministry Planning Unit	Dr. Phonepraseut
Director of Mahosot Hospital	Dr. Sommone Phounsavath
Director of National Institute of Hygiene and Epidemiology (NIHE)	Dr. Sithat Insixiengmay
Deputy Director of NIHE	Dr. Somthana Douangmala
Vice Rector of the University of Health Sciences	Dr. Khampiene Philavong
Head of Academic Affairs of the School of Public Health	Dr. Somboun Phomtavong

g) マホソット病院打合せ

参加者　JICAチーム

WHOチーム

大使館長嶋一等書記官

マホソット病院長

内容　病院の現状説明

450床　2つの病院敷地

外来　3～400人/day

ラオスの1/6の患者をカバー

入院患者　3000/year

MD 120名、Nurse 200名

日本への協力依頼

現在JOCV 2名要請中

研修員（Surgery, Gastro-enterodisease etc）

機材（Cardiology, Fiber scope etcの更新）

h) 母子保健研究所（MCH Institute）

参加者　JICAチーム

WHOチーム

大使館長嶋一等書記官

研究所副所長

Dr. Sompoon

内容　研究所の概要

本省の母子保健課から、'89年11月に研究所へと変換した

28名のスタッフ

MCH活動の運営と研究が任務

（現状は運営のみ）

MCH従事者の再教育機能

問題点

[ヒト、カネ、モノ] 不足

病院用のビルに移転してきたが建物のみで他に何も無い状況

i) 国立医科大学打合せ

出席者　JICAチーム

WHOチーム

ラオス側

別添リスト

内容　大学の説明

'69年設立、唯一の医科大学

薬学部（30名）、歯学部（30名）

医学部（120名）、公衆衛生学部（設立準備中）

教員133名（MD 33）

大学教育もラオス語

大学の問題点（先方の説明）

教員の質

海外研修、専門家の投入

機材の不足

教員実習用の車両の不足

学生宿舎

Lab.の試薬、教材不足

現状での援助

WHOの２つのプロジェクト

j) 医療技術専門学校打合せ

出席者　JICAチーム

WHOチーム

副学長他

内容　学校の概要

看護婦・保健婦コース（95）

Hygine Inspector（30）

Lsb. Technician（30）

Rehabilitation（15）

看護コースにはWHOの援助あり

問題点

実習用のLab.の不足

教材、試薬などの不足

k) 国立衛生研究所打合せ

出席者　JICAチーム

WHOチーム

長嶋一等書記官

ラオス側

Dr. Sunthana Douagmala（副所長、EPI担当）その他

内容　NIHEの活動

Administration

Immunization & Epidemiology

Lab. Work

Water Supply & Sanitation

EPI活動の問題点

接種率の低さ

地勢的な制約、アクセスの悪さ

地域格差

担当者へのモチベーションのあり方

Lab.活動の問題点

予算上の制約

↑外国援助への期待

その中で、7名のスタッフでProvinceの職員の再研修を行っている

i) 対外経済関係省

出席者　JICAチーム

WHOチーム

ラオス側

Dr. Boutheang Mounlasy

Deputy Director

内容　ラオス政府の経済開放政策の概要

経済セクターの自由化

地方自治制度の導入

対外政策のオープン化

外国からの投資促進

経済・技術協力

m) SIDAとの打合せ

出席者　JICAチーム

WHOチーム

Mr. Rolf Samuelsson

First Secretary of Embassy

内容　SIDAの対ラオス援助の概要

'74年から、人道援助として開始

林業、建設部門への機材供与を中心にしたが、プロジェクト型へ移行

保健部門ではUNICEFへ資金援助してプロジェクトをUNが実施

UNICEFプロジェクトは4つの県が対象

L/Cについては問題点あり

また基本的に、Planning/Monitoring/Evaluationを直営でやって

プロジェクトの運営はコンサルタントに移行している

n) 保健省最終打合せ

出席者　JICAチーム

WHOチーム

ラオス側

Prof. Vannareth Rajpho

Dr. Bovora Chounlamountry

Dr. Ketsamay Rajphangthong

内容　Findingsの説明

WHO/日本側のInitial Project Conceptの説明

ラオス側の反応

基本ラインについて合意

早急に正式要請書をとりまとめて提出するので、次のミッション（事前調査）の派遣を希望する

II-3 フィールド視察の概要

a) Phone Hong District Hospital

郡病院とProvincial Administrative Office（ビエンチャン県）がある

同県は8つの郡から成り16,111km²

人口293,466人

県病院が1年前に建設された（50床）

看護学校とLeprocy棟が付属

地方自治の精神から、中央政府（保健省）からはPolicyと大まかな指示があるのみ

実施と予算は県独自

保健要員MD 54, Medical Assistant 187

Reg. Nurse 362, Staff 42 (1990)

又、中央からの補助が無くなり、末端のDispensaryが過去10年間で161→57へと減少

b) Thorakhom District Hospital

15床のDistrict Hospital

郡内に11のCommunity Dispensary

郡内のHealth Staff MD 3, MA 27, Nurse 43

→※うち46は病院、残りの人員はDispensary

あとCommunity Health Worker（ボランティア）18

と、T. B. A. 50名

主要疾患―――ARI、マラリア、下痢症etc

郡内に3つのパイロットプロジェクトあり、うち一つはフランスのNGO (MAP)のもの

ポリオプログラム　接種率　89%

III 調査結果

III-1.調査先の状況の概要

1) ラオス国保健省の姿勢

保健省は大臣、副大臣以下日本の医療・保健面での援助に期待するところが大きい旨、明瞭に表明している。これまでの国際機関、西側諸国（スウェーデン、オーストラリアが主）の援助は郡単位の地域割になっている模様。

2) WHOの姿勢

WHOとしては国際機関として、その主要資金援助国である日本が行う二国間援助を尊重し、その結果を尊重する。WHOが従来から行っている、主としてEPI援助についても日本が協力してくれることを期待する。

3) SIDAの姿勢

従来からの援助国であるスウェーデンは、1974年以来森林関係の援助から始めたが、1990年から保健関係についても1700万クローネをコンサルタント会社を使う形で援助を始めた。内容はラオス国外での要員研修、国内での環境教育、ワークショップなどである。キーエリアではEPIを主とした母子保健関連援助をユニセフを通じて500万クローネ、他に飲料水供給、薬品供給、大学の実験室関係などソフト面での援助を企画している由。要は、スウェーデンはユニセフを通じての援助を計画している模様。

4) 保健・医療要員の教育

最高学府は国立保健大学S.H.S.で、毎年医師120、薬剤師35、歯科医師25、医療技術士30、看護婦20、等を教育している。大学は卒業生の質の向上を計りつつあり、卒後教育として専門医（内科、外科、小児科、産科）の教育を開始した。医療技術短大S.T.では、看護婦、助産婦（年間95）、衛生監視員（30）、薬剤師（30）、衛生検査技師（30）、リハビリ関係（計45）、等を養成している。しかし教育器材、施設は極度に不足、不良であり、援助が要望される。なお、医療助手の養成は数年前に中止された。医学部卒業生が進む公衆衛生学部S. P. H. は保健行政担当者養成の目的で開設準備中。

5) 国立マホソット病院

医学部付属病院を兼ねる唯一の国立病院は、フランス領時代の古い建物と最近建て増しされた建物が混在している。計450床、外来300～400／日、入院20000／年、死亡率３％／入院。医師120、看護婦200。県病院レベルからの研修も受け入れている。母子保健ユニットあり、指導と予防接種も行っている。医療費は本人負担なし。

6) 母子保健研究所

保健省の母子保健課が病院であった建物に移って組織替えされた。スタッフも3人ほどが21人に増えたが、建物の内容は何もなく、研究所としては今後の充実が期待される。予定されている仕事は、統計、研修、管理、技術開発、情報、国内・国際協力などである。なお、郡レベルに母子保健担当者は最低1人はおり、事務室、指導室はある。

7) 国立衛生・疫学研究所

感染症のサーベイランス、それに伴う多少の実験室、EPIのためのワクチン保存施設（冷凍庫、冷蔵庫）、疫学と飲料水供給関係の研究部、ワクチン輸送用のWHO供与の車両を持つ。予防接種実施率は、最高のビエンチャン市で65%、最低の県で3%、一桁の県が8県はある。実験室では感染症診断用のキットを要望。サーベイランスシステムとしては主要4病院、4県病院を定点とし、16疾患につき5県をカバーする形で実施中。90年の成績では、定点病院の入院数は、ポリオ17、麻疹269、ジフテリア1、百日咳4。

8) ビエンチャン市外農村部（トラコーム郡）

県レベルの衛生担当部、病院、それに郡レベルの衛生担当事務所と病院を訪問、視察。病院はバラック風の建物、現在は乾期で入院患者が少ない。手術室は県病院では一応備えている。薬品は十種類程度はある。レントゲン器械は県病院にもない。

III-2 調査の所感

(1) 1988年より新経済メカニズムを導入し、自由解放経済への道を取ろうとしているラオス国は、政府の財政困難から開発計画が思うように進んでおらず、外国からの援助に大変強い期待をいだいている。その中で保健医療分野についても必要予算の3分の1しか確保されない事情にあり、人材不足、保健分野のマネージメント、システムの非効率性あるいは薬品、機材の不足等大変厳しい状況にある。このような中で、必要な協力内容は、まず乳幼児死亡率の低下等を目指し、地域の保健水準向上のため、プライマリーヘルスケアへの取り組みを強化することにあると思われる。PHCの導入部として母子保健、予防接種拡大計画（EPI）に力点が置かれることが望ましい。

以上の観点より、先方に対し日本側のより具体的な協力姿勢を示す為の一つの試みとしてWHOチームとの十分な連携のもとに、ひとつのプロジェクトのアイデアとしてローカルコストのあまりかからないプロジェクト方式技術協力による地域保健向上プロジェクト案（本プロジェクト案は、WHO側も保健医療システム、マネージメント等の専門家を派遣して協力するとの内容となっている。）を取りまとめ非公式な形であるがと前置きの上、ラオス側に提案し先方の感触をさぐってみたところ、ラオス側は本プロジェクト案に大変強い興味を示し、先方は本プロジェクト（案）を参考として、日本とWHO側の夫々に対して外交ルートを通じ正式要請書を出す手続きを取りたい旨述べた。

(2) WHOとの協力について

WHOと合同でミッションを派遣し、医療関係のニーズ等を調査するのは今回が初めての試みである。今回の調査に当り、アポイントメントの調整、訪問先への案内、連絡についてWHO側の多大な協力があり、また、ラオス側WHO事務所の有する情報及び政府機関、国際機関、NGO等とのネットワークを十分利用でき、また、WHOジュネーブ本部及びWPROからも担当職員が参加し、夫々の持つ情報、ノウハウが大変参考になったばかりでなく、日本人専門のリクルートが難しい保健医療システムの開発、マネージメントの部門に専門家を提供することをオファーする等わが国との協力に対し大変積極的であった。WHOの有するノウハウ、情報量、ネットワークはわが国の保健医療分野に置ける技術協力を進めていく上で有益であり、今後ともWHO側との十分な連携が望ましいと思われる。

III-3.今後の取り進めぶり等

1. 「NOTE FOR THE RECORD」について

WHOより、本件ミッションの調査内容などについて後の参考のために何か記録を残したい旨の要望が出され、別紙のとおり、本ミッションが作成した地域保健向上プロジェクト（案）を含む「NOTE FOR THE RECORD」を作成した。（NOTEはラオス政府にも参考として手交ずみ）

2. 今後の取り進めぶり

(1) 新しいプロジェクト（案）は、ラオス政府の強い要望をも考慮に入れると、平成3年度内に実施に移していくことが望まれる。

(2) WHOラオス事務所の説明によれば、ラオス政府からの正式要請書は5～6月頃に我が方に提出される可能性がある由。

(3) 次のミッションは、上記正式要請書を入手してから派遣されることとなるが、同調査団は、プロジェクトサイト決定などのためラオス国内で現地調査を行う必要があるところ、ラオスは雨期（6-9月）に入ると全く動けなくなるので乾期、特に10月以降になってから派遣することが必要な由である。

3. 協力隊員について（稲垣JICA/JOCV駐在員より聴取した内容。）

(1) 現在4名の隊員が派遣されており（ただし1名は病気帰国中）、内1名が医療関係である。ラオス政府からは、新規派遣要請として30名以上が出されているが、そのなかに医療関係者が5～6名含まれている。（例えば、ヴィエンチャン市営のセタティラート病院から、助産婦、臨床検査技師、ICU看護、X線技師の4名が要請されている由。）

(2) 邦人医療対策の観点よりも、ヴィエンチャン市内の特定の病院にテコ入れすることが極めて重要と考えられ、その意味からも、協力隊員をグループ形式で派遣し、医療機材供与である程度の機材を揃えるのがよいと思われる。

（本ミッションは「ヴィ」市内の国立病院等を視察したが医療機材の不足や老朽化はひどいものであった。また、上記地域保健向上プロジェクト（案）の実施にあたっては、協力隊員との連携も考えられる。）

NOTE FOR THE RECORD
JAPAN/WHO JOINT MISSION
March 1991

Members of the Mission

Prof. M Hirayama, Director, Nippon Aiiku Research Institute for MCH and Welfare,
Mr S Sato, Technical Cooperation Division, Ministry of Foreign Affairs,
Dr K Ito, Dept of Internat. Cooperation, National Medical Centre Hospital,
Mr M Watanabe, JICA, Medical Cooperation Division,
Dr F Amini, Acting WHO Representative and Medical Officer/PHC, Vientiane,
Dr R Nesbit, WHO Medical Officer/EPI, Vientiane
Dr S Omi, WHO/WPRO, EPI
Dr M Mugitani, WHO/HQ, External Coordination Office
Dr K Janovsky, WHO/HQ, Division of Strengthening Health Services/ICO

Findings

The mission identified urgent needs for support in the following areas of the health sector:

1 the development of the health system in general, covering policy formulation; human resource development; organisation, planning and financing; drug management; health statistics and information;

2 health programme development, particularly in the area of MCH, EPI, polio eradication, and the control of other infectious diseases;

3 health services delivery and utilisation at provincial, district and commune level.

Preliminary Draft Project Outline

The attached draft project outline is based on preliminary discussions of the Japan/WHO Joint Mission during their visit to Lao PDR, 10 - 17 March 1991.

Next Steps

It is hoped to come to an agreement concerning the implementation of technical cooperation between Japan, WHO and Lao PDR in the course of the next Japanese fiscal year (April 1991 - March 1992).

It is proposed that the Lao Ministry of Public Health prepare a project proposal based on initial discussions with the Mission and submit it through formal channels to the Japanese government and WHO. A second mission will take place after receipt and review of the project proposal submitted by the Lao Ministry of Health.

DRAFT

JAPAN/WHO COMMUNITY HEALTH DEVELOPMENT PROJECT IN LAO PDR

Preliminary Project Outline
developed by Japan/WHO Joint Mission
March 1991

Objectives

1 Reduce morbidity and mortality of vulnerable groups, particularly women and children.

2 Improve health services delivery and utilization.

3 Strengthen health planning, management and information.

Strategies

1 Support of the development and implementation of comprehensive PHC services in a selected geographical area.

2 Although PHC services cover the full range of preventive programmes and curative services (EPI, MCH, CDD, ARI, malaria, tuberculosis, nutrition, medical care), EPI activities would be used to serve as the critical entry point to the improvement of health status in the target population and to effecting greater uptake of services.

3 Japanese inputs would include expert services (eg. medical doctor, nurse, laboratory technician, and so forth); training (fellowships, in-country training, workshops); and essential equipment at provincial and district level.

4 WHO would provide technical expertise in the area of health systems development, particularly planning, financing, management and information support.

5 In view of its emphasis on EPI, the project would establish a strong link with the National Institute of Hygiene and Epidemiology where WHO is already providing long-term technical assistance. The project would also be linked other ongoing WHO-supported PHC activities, particularly the Strengthening Health Management Programme, and to the PHC Support Network.

6 Monitoring, surveillance and evaluation would be an integral part of the project design. Indicators for reviewing project performance and impact could include

- o health status indicators (morbidity and mortality)
- o health services indicators (trends in utilization and uptake of selected services, such as EPI and MCH)
- o planning and management performance indicators (formation of district health management teams, preparation of provincial and district action plans, collection and use of health and management information, etc).

Principles and Assumptions

1. Japanese support would be started in a limited geographical area of the country. However, this is seen as part of national efforts to extend PHC development throughout the country.

2. Through continuing monitoring and evaluation, it is expected that the implementation of PHC in the project area could serve as a model. Lessons learned would be used in other provinces. In this context, WHO can play an important role in the liaison and coordination with other donors and UN agencies active in PHC development.

3. Issues of sustainability, absorptive capacity and adequate support by the government of Lao for recurrent costs, particularly salaries of its health workers, should be taken into consideration.

Other Points of Information

1. Japanese inputs would be provided through JICA in the form of project-type technical cooperation.

2. If additional WHO inputs are required, sources of funding will need to be identified.

3. The Japanese contribution to EPI through the supply of equipment, provided under a multibilateral agreement with UNICEF, is expected to continue.

III-5.ラオス地域保健向上計画（試案）概要と展望

III-5-1.概要

1) 目　的　i) 重点対象集団、特に婦人と小児の死亡率、罹患率減少

ii) 保健医療サービス供給と住民医療体制

iii) 保健計画・運営管理・情報網強化

2) 方　法　i) 特定地域での包括的地域保健（PHC）の開発と実施に対する支援

ii) PHCとは予防・治療サービス全て（EPI, MCH, CDD, ARI, malaria, TB, 栄養, 臨床医療）を含むものであるが、対象集団に対する保健状態の改善と保健サービス需要向上に対する導入部としてEPI活動を取り上げ、順次PHC活動を拡大・強化する。

iii) 日本側はプロジェクト方式技術協力による専門家派遣、研修員受入、機材供与等を行い、県・郡レベルの整備を行う。

iv) WHOは保健システム開発、特に企画立案／財政／運営管理／情報に関わる技術／知識（人材派遣、fellowship）の提供を行う。

v) WHO既存事業との関係

・EPI重要性の観点から長期専門家（Dr. Nesbit）派遣中のNIHEとの連携強化

・保健運営管理強化計画等、現在実施中のPHC活動（Dr. Amini）とも連携する

vi) 事業計画設計に必須な点検／監視／評価の指標は以下の通り

・保健状態指標；死亡率、罹患率（殊に母子）

・保健サービス指標；（地域住民による）EPI,MCHの活用状況と傾向

・企画立案／運営管理履行能力指標；地区保健実践チームの編成と実働、県／郡実施計画策定、情報収集／利用／配布（surveillance）

3) 基本方針　i) 当初は日本が地域を限定して支援を開始するが、PHC活動を全国に拡充していく国家的努力の一部となろう。

ii) 継続的な監視と評価を通じたモデル事業としてのPHC実践が期待でき、得られた教訓は他の県にも適応されることになろう。そこでWHOの果たすべき重要な役割はPHC活動に熱心な他国の途上国援助機関、国連機関との連絡調整となる

iii) ラ国側の自立発展性に鑑み、受入能力と適切な財政的基盤を確保する為、ラ国政府は事業運営経費、殊に地方要員の給与支払いにも十分な配慮をするべきである

4) その他　i) 日本側の投入はJICAのプロジェクト方式技術協力による事になろう
ii) WHOの追加投入が求められる時には、その財源が明示される必要があろう
iii) 日本政府とUNICEFとの合意に基づくマルチバイ方式によるEPI機材の継続的供与が今後も期待される

III-5-2. 展望

1. JICAプロ技構成の基本；
1) ラオス政府側の財政的・人的負担を最小限にする→草の根運動的住民参加による組織化
2) WHO, UNICEF等の貢献を最大限に引き出す→タイ国人材と組織の活用
3) ラオスPHC活動拡充を目標とし、EPIをその導入部として取り上げる。具体的にはEPI活動では予防接種とSurveillanceを取り上げる。

2. 投入人材（専門家と協力隊員）・国内支援体制
1) 専門家派遣
NGOとの連携（地域住民啓蒙・組織化、Cold Chain維持）
Thai PHCプロジェクトとの連携？
2) 初期計画地域選定と暫定実施計画策定
3) 活動（含む衣食住）拠点設営
移動・輸送・通信手段確立（タイ側陸路利用を含め、Site-Base-Vientiane-Tokyo）

3. WHO、ラ国政府の具体的貢献の確認
1) WHO；タイ東北地方保健機関と人材（Trainer）の活用、住民啓蒙用教材と指導者教本、
2) ラオスPDR；Province／Districtの積極的事業推進eg.）婦人・青年団体の動員　ラオス－タイ国境の自由通行

4. 地域経済の視点

IV　参考文献（資料）

IV-1. 参考文献（資料）の説明

IV-2: 今回調査時の主要面談者リスト

IV-3: Health Systems Development in Lao PDR:
Major Probrems and Current Issues
(Dr. Katja Janovsky)

IV-4: Implementing primary health care in Laos
(Dr. Katja Janovsky)

（IV-3, IV-4、いずれも今回調査にWHO側団員として参加したDr. K. Janovskyから提供されたラオス国保健医療事情に関する参考資料）

IV-5: フランス・WHO合同調査団による現地報告書（仮訳）

IV-6: project proposal for the JICA project-type technical cooperation

（III-4のNote for the Recordを受け、ラオス国で作成されたJICAへの技術協力要請のドラフト、但し保健大臣の承認待の状況）

IV-2.主要面会者リスト

在ラオス日本大使館

1．特命全権大使　　安藤茂実
2．参　事　官　　村田遥人
3．一等書記官　　長嶋仲治
4．一等書記官　　谷口宏文

WHO

1．Dr. Masato MUGITANI, External Relations Officer, WHO/Geneva
2．Dr. Katja JANOVSKY, Division of Strengthening Health Service, WHO/Geneva
3．Dr. Shigeru OMI, EPI/CDD Programme, WHO/Manila
4．Dr. Fereydoun AMINI, Acting Representative, WHO/Vientiane
5．Dr. Richard NESBIT, EPI/POLIO Programme, WHO/Vientiane

MINISTRY OF HEALTH

1．Prof. Vannareth RAJPHO, Vice Minister
2．Dr. Bovora CHOUNLAMOUNTRY, Chief of Cabinet
3．Dr. Ketsamay RAJPHANGTHONG, Coordinator of International Cooperation

UNICEF

1．Ms. Anne SUTHERLAND, Representative

UNDP

1．Ms. Ameera Hag-Perera, Resident Representative
2．Ms. Takeko IINUMA, Programme Officer

MAHOSOT HOSPITAL

1．Dr. Sommone PHOUNSAVATH, Director
2．Dr. Vithoune VISONNAVONG, Director of Opthalmology Department

MATERNAL AND CHILD HEALTH INSTITUTE

1．Dr. Khamphong KHAMHOUNG, Deputy Director
2．Dr. Semchanh XAISIDA, Chief of Health Education Section

COLLEGE OF HEALTH TECHNOLOGY

1．Dr. Tanoy SITHIRATH, Deputy Director
2．Dr. Khan OUTHEN, Deputy Director
3．Dr. Souphaline MANIPHON, Chief of Service Technico-Administration

UNIVERSITY OF MEDICAL SCIENCES

1. Dr.Khampienne PHILAVONG,Vice Rector of University of health sciences. Director of School of Public Health
2. Dr.Somboon PHOMTAVONG,Director of Academic affairs of School of Public Health
3. Dr.Khamtouane LUANGLATH,Lecturer oro dental surgery ,School of Dentistry
4. Dr.Outhip SOUNTHAVONG,Lecturer,Department of Pharmacognosy,Faculty of Pharmacy
5. Dr.Sang,Lecturer of Microbiology,Faculty of Medicine
6. Mr.Aroungnadeth SITHIPHAMH,Chief of Finance and Equipment

NATIONAL INSTITUTE OF HYGIENE AND EPIDEMIOLOGY

1. Dr.Sithat INSISIENGMAY,Director
2. Dr.Somthana DOUANGMALA,Deputy Director

MINISTRY OF EXTERNAL ECONOMIC RELATIONS

1. Dr.Bountheuang MOUNLASY,Deputy Director

SIDA

1. Mr.Rolf Torsten SAMUELSSON,First Secretary

J.O.C.V.

1. Mr.Mitsuo INAGAKI,Resident Representative

HEALTH SYSTEMS DEVELOPMENT IN LAO PDR: MAJOR PROBLEMS AND CURRENT ISSUES
Draft Notes

By any standards, Lao PDR has one of the most underdeveloped health systems in the world. Three major problem areas underlie many of the critical issues currently of concern to the Ministry of Health.

1 Lack of a policy framework for health

Health is afforded a low priority by national and local government in comparison with sectors concerned with production and defence. Within the health sector itself, there is little sense of purpose or priority. Instead, there is increasing confusion between the aims of hospital-oriented senior mangement in the Ministry of Health; managers of vertically run public health programmes based in separate institutes; and of provincial and district managers concerned to develop more integrated health systems. Despite publically stated support for PHC, there is no clear policy framework to support its implementation at provincial or district level. Utilisation is uniformly low and government facilities frequently operate in parallel with well-used private services. There is a perceived need in the Ministry for more focussed debate on health policy issues. But there is no effective forum where this can take place, and where resolutions can be linked to policy action. Key decisions affecting the sector tend to be taken at political levels of government, to which few technocrats have access.

2 Health financing

The principle of self-sufficiency for provinces and districts presently precludes any direct financial subsidy from central government. The low priority given to health, combined with the weak resource base of provincial and district administrations results in the sector being grossly underfunded. Although annual budgets have to be submitted to the provincial or district administrative committee, the overall scarcity of resources can make this a largely theoretical exercise. As health committees often receive no indication of the actual level of resources that will be made available to them, they cannot even plan the use of a restricted budget. To the extent that operating funds are available, about 90% are spent on salaries. However, in many districts, staff have not been paid for several years.

3 Human resource development for health

Lao PDR has a shortage of senior personnel with the experience and skills required for critical planning and management responsibilities. An equally serious problem is the number and orientation of more junior personnel. The

present system is geared to producing more personnel than the country can afford, and their clinically-oriented training fails to prepare them for the tasks they are required to do. Thus, we find large numbers of inadequately trained, inappropriately oriented health workers in poorly equipped and underutilised facilities. Because of lack of funds for fuel and per diems little outreach takes place. As salaries are not paid health workers have to spend time elsewhere making a livelihood.

Selected Current Issues

* **Equity and decentralisation in health systems development**

  Although in absolute terms, scarcity of resources affects the whole country, some provinces and districts are relatively better off than others. Without some provision for central subsidy, the development of health care is likely to become increasingly inequitable. So far there has been a tendency to direct projects and additional inputs to provinces that already have a basic health infrastructure. Ways of ensuring more equitable distribution of resources between provinces are currently being actively discussed by the central government.

* **Central support for salary costs**

  With the exception of the Municipality of Vientiane and a few other favoured areas, districts and provinces are unable to meet their commitments to pay staff salaries. There has, as a result, been increasing discussion about the need for central government support to pay salary costs. The resource implications of such a change are considerable, and it is not clear where the extra funds will come from. The Ministry is concerned not to increase the dependence of provinces on the centre unless absolutely necessary. It appears that the government is, however, prepared to accept donor support for salaries in health and other welfare sectors.

* **Health care financing: increasing operating costs**

  The Ministry of Health recognises that there is a need to increase the the availability of operating costs throughout the system. Casual observation suggests that a wide variety of informal income generating mechanisms, developed by health service staff, already exist. Experimental initiatives to explore the posssibility of cost-recovery are being developed as a part of NGO and other donor-assisted projects. On a larger scale, an insurance-based system for employed workers is being seriously considered, and fees for service for those that can afford to make payments, although not

yet formally accepted as government policy, are being widely discussed in the Ministry of Health.

There are, however, many difficulties to be overcome. When utilisation is so low, there is clearly a danger in introducing fees of any kind. It is argued that low utilisation is mainly a function of shortages of staff, equipment and drugs but even in well-resourced pilot districts patients are notably absent. The introduction of social security, for what will necessarily be a small proportion of the population, may result in scarce resources being drawn away from the state-funded sector. Finally, it is important to realise that the generation of income through fees will have only a marginal impact on the overall recurrent cost problems of the health sector.

* **Fragmented structures for human resource policy and planning**

There is an urgent need to match output, orientation and resources in preparing plans for the development of health personnel. But the structure of the Ministry of Health makes a holistic approach to the critical issue of human resource development extremely difficult. At the present stage in the Ministry's reorganisation, three of the four vice-ministers have responsibility for different aspects of personnel policy. The School of Public Health and other training schools relate to one vice-minister; a second is responsible for personnel management issues; and all public health programmes and Institutes, which have a major role in-service training, report to a third vice-minister. The Division responsible for health services financing reports directly to the Minister of Health. There is no overall body concerned with coordinating HRH policy and planning. Despite the problem at central level, provinces may in initiate remedial action in consulation with the Ministry of Health. For example, the Health Committee of the Municipality of Vientiane has started to reduce the number of staff employed in some districts and have agreed that, in future, new staff will be taken only to replace those leaving.

* **Relationship with the private sector**

In many parts of the country private pharmacies are the major source of medical care -- even in situations where government facilities are relatively well supplied. Government is now concerned to prepare legislation which will restrict the operation of the private sector, with the aim of reducing the risk of treatment by unqualified personnel, and preventing the use of illegally imported drugs. It is clear, however, that the effective enforcment of such legislation will be difficult. The private sector presently fulfils a demand for personal medical care, which the government has limited capacity to meet. Collaboration, with a view to improving the quality, controlling the charges and even sharing the income of private facilities, may be a better strategy than ineffective regulation. Strategies to this

effect are currently being implented in some communes of Vientiane Province.

* **Development of planning and management capacity**

District and provincial personnel have limited experience of planning or management. In-service management training courses provide them with basic concepts and techniques, but the health system as it presently operates provides little reason to plan and few resources to actually manage. Although they are likely to have limited impact, strategies based on institution-based training alone account for the majority of efforts to develop health management. As a result of management training courses district health committees have started to collect more data. It tends, however, to be information collected for its own sake rather than for the planning or management of services. The Strengthening Health Management Programme is the first initiative to combine management development workshops with the provision of operating funds for implementing short-term plans developed by district and provincial management teams.

Cassels/Janovsky
July 1990

IV-4.

IMPLEMENTING PRIMARY HEALTH CARE IN LAOS:

Trends, Issues and Options

Dr Andrew Cassels[1]
and
Dr Katja Janovsky[2]

November 1989

---

1 WHO Consultant and Senior Lecturer, Liverpool School of Tropical Medicine, UK

2 Scientist, District Health Systems Group, Division of Strengthening Health Services, World Health Organization, Geneva.

1 INTRODUCTION

The stated policy of the Ministry of Health and Social Welfare in Lao PDR places strong emphasis on the development of viable district health systems in order to facilitate the implementation of Primary Health Care. But at this time, there is no accepted common framework within which different strategies for strengthening districts can be carefully considered, adopted and coordinated. The absence of such a framework has become of critical concern. Many non-governmental agencies have had to decide on their approach to Primary Health Care and to district development without adequate ministerial guidance on technical or organisational issues, while the Ministry has tended to react to diverse offers for support rather than taking an active lead in determining what is required to implement its policies.

It is hoped that this paper will contribute to the development of an acceptable framework which can guide different programmes and agencies in health development towards effective and sustainable action. Toward this end, the paper aims to

- present a preliminary analysis of current trends in the health sector in Laos,
- review major strategic issues, and
- outline possible options for addressing these issues.

In reviewing and developing strategic options, the paper builds on the deliberations of the National Meeting on Strengthening District Health Systems which took place at Thalat in October 1989. The objective of that meeting was to discuss issues in the implementation of Primary Health Care in Laos, to explore strategies for improving the functioning of districts, and to identify ways and means for more effective coordination of inputs and activities.

This paper is organized as follows. After the introduction, an analysis of the situation, covering the historical, socio-economic and organisational context of Primary Health Care development as well as current trends in health policy and implementation, is presented. The next section deals with the major issues addressed at Thalat, followed by an outline of different strategic options. The last section very briefly outlines the next steps in the development of a strategic framework for strengthening district health systems in Laos.

2 SITUATION ANALYSIS

2.1. Economic Situation

Following the proclamation of the Lao People's Democratic Republic in 1975, measures were introduced to establish a socialist system of production, to encourage the formation of co-operatives, and to adopt a centralised form of economic planning. Despite only modest growth in the industrial sector during the next ten years, rice production doubled and the Government's primary goal of food self-sufficiency was largely achieved.

With a population of less than 4 million, a large land area, rich in agricultural, forest, mineral and power resources, the potential exists for rapid economic growth. At present, however, Lao PDR remains one of the least developed countries in the Region and in the world[3]. Its economy, based largely on agriculture and the export of hydro-electric power, remains highly vulnerable, as was demonstrated by the impact on economic growth of the 1987 drought. As a land-locked country, Lao PDR is also dependent on co-operation with its neighbours. In this respect, it clearly stands to benefit from the increased political stability of the Indo-China Region and the renewed friendly relationship with Thailand. Future development requires that a number of inter-related constraints be addressed: the continuing under-exploitation of the agricultural and forestry sector; the need for a stronger export base to overcome the low level of foreign exchange earnings; the poor state of transport and communications; and the lack of skilled personnel.

The New Economic Management System (NEMS) introduced by the Government in 1986, aimed to stimulate more rapid and sustained growth. The reforms reflect an attempt to liberalise the economy by the adoption of a more market-oriented approach to development; increased involvement of the private sector; a more flexible system of indicative planning; and decentralised economic management. As part of NEMS, the structure of the Government itself has been reorganised to reflect greater decentralisation of decision-making power, and greater responsibility has been given to the provincial and district governments. Since 1987, for example, provincial governments have assumed full responsibility for the administration of health and education services.

[3] GNP per capita estimated US$ 156 in 1987 (World Bank)

It is clear that Lao PDR will not be able to eliminate the continuing deficit in its balance-of-payments in the short or medium-term and will, therefore, remain dependant on continuing aid flows, at highly concessional rates. The need to focus on the productive sectors of the economy, however, must be balanced by social sector investment. At the recent Round Table Meeting in May 1989, it was suggested that support to health and education should be substantially increased.

2.2. Health Sector Overview

Despite efforts made since 1975 to improve the general situation, the health system in Lao PDR remains seriously under-developed. National estimates for Infant Mortality Rate vary considerably (between 100-150/1000 live births), depending on the source consulted. Although the quality of available data is poor, two important trends can nevertheless be detected. Firstly, IMR has declined very slowly over the last 25 years, in contrast to other countries in South East Asia. Secondly, mortality rates vary enormously in different parts of the country. Estimates of IMR pf up to 290/1000 live births have been quoted for remote rural areas, compared to 50/1000 in Vientiane.

High rates of mortality are matched by high fertility rates (Crude Birth Rate 42/1000) and the population growth rate is estimated at 2.4%.

Reliable information on health and nutritional status is scarce and mainly derived from facility-based data. Malaria, diarrhoeal disease and respiratory infections are reported as the most important causes of morbidity and mortality. Seasonal epidemics of dengue fever are associated with an increasingly high case fatality rate. Endemic goitre and associated cretinism is common in the north of the country. Immunisation rates, especially in areas distant from the main rural centres are very low.

Poor health status and weak infrastructure are partially a symptom of the country's overall economic situation, but are due also to underfinancing of the health sector during the past decade. Health development expenditures, as a proportion of total development expenditure, have fallen during the current Five-Year-Plan. Recurrent spending on a constant per capita basis has remained unchanged -- during a period in which the number of health personnel employed has increased substantially.

The health care system in Lao PDR has been subject to several different influences. The basic structure is that inherited from the colonial period. Personal medical care is provided through a network of provincial and district hospitals and separate, vertically-organised programmes are responsible for public health services. In this system, the Ministry of Health is primarily concerned with the management of curative facilities, and is supported by specialised public health institutes. Many of the developments of the last few years have been consistent with this structure. The Ministry continues to give priority to hospital development; the Institute of Malaria and Parasitic Diseases has been strengthened and has its own network of antimalarial field stations; EPI has been established as a centrally-controlled vertical programme; and a new MCH institute, separate from the MoHSW has been proposed. This vertical structure continues at Provincial level where programme officers work on specific disease control and public health interventions. Provincial support to the district, to the extent it is provided at all, is organized along the same lines.

The other major influences on the health system have been the Government's support for a policy based on Primary Health Care and, more recently, the introduction of the New Economic Management System, which gives greater autonomy to Provincial and District governments. These changes, which have important implications for the orientation of the system as a whole, have been superimposed on existing structures, resulting in a health care system that lacks internal coherence.

The effective implementation of Primary Health Care requires, for example, not only that more village-level workers be deployed and more dispensaries be opened, but also that management systems be in place to support them. It requires also that training of staff be geared to community health rather than personal medical care. To date, the basic system-wide changes needed if Primary Health Care is to take root in a form other than just an expanded series of intervention-specific vertical programmes, have not been made.

Decentralization was introduced primarily as a strategy to stimulate economic growth as well as popular participation and self-reliance. It also has profound implications for the planning, management and financing of the social sector. But the extent and nature of decision-making power at central, provincial and district-level in relation to health care has not been sufficiently clarified. The respective roles and responsibilities of the Ministry of Health and Social Welfare, the vertical programmes and provincial governments for providing material and

technical support to districts in a decentralised system have yet to be fully institutionalised.

The central Ministry of Health is caught in a vicious circle which reinforces its weakness in strategic planning and in providing guidance. Despite decentralization, many public health interventions are directed from the centre. However, responsibility for these management-intensive programmes lies mainly with specialised institutes. Thus, efforts to improve health sector performance are organised by vertical programmes or, alternatively, directly at field level, rather than through the Ministry. It is not yet clear to what extent the current re-organisation is likely to remedy this situation.

The apparent complexity and incoherence of the health system in Lao PDR can thus be explained, to some extent, by the fact that major new policy initiatives (Primary Health Care) and fundamental administrative changes (decentralisation) have been accommodated, without changing the basic structural orientation of the system. Although the focus of this paper is on strategies to strengthen the districts, this analysis demonstrates the need for a system-wide overview of health systems development in Lao PDR if further fragmentation is to be avoided.

2.3. Current Trends in Health Systems Development

This section of the paper is based on available documentation, field visits, observations and discussions with a wide range of government and aid agency personnel in Lao PDR. It is presented as a series of trends or themes, which seem important in describing and understanding the health system as it presently functions in Lao PDR. Many of the problems which are identified are clearly inter-related.

The underlying issues that emerged from this preliminary analysis formed the basis for discussions at the National Meeting on Strengthening District Health Systems which took place at Thalat in October 1989. These issues are summarised in the form of problem statements in the next section.

- **Donor-led development**

In the absence of an overall policy framework to guide health sector development, the Ministry of Health and Social Welfare has tended to adopt a reactive stance to offers of support. The result is that donor assistance has sometimes been accepted without a full assessment of whether it addresses priority needs, or an analysis of its full organisational or resource implications. This issue is particularly important in relation to some facility construction and to the provision of pharmaceuticals. The needs of many donor agencies (for visible outputs and rapid disbursement of funds) do not always coincide with the needs of governments to build sustainable systems. At the same time, the needs of politicians and doctors to start improving the health system with curative services do not correspond with the priorities set at Alma Ata.

Non-Governmental Organisations (NGOs) active in Primary Health Care have responded to the current situation by forming their own coordinating group to review and discuss their strategies for community-oriented health care. In the donor community, UNDP has been taking the lead in the dialogue with government on development policy and in coordinating the activities of bilateral and multilateral agencies. Clearly, with the number of donors to the health sector increasing, as is probable in the current political and economic climate, the need for the Ministry to take the lead in defining priorities for health care development will also increase.

- **Emphasis on pilot projects**

Several Primary Health Care pilot projects have been started in different parts of the country. There would appear to be a danger, however, that these pilots have become less a way of learning how to overcome operational problems, and more a way of concentrating limited resources. Although programme documents refer to pilot districts, in reality, activities are often focussed on a few communes or villages. There is little evidence that current pilot projects are addressing the issues of district-wide systems development.

If sufficient resources are available, if appropriate training, supervision and logistic support are provided, the implementation of Primary Health Care can be effective. This is not in doubt. What is more difficult is to

determine how to provide adequate resources, how to reorient basic and in-service training, and how to develop appropriate managerial and supervisory systems, given the existing organisational, financial and political structures which determine what is possible on a nation-wide scale. Many pilot projects appear to avoid rather than answer these questions.

- **Facility construction as the starting point for district health systems development**

The Ministry of Health and Social Welfare attaches a high priority to the construction and rehabilitation of district hospitals. This is seen as an essential first step in strengthening (or in some cases, starting) district health systems. Although a credible curative and referral service is an essential part of the health system, the opportunity costs of the present strategy are considerable. This is true not just because of its financial implications (particularly in terms of the resources that will be required to meet recurrent costs), but because of the effect on the training and distribution of health manpower. Training of medical and paramedical staff is biased virtually totally toward curative care. The current orientation of hospitals -- which absorb the majority of trained staff - is almost exclusively curative and static in nature. Hospitals also receive the largest share of the health budget, and low levels of utilisation imply inefficient use of these resources. The limited use of existing hospital services would suggest that there is a need to consider both complementary and alternative strategies for strengthening district health systems.

- **Health manpower development**

At present, the schools charged with training medical assistants and auxiliary nurses -- the two most important paramedical cadres for staffing district hospitals and dispensaries -- have continued to produce new graduates every year without any reference to national or local requirements. An implicit assumption in the current approach to planning human resources is that more trained workers are needed. However, initial evidence would suggest that the problem is not one of quantity, but rather one of orientation and quality of existing staff.

The curriculum for medical assistants has remained much the same since French colonial times, while the training of auxiliary nurses has no set curriculum. For each cadre, the teaching of public health and PHC occupies just a small fraction of the total curriculum, which otherwise concentrates on clinical tasks performed in institutions. Donor assistance has so far failed to demonstrate a holistic approach to the problems of human resource development.

♦ **Health systems at provincial, district and sub-district level**

Although districts are supposed to be financially independent, the Province should provide technical support, supervision and guidance to the districts. At present, it is unclear to what extent the province actually fulfills this role. Even though provincial staff have been involved in the implementation of special pilot projects, little attention has been paid to *developing province-wide management or supervisory systems.*

Despite district health systems becoming the focus of attention, there is actually very little actually going on below the district level. As previously noted, most resources are concentrated in the district hospital. It is widely reported that many of the dispensaries enumerated in lists of district facilitaties do not function. Even if their training equipped them for the job, nursing auxiliaries and medical assistants that do get posted to dispensaries are poorly supplied and rarely supervised. The terrain in many parts of Lao PDR makes regular visits to dispensaries very difficult. Only specific events, such as reported epidemics, bring about intensive but short-lived outreach efforts.

Considering the size of provinces (on average about 200,000 population) and of districts (ranging from 20,000 to 40,000 outside of Vientiane Municipality) as well as the crucial role of the province in support of the district, it could be argued that the first line of intervention to strengthen the intermediate level should be the province, not the district.

♦ Resource allocation

District and provincial governments, whose primary concern is to increase their resource base, tend to afford a low priority to the health sector. At

present, recurrent budgets are largely consumed by salary payments, but even if funding increased, it is likely that the needs of the district hospital will predominate.

Under the present system, districts are dependent on locally raised resources for funding health care activities, including the payment of all salaries. Other than in exceptional circumstances, support from the province is limited to supplies and equipment. Even in districts with a relatively well-developed tax base, large deficits are reported. When funds are inadequate to even meet salary payments, there is little incentive to devote time and energy to preparing plans. Not surprisingly, district staff see planning as a largely theoretical exercise.

The extent to which the central government provides financial support to less developed districts is not clear. Without some form of subsidy, however, there is a danger that inequity in the provision of health care will increase with decentralisation.

♦ **Decentralization**

The principle of self-sufficiency of provincial and district governments appears to be widely accepted. As noted above, however, the extent of decision-making power at each level, and the responsibilities of the centre and province in support of the district are far from clear.

There is a need for the Ministry to establish operational policies and to initiate the preparation of procedures to guide the work of district and provincial management teams. Even in a decentralised system, these teams need essential support systems and services which will remain the responsibility of the centre.

Decentralisation is considered an important condition for Primary Health Care to be implemented. This is particularly true for fostering community involvement in health. However, evidence from a number of countries suggests that decentralization often deepens the curative bias, with the felt need of the population for curative services and drugs, and the concern of local administrations to meet these needs.

At present there is no convincing working model of an alternative to hospital-based care (despite the many pilot projects) and administrators recognise the political importance of curative over preventive services.

The problem is that the only way of redressing the balance will be to depend increasingly on donor-funded, centrally-managed vertical programmes. Unless carefully controlled by the Ministry of Health, this may have the effect of reducing the potential autonomy of the district, and increase dependance on external funds.

- **Low utilisation of public sector health facilities**

Many government health facilities, particularly those at village and commune level, are grossly under-utilised. It is reported that this is due to inadequate supply of drugs. By contrast, private retailers of both traditional and modern remedies are conducting thriving businesses.

If under-utilisation is only a function of scarcity of supplies, then measures to increase the availability of drugs are likely to improve the situation. This can most easily be effected by implementing a system of user-charges, to provide an income with which supplies can be replenished. Given the scarcity of resources for health care at district level, this is a much discussed option. There is a danger, however, that the therapeutic reputation of public sector facilities is so low that introducing charges will decrease utilisation even further.

It will, therefore, be necessary to investigate the nature and structure of demand for health care more fully. Although a proportion of the population is prepared to pay for treatment in the private and in the traditional sector, the relative size of this proportion is unclear. So too is the extent to which people will be prepared to pay for services provided by the public sector.

- Vertical projects

The problem of ensuring that adequate resources and managerial attention are devoted to priority public health programmes, particularly in an under-resourced decentralised system, has already been referred to above. In Lao

PDR, malaria receives first priority in national disease control programmes. A recent document illustrates a problem which is likely to increase, when it states on one hand that "emphasis has been given to the development of malaria control as a part of primary health care through active and continuous involvement of the community..." It then goes on to say that "effective implementation .... has been hampered by lack of logistic support..." and that there is therefore a need "to strengthen the organisational structure of the Institute of Malaria and Parasitic Diseases".

As other priority interventions are identified either by the Ministry or, as is more often the case, by donors, so it is likely that additional vertical programmes will be formed. EPI is already organised in this way. It is felt that MCH will benefit if it comes under the control of a separate institute.

Although effective in ensuring the financial and managerial viability of programmes in the short-term, separate vertical programmes tend to take on a organisational life of their own. Evidence from other countries has shown that integration is likely to be hampered by the reluctance of project staff to surrender control over budgets or personnel. The Ministry of Health will need to ensure that vertically-organised management systems do not prejudice the development of effective management systems at district and provincial level for an integrated approach to PHC.

- **Scarcity of health status information**

Most published information on health needs and health status in Lao PDR is derived from facility-based data. Given the level of utilisation of government facilities, the reliability of these data must be limited. The level of socio-economic development in Lao PDR is such that the existence and magnitude of many health problems can be predicted with some confidence.

However, a review of available documents raises a number of specific questions relevant to health strategy development. To what extent, for example, is the emphasis given to epidemic control in present national health strategies actually justified? Are these not seasonal fluctuations of endemic diseases for which preventive measures are available? The term "epidemic" favours the campaign-style control strategy, whereas a more

sustained and systematic approach to behavioural change and disease prevention may be more appropriate. The achievement of self-sufficiency in food production should be reflected in improved childhood nutritional status. Is this in fact the case? If not, does it raise questions of resource distribution or nutrition education?

There is an obvious need for better information on health problems, health status and health-related practices, requiring population-based data systems. There is also a need for improving the monitoring and evaluation of ongoing pilot projects in order to assess lessons learned from the experience of these projects. However, in deciding on priorities in the development of information systems, it will be important to recognize that decisions concerning the allocation of resources, distribution of staff and contents of training curricula are likely to continue to be made on the basis of several factors of which objective epidemiological information is only one.

3 KEY ISSUES AND OPTIONS

The preceding section raises many questions concerning the implementation of Primary Health Care in Lao PDR. Three underlying areas of concern emerge from this preliminary analysis, and these formed the basis of discussions at the Thalat Meeting on Strengthening District Health Systems in October 1989.

The three areas of concern -- organisation, resource allocation and human resource development -- are used in this section of the paper to summarize key problems and briefly review some ways in which they might be addressed. The options for action presented here are largely those proposed at Thalat, and the list is by no means exhaustive. These activities represent a series of closely-related initial steps towards the development of a coherent approach to the implementation of Primary Health Care in Laos.

3.1. Implementation Planning: Organisation, Coordination, and Information

Problems

* The extent of decision-making power at each level and the responsibilities of the centre and province in support of the district are not clear. Decentralization has left many districts without proper support and guidance.

* There is little coordination or integration between the different elements of the health care system: hospital and outreach services; public and private sector; government and non-government programmes; traditional and modern systems. Of particular concern for the development of overall provincial and district management systems is the degree to which vertical programmes dominate activities in the health sector.

* Monitoring and evaluation of activities and projects is inadequate and essential information required for planning and management is often not available. Population-based data on health status and health needs is not available, and routine health and management information systems do not function effectively.

Actions Proposed

1 A national meeting should be held to discuss and clarify the roles and responsibilities of province and district. Such a meeting is only likely to be useful, however, if considerable preparatory work would be done. Such preparations would need to include the production of working papers which outline specific issues and problems as well as concrete suggestions for addressing them.

2 Following such a national meeting, detailed guidelines regarding organisation at district and provincial level should be prepared and distributed to all concerned.

3 The role of the district hospital needs to be re-examined and several options considered. The first of these is to expand the work of the hospital to encompass not only curative services and static MCH work, but also outreach, supportive supervision and continuing education. Towards this end, it is suggested to integrate hospital and health office activities. Another option is to strengthen the district health office by transferring resources and under-utilized personnel from the hospital to the health office. This option will require the development of sound channels of communication between the health office and the hospital under the guidance of the District Medical Officer.

4 A review of information needs at provincial level should be carried out with a view to establishing an improved health and management information system which can be linked to the decisions to be made at this level. Such an information system might include a programme of population-based surveys in order to improve data about actual health conditions and needs in the country.

5 Monitoring and evaluation systems should be set up to ensure that lessons learned from pilot projects are effectively disseminated, and that the experiences of non-pilot districts are also reviewed. Future pilot projects should address clearly defined operational problems and be linked to the planning of nation-wide strategies from the outset.

3.2. Economics: Resource Allocation, Financial Management and Financing

Problems

* Health is a low priority in the overall allocation of government budgets.

* Hospitals consume most of the available resources.

* Salaries consume most of the available recurrent budget

* District medical officers and district health committees lack knowledge and skills in financial planning and management.

* Overall policy regarding charges for drugs and services is unclear.

* The supply of inappropriate types and quantities of drugs, many labelled in unfamiliar languages, results in a serious waste of resources.

Actions Proposed

1 Health should be promoted as an investment in support of productive sectors in order to attract more funding at all levels.

2 Consideration should be given to reducing staffing levels in general, and in hospitals in particular (see also below). A reduction in numbers of health personnel would have a positive effect on availability of funds to pay workers in post and to finance other non-salary recurrent costs.

3 A variety of community financing schemes should be tested and critically evaluated with a view to contributing to the development of a national strategy for health care financing. However, if the population is going to be asked to financially contribute to health services, then there is a need to improve the quality of services and to find ways of involving communities in decision-making.

4 A comprehensive drug management programme, in line with the National Essential Drug Policy, should be established in order to develop a unified system for selection, quantification, procurement, distribution and use of essential medicines.

3.3. Human Resource Development: Manpower Policy, Planning and Training

Problems

* The major problem is not that there are insufficient health workers. Rather, those in post are inadequately trained and inappropriately oriented.

* The basic training curriculum of medical assistants and auxiliary nurses does not provide the necessary skills for implementing Primary Health Care.

* Continuing education and supervision are inadequate.

* Job descriptions of most health workers are either unclear or non-existent.

Actions Proposed

1 A manpower plan should be drawn up to determine feasible staffing patterns for the implementation of Primary Health Care in districts. The financial implications of such a plan need to be carefully considered to ensure that health workers in post not only to obtain their salary but also have a budget for supplies, maintenance and outreach activitiies.

2 Government should review the present deployment of different cadres of health workers in view of its stated PHC policy as well as its budgetary limitations. Consideration should be given to both, cutting down staff numbers and redeploying staff from cities and hospitals to PHC facilities in rural areas. A temporary moratorium on basic training should also be considered.

3 The basic training curricula of medical assistants and auxilliary nurses should be reviewed and substantially revised to reflect the required tasks of health workers in the district. Re-training of trainers and tutors will need to be an integral part of this proprosed re-orientation of basic training towards Primary Health Care.

4 There is a need to ensure that continuing education and refresher training is coordinated, and not provided separately through each individual vertical programme. Coordination of in-service training could become the responsibility of the Provincial Health Office.

5 At provincial and district level, job descriptions need to be either reviewed or newly prepared to ensure that all staff are fully aware of their and their colleagues duties and to promote the development of integrated team work schedules.

4 NEXT STEPS

The problems identified in this paper cannot be addressed in isolation. They are closely related. A change in one aspect of the health care system will affect its other component parts. A decision to embark on a major hospital construction programme, for example, will have serious implications for health sector financing, manpower development, information systems, and so forth. To date, many initiatives in the health sector in Lao PDR have either tried to deal with system-wide issues in the relative isolation of pilot projects, or been implemented without due regard for their effect on the system as a whole. There is an urgent need for a more holistic view.

The previous section has outlined a number of steps that will contribute to the development of a more coherent approach to Primary Health Care implementation. By setting out these steps in one document, the important relationships between the different parts of the health system can be more easily appreciated. There is still a need, however, for broader strategic decisions to be made: by the Government of Lao PDR in relation to the priority to be given to the health sector; and by the Ministry of Health in relation to the overall approach to health care development. Of immediate concern, in this respect, is the role of the Ministry of Health itself. Unless there exists the capacity at the central level to develop a strategic framework to guide Primary Health Care Implementation, it is likely that the fragmented project-by-project approach, in which individual donors' priorities can override local needs, will persist.

IV-5.フランス・WHO対ラオス協力合同調査団報告書

1991年2月16日

期間；1991年2月10日から2月17日まで

調査団の構成；

（フランス）

・ジャン・クロード　ルクレルク医師（仏外務省　開発協力局）

・アラン　ティオリエ氏（在ビエンチアン　フランス大使館　国際協力顧問）

（WHO）

・ロバート　カミング医師（ジュネーブICO）

・A.ロムアルデス医師（マニラ地域事務所）

・ズィア　ウル　イスラム医師（WHOラオス代表）

面談者；	厚生大臣	Son. Excellance M. Kambou Sounixay
	副大臣	Pr. Vannareth Rajpho
	医師・対外責任者	Dr. Bovara Chounlamany
	その他の厚生省職員	
	対外経済関係省副大臣	M. Kitthong Vongxay
	ユニセフ代表	
	スウェーデン大使	
	オーストラリア大使	
	複数のNGO	

見学先；　医療センター（ヴィエンチャン）

訓練センター（ヴィエンチャン）

地方（地方都市とその周辺での衛生状態が一般的にどの程度かの印象をつかむため。）

保健医療分野の基礎的な困難に立ち向かう姿勢はできているが、保健医療システムのいろいろな段階でかなり深刻な欠点が存在している。

この弱点は特に、計画、組織、管理、経済分析、人材養成にかかわる点において顕著である。

事実上、調査は短期間で行われたため、プロジェクトの細かい点にかかわる話までは至らなかった。

最優先と思われる課題、またフランス・WHOによる援助にもっともふさわしいと思われる課題がいくつか出された。

調査の終わりに保健省の代表者達と検討したこれらの提案事項は同意を得るために保健大臣にゆだねられることになる。保健大臣は、協力の具体化に責任を持つことになる。

提案事項は以下の通り

1. 人材養成

目的； Institution buildingの観点から保健省を援助する。（人材養成促進という国策の実現に資する）

以下の事項を考慮に入れるべきである。

・保健衛生に関する仕事をすべてのレベルで明確に文書化する。

・人材の必要な部門をはっきりさせる。

・レベル別の採用基準を定義づける。

・それぞれの部門で要求される人員の数（経済的な可能性と、どう使いこなすか）

・ラオス及び他の国々におけるいろいろな人材養成システムを調査する。

人材のリストと器具、設備の目録が必要であり、その調査は全国17の地方で合同に行われるべきである。

同じように保健衛生関係の仕事全体において、組織（仕事の手順も含む）の洗い直しも考慮されるべきである。

計画；

（保健省）

評価促進室（Use cellule d'animation et d'evaluation）の設置、人材の合理化と活用政策を推進してゆく

期限のきめられたプログラムを使い、また年間実績をもとに計画をたてる。

公衆衛生学校、保健技術職業学校のような専門学校等が重要な役割を演ずるべきである

（フランス・WHO）

技術面、財政面で評価促進室を援助する。つまり評価促進室が決定した事項につき相談役になり、訓練を助け、財政を支えるということである。他国における研修も考えられている。

2. 保健省における計画経済と構造

目的； 中央クラスにおける保健省の能力の強化（計画経済、組織、経営分析等政府に選択による）

既存のまた潜在的な手段に寄りかかりながらも、国家的優先事項という現実的支点から、国の保健医療政策を増強してゆくべきである。

ひとつの国家的政策が存在するということは、結果的に、外からの援助を秩序立てる能力を強める事になる。

計画； 実際に今ある部門（計画経済部門、財政管理）の強化。
これにより財政面の見積もりが可能になる。

（フランス・WHO）

以下の部門における必要に従い、技術、資金協力を行う

・コンサルタント及び／または2ヵ月から4ヵ月期間での技術援助、研究所及び工場形態での援助さらにそれを支援する業務

（その他の援助団体）

・国家計画によるプロジェクトの統合は評価される。統合されることによりいくつかのNGOは医薬品分野で根本的に回復した

各活動のはっきりした内容は保健省により用意される書類に記載される予定である。フランス、WHO、ラオス保健省の資金分担については、この書類の引渡しの後に決定される。

IV-6.

Project Proposal for

the JICA project-type technical cooperation

"Community health development project"

Requested by
LAO-PDR Ministry of Health

Table of content

1. Summary of the requested project.
1-1. General objective
1-2. Main Activities
1-3. Duration
1-4. Responsible organization

2. Current situation of health development in LAO-PDR and justification of the project.
2-1. Introduction.
2-2. Health status
2-3. Health resources
2-4. Justification of the project

3. Project content
3-1. Overall Goal
3-2. Project purpose
3-3. Output of the project activities
3-4. Main Activities
3-5. Asumptions
3-6. Monitoring and Evaluation

4. Assistance requested by JICA
4-1. Dispatch of Japanese expert
4-2. Training of LAO health personnel
4-3. Equipment assistance
4-4. Technical supporting system in Japan

5. Administration and coordination committee of the project
6. Tentative time schedule of the project

1. Summary of the project

1-1 General objective;

To develop the provincial health system in order to manage important health program such as EPI which can contribute the health status of the LAO people.

1-2 Main activities;

1) Strengthening the PHC oriented provincial health service system
2) Strengthening the management system of integrating EPI into the provincial health service system
3)Promotion of information, education and communication at provincial level so as to increase the coverage of EPI.
4) Promoting intersectoral collaboration between Ministry of Health and various kind of organization such as women's union, youth goup, educational sector and others at provincial level.
5) Promotion of training of the health personnel in the field of health management such as EPI management

Duration;
November 1991 to December 1996

Target Area;
Initial Province; Savannakhet Province
After project team becomes accustomed, it is expected to extend to other provinces such as Khammouane and Northern part of LAOS.

Responsible organization;
Ministry of Health, LAO-PDR.
(1) NIHE(National Institute of Hygiene and Epidemiology), Ministry of Health, LAO-PDR
(2) Savannakhet Provincial Health Office
Other implemented provincial health offices

2. Current situation of health development in LAO-PDR and justification of the project.

2-1. Introduction.

Lao People's Democratic Republic(LAO-PDR) is a land-locked country in South-East Asia, bordered by China, Burma, Thailand, Cambodia and Vietnam. It covers an estimated area of 236,300 km2, And had estimated population of 4,17 million in 1990. Most of the population live in rural areas(85 % of total population) where communications particularily in rainy season are very difficult between villages and districts.

The country is divided into 17 provinces, including Vientiane Municipality. There are 121 districts, 852 communes and 11,374 villages. Provinces are administratively decentralized and each province decides on its own priorities, manpower and budget based on the availability of local resources.

2-2. Health status

Basic Health Indicators

Indicator	Value	Year
Crude birth rate	47 per 1,000	(1988)
Crude dealth rate	18 per 1,000	(1988)
Number of live births per year	179,400	(1988)
Infant Mortality rate(Live births)	104 per 1,000	(1988)
Under 5 Mortality rate	193 per 1,000	(1985)
Population growth rate	2.9 %	
Population under 15 years	43.2 %	
Populaton over 65 years	2.9 %	
Life expectancy	45 years	(1988)
GNP per capta	180 US$	(1989)

Table 1987 MORBIDITY RATE PER 100,000

Disease	Rate
Acute Respitatory Infections (probably including undiagnosed EPI diseases)	5,386/100,000
Diarrheal Diseases	3,725/100,000
Maralia	3,289/100,000
Dengue Hemorrhagic Fever	560/100,000
Hepatitis	370/100,000
Tuberculosis	195/100,000
Measles	145/100,000
Meningitis	60/100,000
Pertussis	55/100,000
Trachoma	44/100,000

The three main morbidity causes in 1987 for communicable diseases reported by WHO survey in 1987. It is believed that acute respiratory infections include certain number of vaccine-preventablethrough EPI programme. Because EPI programme covers so few children, diseases such as measles, tetanus, polio, diphteria and wooping cough are very prevalent.

EPI Target diseases

There is no reliable surveillance system to provide data on morbidity and mortality from the EPI target diseases in the country. The recent instituted sentinel surveillance system provides information on hospitalized cases from several major urban centres.

Number of reported cases of EPI Target Diseaes (1982-1990), Lao-PDR

Year	Diphteria	Measles	Pertussis	Polio	Total Tetanus	Neonatal Tetanus	Tbe
1982	813	383	396	46	454	-	4706
83	64	1076	652	24	233	-	4700
84	37	924	1813	13	31	-	6528
85	23	1492	2881	523	88	-	4258
86	37	1367	286	182	43	-	1514
87	189	2580	980	480	37	-	3458
88	23	1418	2523	228	32	-	5783
89	14	2793	271	91	44	-	2952
90	9	2168	855	18	27	4	2087

2-3. Health resources

Ministry of Health provides the overall guideance for the health services, although provinces are administratively decentralized with each provinces deciding its own health priorities, manpower and budget based on the availability of local resources.

EPI activities in LAO-PDR began in 1979 in some pilot districts. The programme in administered at the central level by the National Insitute of Hygiene and Epidemiology(NIHE), which serves as the national focal point.

Table
ESTIMATED IMMUNIZATION COVERAGE BASED ON ROUTINE REPORTS

Vaccine	1985	1986	1987	1988	1989	1990
OPV 3	4	5	10	17	22	30
DPT 3	4	5	10	17	21	21
BCG	8	10	15	27	29	31
MEASLES	6	10	11	19	18	29
TETANUS 2	2	4	6	5	4	11

2-4. Justification of the project

Support of the development and implementation of comprehensive PHC oriented health services in provincial level is very important in LAO-PDR.

Although PHC services cover the full range of preventive programmes and curative services(EPI,MCH,CDD,ARI,nutrition and others), EPI activities would be used to serve as the critical entry point to the improvement of health status in the target population and to effecting greater uptake of services.

Stepwise introduction of PHC components should be done. Once Provincial and District Health System established through EPI system development, this channel can be utilized for other PHC components step by step. Furthermore, EPI programme serve as a model for other vertical programme for the intergrating to provincial and district health systems so as to strengthen their quality of services and develop the comprehensive health system.

In this moment, EPI is selected because of the high priority by the LAO Ministry of Health. It also has the network among whole provionces and a lot of experiences working with international cooperation including JICA. EPI can reach the remote area and needs an efforts of mobile activities, community participation, logistical management skills. EPI programme is most cost-effecitve and can save a lot of lives in Laos acordings to the leading cause of death. Most important justification is that high EPI coverage was the first acheivement(OPV coverage becaome more than 80 %) and initial indicator in the project of PHC oriented District Health System development. Therefore, PHC oriented Provincial and District Health System development should be the main strategy of the EPI management as well as EPI can be the critical entry point to develop PHC oriented provincial health systems.

Concerning project area, geografical stepwise introduction (province by province) should be done. After the implementation of health programme in Laos for several years, national level is strengthened. At present, it is urgently necessary to strengthning mid-level(provincial and district level). In addition, it is very difficult to establish the cooperation among many vertical programme at central level so as to develop the integrated health system.

After Getting experiences in initial provinces to expend implemented province yearly is quite necesary. Feasibility survey to select next province should be done one year before. We should also have the activities of technical transfer(technical cooperation) among provinces. It extends the project results to whole country.

Criteria of the project area;
(1) Population
(2) Health service level such as EPI coverage
(3) Potential and capability of provincial conterparts
(4) Geografical position of the province in the whole country.
(5) Transportation (to Vientiane and other provinces)
(6) Security
(7) Electricity
(8) Not so much competitions with other organization.

Acordings to these criteria, Savannakhet province could be the initial province. The reason why is as follows;
It is most populated area (15.2 % of total population), # Immunization coverage is still below than national average (about 10 % for OPV3, DPT3),
Provincial staff has a potential. There is one good model of PHC oriented District Health System in Champhe which is very useful to learn so as to develop project strategies,
Geograficaly it is the central of southern part of Laos,
There are no competitor in the EPI field.

3. Project content

3-1. Overall goal
Health status of LAO people will become better
(Indicators & means)
Mortailty and morbidity of EPI disease

3-2. Project purpose
To develop the provincial health system in order to manage important health programme such as EPI which can contribute the health status of the LAO people.
(Indicators & means)
EPI immunization coverage by EPI surveillance system

3-3. Output of the project activities
1) People are willing to utilize the health services
(Indicators & means)
Trends in health service utilization by analysing registerd records of health services.

2) People can access to the health service more easilily
(Indicators & means)
Catchment(Covered) area retrospective analysis by health services record.

3) Provincial health personnel develop the skill of planning and monitoring so as to manage the health programme.
(Indicators & means)
Preparation of provincial and district action plans for EPI activities.
Collections and use of health information.

4)Provincial health services can provide high quality immunization technically.
(Indicators & means)
At random visit to observe management level of cold chain, vaccine, sterilizer and immunization technique.

5)Social mobilization by other sectors and community participation will be done to bring the target population to the immunization services.
(Indicators & means)
Observation of meeting with other sectors.
At random visit to selected communities for in-depth interview.

3-4. Main Activities
1) Strengthening the PHC oriented provincial health service system
2) Strengthening the management system of integrating EPI into the provincial health service system
3)Promotion of information, education and communication at provincial level so as to increase the coverage of EPI.
4) Promoting intersectoral collaboration between Ministry of Health and various kind of organization such as women's union, youth goup, educational sector and others at provincial level.
5) Promotion of training of the health personnel in the field of health management such as EPI management

3-5. Asumptions
(1) This project would be started in a limited geografical area of the country and special emphasis on EPI. However, results of the project could serves as a model. Thus, it contributes to extend PHC oriented health service system thoughout the country.
(2) To maximize the limited resources, the project should cooperate with other agencies. UN agency in Vientiane such as WHO and UNICEF are expected to support this project technically and logistically from the central level.
(3) Issues of sustainability, absorptive capacity and adequate suuport by Lao government for recurrent costs should be taken into consideration.
(4) JICA is expected to contact Technical Institute in Japan which can continuously dispatch Japanese experts to this project especially in the field of EPI management.
(5) Lao government will dispatch the counterparts for each Japanese experts for technical transfer.
(6) Lao government will arrange the project central office at NIHE and the project implementating office at provincial health office.
(7) Lao government will offer necessary permission of the travel inside Laos to the project team.
(8) For the convenience of the project, Lao government together with Savannakhet provincial authorities are requested to consider the permission of the border pass between Savannakhet-Mukdaham in Thai and other neseesary borders. Ministry of Health will request Ministry of Foregn affairs to issue the multiple entry visa for the experts in this project.

3-6. Monitoring and Evaluation

Monitoring, surveillance and evaluation would be an integral part of the project design. Because of the limited acuracy of exixting health information system, development of the health information system especially EPI surveillance system become one of the projects activities as well as the information source of indicators. Indicators for monitoring project performance and impact are shown above.

Yearly mornitorng, especially at the end of first year and Mid-term evaluation should be done by checking indicators and looking at the sutiation of the assumption.

4. Assistance requested to JICA

4-1. Dispatch of Japanese expert

Requested Japanese experts are as follows;

<1> Long-term experts;
1. Project Leader
2. Project Coordinator
3. Experts in the following fields:
 (1) Immunization Program(EPI) Management
 (2) PHC oriented health system development
 (3) IEC(Information, Education and Communication)
 (4) Epidemiology
 (5) Public Health Nurse
 (6) Equipment maintenance specialist

<2> Short-term experts;
 (1) Cold chain specialist
 (2) Vaccine/Laoratory specialist
 (3) Equipment repairment specialist
 (4) Computer specialist
 (5) Audio-visual specialist
 (6) Printing and Information specialist

<3> Volunteers (J.O.C.V.)

Foot note for job explanation

Since this project emphasize EPI activities, thus EPI management specialist should be the team leader.

It seems to be good if Thai public health personnel can work as JICA expert especially in the field of "PHC oriented health system development" because of their extensive PHC experiences and language ability.

IEC is expected to work in the field of social mobilization and social marketing for the promotion of the EPI and PHC program.

Epidemiologist is responsible for making effective health infromation system, especially EPI surveillance system.

Public health nurse should communicate women's organization which is very key group in this project. She is also expected to promote MCH activities for mothers at the village level.

Equipment maintenance specialist is quite necessary because of several experiences of formar EPI activites in LAOS which come from weakness of the local enterprise in this field.

Short-term experts mentioned above are very important to maintain high standard health service such as vaccine delivery.

Japanese volunteers are expected to be the core person of mobile health service team which is necessary to deliver health services to the remote area such as hill tribe area in north.

4-2. Training of LAO health personnel

<1> Training in Laos

Because of the shortage of skillful health manpower at mid-level(Provincial and district level), so many training program with the cooperation of Japanese experts are essential. Training in the JICA scheme of mid-level manpower training are expected to be done.

Example of the training course in Laos are;

1) EPI management for district health officer
2) Health information system such as EPI surveillance system
3) Skill development of health education
4)Health education for community leaders such as women's leaders, teachers, monks and others.
5) Cold chain maintenance training for district health officer
6) Others in the necessary field

<2> Training in Japan

JICA polio training course at Kumamoto is quite useful for learning EPI management.

Shor-term training in the field of (1)Health administration, (2)Epidemiology, (3) Infectious disase control, (4)Laboratory technique is also quite necessary.

Individual long-term training in the level of postgraduate would be desirable for further health manpower development and educational system of health personnel in LAOS.

Therefore, one person for each short-term training (It means 5 person per year),2 person for long-term training would be very desirable.

<3> Training in third country(Thailand)

JICA's training of Lao nursing staff in Thainad are very effective because of no language barrier and simillar socio-cultural background. It is expected that training in Thailand in this project is very necessary because of their successful PHC development and integration of EPI, MCH and other disase control program into PHC system.

JICA develop the well-known PHC training institute at Mahidol University in Bangkok and regional training center at Khon Kaen. Both of them now have effetive skill for training of Lao personel.

RDI(Research and development Institute), Khon Kaen University is also expected good resourse for training. Furthermore, To exchange the experience of JICA's new MCH/FP and community health project in Khon Kaen are quite useful.

5. Administration and coordination committee of the project operation

<1> Lao Ministry of Health

1) Prof. Vannareth RAJPHO
DEPUTY MINISTER OF MINISTRY OF HEALTH
(Chairman of the committee)

2) Dr. Bovora S. CHOUNLAMOUNTRI
DEPUTY DIRECTOR OF THE CABINET, MINISTRY OF HEALTH
(Vice chairman of the committee)

3) Dr. Somthana DOUANGMALA
DEPUTY DIRECTOR OF THE NATIONAL INSTITUTE OF HYGIENE AND EPIDEMIOLOGY
National EPI Manager of LAO-PDR
(Secretary of the committe and Project Manager at central level)

4) Dr.
PROVINCIAL CHIEF OF HEALTH DEPARTMENT IN SAVANNAKHET PROVINCE

5) Dr. Souphaxay DOUANGCHAKT
DEPUTY CHIEF OF PROVINCIAL HEALTH DEPARTMENT IN SAVANNAKHET PROVINCE responsible for PROVINCIAL PREVENTIVE MEDICINE including EPI and PHC
(Project Implementator at local level)

6)PROVINCIAL CHIEF HEALTH OFFICERS OF OTHER SELECTED PROVINCES

<2> Japanese side
1) Japanese Team Leader
2) Japanese Project Coordinator
Both of them will cooperate with Lao counterparts mentioned above both in central and local level

Prepareed by ;
Working Group for JICA Project Proposal

Somthana DOUANGMALA
Boun Pheng PHILAVONG
National Institute of Hygine and Epidemiology
Ministry of Health
LAO-PDR

Revised by;

Dr. Bovora S. CHOUNLAMOUTRY
Deputy Director of the Cabinet

Approved by ;

....

Prof. Vannareth RAJPHO
Deputy Minister of Ministry of Health
LAO-PDR

JICA