CHAPTER 21
FRAMEWORK FOR DRUGS

21.1 INTRODUCTION

The framework for drugs cover the following aspects:

- Quality Check of Drugs,
- Rational Use of Drugs,
- Drug Supply Management
- Revolving Drug Funds,
- Traditional Medicine, and
- Human Resources for Drugs

The National Drug Policy provides the general framework for drugs, but more strategic perspectives would be provided in this chapter.

21.2 IDENTIFIED ISSUES

21.2.1 Quality Check of Drugs

(1) In order to secure the supply and distribution of safe, effective and good quality drugs, scientific quality checking of drugs is needed. The Food and Drug Quality Control Centre (FDQCC) has conducted pre- and post-marketing testing. A problem in quality checking of drugs is unsustainable operation of FDQCC. Sida has supported FDQCC by bearing part of the operating costs, such as those for purchasing chemicals, but there is no sustainable source of revenue to enable the purchase of chemicals and maintenance of equipment. MOH collects fees from registering drugs for sale in Lao PDR (US$100 per one of foreign-made drug and US$30 per drug made in Lao PDR). US$10 of the drug registration fee is retained by FDQCC. This amount of money is not enough to sustain the operation of FDQCC.

(2) There is an erratic flow of samples to the FDQCC laboratory. Moreover, there is poor maintenance, utilisation of equipment and supervision within FDQCC.

(3) A drug law and regulations have been established. In order to secure the quality of drugs to be sold in Lao PDR, registration and quality checking of all drugs sold in Lao PDR is mandatory. At present, a registration system exists. However, information on

drugs registration is not shared within Ministry of Health (MOH), even in the Food and Drug Department (FDD) of MOH. Drug inspectors do not have access to the most recent list of registered drugs.

(4) Inspection procedures for manufacturers (GMP), importers (GWP) and pharmacies (GPP) have been adopted. Sida has conducted training for drug inspectors at District level only in five pilot provinces. In other provinces, the skill and capacity of drug inspectors is not known. Guidance of operating pharmacies has been conducted, but it varies between provinces.

(5) Due to the lack of strong regulations, little inspection has been done of unregistered pharmacies and drug vendors.

21.2.2 Rational Use of Drugs

Irrational use of drugs is harmful to the health of drug users, for example resulting in side effects. More seriously, the irrational use of drugs tends to create resistance to drugs.

(1) A set of standard treatment guidelines has been made to cover seven common diseases (malaria, tuberculosis, diarrhoea, dengue fever, leprosy, parasites, and pneumonia). Standard treatment guidelines for emergency cases are under preparation, to be completed in 2002. But health workers have not yet used the standard treatment guidelines.

(2) The standard treatment guidelines for seven common diseases are insufficient. Treatment guidelines covering more diseases are needed for hospital care. Furthermore, treatment guidelines for health workers of different skill levels or for different levels of health facilities need to be prepared. Especially in the treatment guidelines for emergency care (under preparation), at each level of facility, it is necessary to clearly delineate what should be done and what should not be done, but to refer certain patients to upper levels of facilities. At the same time, booklets describing decision trees in treatment should be prepared for health centres and village health volunteers

(3) An essential drug list has been prepared. Regular revision of the essential drug list has not been conducted since 1997, although it is stipulated.

(4) Any health workers can prescribe drugs. Drugs are mostly sold without prescription.

(5) Since many health workers were trained in short training courses during the war, there are many persons who have limited knowledge on drugs. And there are no regulations on who must prescribe drugs. Health workers do not follow up patients' drug use, do not have the concept of rational prescribing among them, and do not conduct evidence-based treatment and prescription.

(6) There are few health staff who can practise rational dispensing even at public health facilities, because private pharmacies operated by pharmacists account for 16% of the total private pharmacies. At most pharmacies, there are few pharmacists working at the counter.

(7) Staff at the counter of pharmacies do not have any training in drug dispensing.

(8) There are few staff at the counter of pharmacies who can conduct proper drug counselling with customers about self-medication.

(9) According to the regulation of EDL, supervision/ monitoring for hospitals should be conducted once per year. 10 indicators for Rational Use of Drug evaluation have been determined. Examples of irrelevant use of drugs include the use of expired or ineffective drugs at the provincial level that were donated from foreign countries. There are no clear guidelines to regulate the irrational use of drugs. As a result, use of non-essential drugs, drug sale without consultation and injection by unlicensed health workers are prevalent. Moreover, there are no clear guidelines (including penalties) to evaluate and regulate village-level RDFs

(10) Many people practise inappropriate and dangerous self-medication. People tend to have excessive expectations of drugs. People's excessive dependency and expectations of injections are prevalent. Especially in areas without medical doctors, the irrational use of drugs is widespread. Drugs prohibited in Lao PDR are used.

21.2.3 Drug Supply Management

The government budget covers only a tiny part of expenditure on drugs, the major part consisting of supplies from the Revolving Drug Funds (RDFs). This supply system also varies from province to province and in some provinces, where decentralization is much in progress, the task is carried out at the village level. However, there is some discussion over whether to see this as the product of decentralization efforts or just a renunciation of responsibility at the upper level. In addition, there are many problems, such as how to co-ordinate with other programmes that still preserve the central procurement/distribution system.

(1) Drugs are selected based on the essential drug lists for different levels of health facilities. However, some projects make their own selection because the list does not have legal status, and because it does not meet actual needs. Drug procurement committees do not have enough knowledge on essential drugs and on registered drugs. Drug selection is not always based on the essential drug list. On the other hand, donor projects tend use their own drug lists.

(2) In the past, essential drugs were purchased by MOH and distributed through the Medical Products Supply Centre (MPSC). Responsibility for procurement has been transferred to each province, and now essential drugs are procured at the provincial level with the government budget. This change has made it difficult for MOH to grasp the actual drug purchase situation in Lao PDR. Each province or district conducts drug procurement in its own way. There is no standardised procedure or regulation of drug procurement.

(3) PHOs and DHOs do not have the capacity to procure drugs at the appropriate time and at proper prices.

(4) There is a system by which all the drugs used are recorded in the ledger. However, in reality, some health facilities do not record issued drugs due to a shortage of staff. The reporting system already exists, in which VHVs report to HCs, and HCs to DHO. Since record keeping of drugs is not done accurately, it is not possible to use data on drug use for procurement planning.

(5) Reports are either not submitted or lacks necessary details such as the amount prescribed.

(6) Reports are not submitted on time. The easiest way to access modern medicine is to go to pharmacies.

(7) Many pharmacies are found in towns, but there are only a few pharmacies in remote areas. In remote areas, there are few pharmacies, which might mean a monopoly of drug retail in certain localities.

(8) Some vertical programmes (Malaria Control, Reproductive Health, and EPI) have their own distribution routes for drugs from the central level. Some programmes distribute free drugs (ex. Chloroquine and Quinine) and subsidised medical products (ex. Bed nets and contraceptives). When the same kinds of drugs come for free from certain programmes, people become reluctant to buy those drugs from village-level RDFs, resulting in the expiration of those drugs.

(9) How to sustain the utilisation of bed-nets and contraceptives after such programmes' withdrawal from providing free drugs and products.

21.2.4 Revolving Drug Funds（RDF）

RDF was introduced into Laos in the early nineties. In 1993, the Lao Government officially approved the RDF system and developed National Guidelines on RDF in 1993, approved in 1996.

According to the report of FDD in MOH, by July 2001, RDFs had been introduced into all Central Hospitals, 94% (17/18) of Provincial Hospitals、83% (118/142) of District Hospitals, 87% (491/565) of HCs, and 1,320 villages in Lao PDR.

FDD organized RDF Evaluation Workshops in July 2001 in Oudomxay, Khammuane, and Champasak. They discussed 5 topics: Organisation and Coordination, Implementation of the policy of cost recovery, Drug management and supply, Financial management and Training of RDF management and Village health Volunteers. But the important topic of Rational Use of Drugs was not discussed.

Although According to the RDF forum held in July 2001, VRDFs have been introduced in about MOH has established guidelines for village-level revolving drug funds, donor projects have adopted a variety of models. VRDF have quickly become widespread throughout the country.

(1) Organisation

- Steering committees and RDF management committees are not active. The reasons are that task allocation is not clear and many committees were set up in certain provinces.
- Too little attention has been paid to practical implementation?, drug management has not been in line with established RDF procedures?.
- Staff have been frequently transferred, causing RDF work to be ill-coordinated and ineffective, with task assignment and responsibility not obvious.

(2) Policy

- RDF's roles and criteria are not clear.

(3) Finance and welfare

- Exemption criteria are not clear enough, nor are welfare benefits to staff, the poor, students, monks, prisoners, and migrants.
- The benefits of implementation have not been made clear to health volunteers. Profit shares from selling drugs have been too small.
- The government budget allocation is not enough to cover supervision and training for RDF.
- Some hospitals have almost collapsed because of the deficits they have incurred in running the RDF scheme.

(4) Drug management and supply

- Drug procurement has been uniform across the country despite some provinces already having revolving drug funds.
- The quality of drugs sold in revolving drug funds is low due to the staff not following MOH regulations.
- Information reporting systems, and the collection of financial and drug statistics at different levels have not been properly linked.
- The government budget used to subsidise drugs for poor people each year is too small and is not provided regularly.
- Both prices of and demand for drugs have increased, leading to a shortfall in the RDF supply.
- Drugs in the revolving drugs funds in some provinces were found to have expired due to the low quality of the drug stock and staff not understanding the type of drugs.
- Some drugs in the revolving funds are distributed free by some projects, such as:

- Chloroquine, distributed by Malaria, Parasitology and Entomology treatment project.
- Vitamin-A, Iron, distributed by MCH project.
- ORS, distributed by the Diarrhoea Control Disease (CDD) project.
- Drugs, distributed by skin disease treatment and leprosy treatment and tuberculosis treatment project.

(5) Rational use of Drugs

- Some HC RDFs function as semi-private pharmacies.
- There is poor understanding of the rational use of drugs among both staff and the general public.

(6) Village Drug Kit

- Village health volunteers (VHVs) manage village-level revolving drug funds, but they have different levels of capacity in different areas.
- In some villages, drug prices are more expensive, depending on the method of procurement.
- Supervision (ex. criteria and checklists), regulation and legislation have not kept up with the rapid expansion of village-level revolving drug funds.
- Due to the lack of proper supervision, the irrational use of drugs has been increasing (ex. inadequate selection and periods in using antibiotics, irrational use of injections).
- Although MOH has established guidelines for village-level revolving drug funds, some villages have not followed them.
- Demand for drugs is much greater than before VRDFs were introduced、There is more pressure on VHVs from patients to use drugs
- The VRDF has not been evaluated yet.

21.2.5 Traditional Medicine (TM)

Traditional medicine includes various treatment methods, such as herbs, acupuncture, massotherapy, and herbal sauna.

MOH has emphasised herbal treatment in its traditional medicine policy. The National Drug Policy Project supports the mapping of herbs. The Traditional Medicine Research Centre (TMRC) of MOH has a plan to promote the planting and utilisation of herbs (12 kinds of basic herbs).

Some temples have traditional medicine treatment centres or small schools of traditional medicine that are not recognised and supervised by MOH.

(1) Cooperation and integration between Modern Medicine and Traditional Medicine have been weak, although they are identified as an important area of health strategy by MOH.

(2) Information on traditional medicine, which is available in temples or private facilities, is still limited.

(3) There is little cooperation between public health facilities (hospitals and health centres) and TMRC.

(4) There are only 2 official education centres for traditional medicine in Laos (TMRC and Traditional Medicine Hospital).

21.3 OBJECTIVES AND KEY DIRECTIONS

21.3.1 Quality Check of Drugs

(1) To continue an adequate level of operation of FDQCC is essential for quality checking of drugs. To improve the management of the laboratory by increasing the number of samples from inspectors and the drug registration section of MOH. For this purpose, it is also necessary to have a financial mechanism to support the sustainable operation of FDQCC.

(2) To disseminate, implement and enforce the drug law and regulations. To establish an information system for enabling drug inspectors and other officers to get access to information on registered drugs in Lao PDR.

(3) To increase drug inspection activities.

(4) To increase the penalty for violators of the drug law and regulations and to enforce the law and regulations.

(5) To train inspectors and expand the network of inspectors.

(6) To share information in FDD.

21.3.2 Rational Use of Drugs

(1) To encourage health workers to use the standard treatment guidelines.

(2) To prepare standard treatment guidelines covering different types of facilities.

(3) To conduct regular revision of the essential drug list.

(4) To regulate those who are allowed to prescribe drugs (for example, only medical doctors and medical assistants can prescribe drugs.)

(5) To introduce evidence-based treatment and prescription.

(6) To establish opportunities for training on clear instructions and advice on drugs for pharmacy staff.

(7) The capacity of PHO and DHO in supervision and monitoring of EDL should be strengthened. Budgets for supervision and monitoring (ex. per diem) need to be secured.

(8) To establish regulations to limit the types of health workers who can perform certain medical treatment including prescribing drugs.

(9) To introduce a system of examination for qualifying health workers and village health providers to prescribe drugs.

(10) To conduct training for pharmacy staff and health workers about clear instructions and advice on drugs.

(11) To continue health education for villagers about rational drug use, using IEC methods.

(12) To enforce the regulations on drugs and medical products allowed to be sold at different grades of pharmacies.

(13) To disseminate the rules of VHVs and village health providers on drug use, for example, VHVs and village health providers are not allowed to give injections to villagers.

21.3.3 Drug Supply Management

(1) To procure drugs using a revised essential drug list (See the Essential Drug List Section.)

(2) Districts or Provinces should take the leadership role in drug procurement

(3) To enhance the capacity of staff working in the pharmacy section.

(4) To introduce a new report format which is easy to use for each level and demonstrating clearly what can be done with such reports

(5) To establish a new exemption system.

(6) For the Government to take full responsibility and give necessary assistance for the sound implementation of the exemption system.

(7) To establish an efficient system of drug procurement at health facilities.

(8) To increase the number of pharmacies in remote areas in order to introduce competition among pharmacies

21.3.4 Revolving Drug Fund

(1) To evaluate existing systems at each level by Provinces and Districts.

(2) To modify existing roles to become more clearly understandable

(3) To review the roles and objectives of village-level RDFs.

(4) To establish a policy for village-level RDFs by involving donors and NGOs.

(5) To strengthen the system of supervision of village-level RDFs by increasing the number of trainers and supervisors of village-level RDFs.

(6) To enhance the capacity of VHVs in financial management of village-level RDFs.

21.3.5 Traditional Medicine

(1) To promote networking of public and private facilities of traditional medicine within Lao PDR.

(2) To strengthen cooperative relationships with neighbouring countries in the field of traditional medicine.

(3) To disseminate basic information on herbs to the public.

21.3.6 Human Resources for Drugs

(1) To enhance the quality of staff in checking drug quality by providing training opportunities to get master degrees for drug laboratory examination.

(2) To assign at least a pharmacist to the district level for drug supply management.

(3) To increase the number of staff who could manage Village-Level Revolving Funds at the central and provincial health offices.

(4) To increase the number of producing pharmacists at all levels of schools.

21.4 POSSIBLE MEASURES

21.4.1 Quality Check of Drugs

- It is necessary to increase the government budget for running FDQCC and the drug registration fees. The increased fees for registration fees should be retained and used for the operation of FDQCC.
- To establish a website for showing registered drugs in Lao PDR
- To clearly give inspectors the power to impose penalties and to revoke licences for pharmacy operation.

- To encourage inspectors' activities by introducing a system to allow inspectors to get a percentage of the penalty collected.

21.4.2 Rational Use of Drugs

- A committee for essential drug selection should regularly revise the essential drug list. It is necessary to establish a committee for essential drug selection, if there is not one already. Revisions should be discussed every year. And at least once every three years, it is necessary to conduct a full-scale revision of the essential drug list.
- It is necessary to introduce different levels of essential drug lists for
- To start to introduce the practice of evidence-based treatment and prescription with large hospitals in towns.
- To strengthen the inspection of drug prescribers.
- In remote areas, where no medical doctors and medical assistants are available, to give permission for prescribing drugs to nurses under the supervision of medical doctors and medical assistants.
- To conduct seminars on rational drug use and prescribing for medical doctors working in private clinics.
- To allow nurses working at Health Centres to prescribe drugs under the supervision of district hospitals.
- For MOH and PHOs to operate model pharmacies, in which to conduct adequate instructions and advice on drugs for patients, and to conduct on-the-job training for pharmacy staff.
- It is difficult to prevent health centres and VHVs from becoming private pharmacies by using RUD10 indicators. It is necessary to for MOH to establish clear procedures and penalties to deal with violations.
- To establish clear guidelines and regulations for RDU at the village level.
- To establish a committee for drug donation for reducing donation of drugs that do not follow International Drug Donation Guidelines.
- To introduce systems of training, examination and registration of village health providers.

21.4.3 Drug Supply Management

- To procure drugs using a revised essential drug list and enforce this.
- Drug procurement should be conducted no lower than the district level.
- To conduct training on drug procurement for district staff twice a year.
- To conduct on-the-job training on drug procurement in DHOs which lack capacity.

- Necessary arrangements should be made so that those who are in charge of drug procurement at the health centre and village levels can purchase drugs at wholesale outlets with which DHO has contracts.
- To assign pharmacists to all district hospitals.
- To conduct training for health centre staff at district hospitals
- To conduct on-the-job training for health centre staff at health centres which have reporting problems.
- To revise the existing report format.
- To make a purchase plan based on the information gained from the reports (e.g. what item is used and how much etc.) and to use the data for future negotiation with wholesaler pharmacies. Feedback on its results should also be made.
- To clarify the eligibility criteria for exemption at hospitals and health centres.
- For MOH, to secure its own budget for allocating exemption money for each province/district.
- To give "pharmacy licences" to pharmacists who work for the public sector, like district hospitals, district health office or health centres in remote areas.

21.4.4 Drug Revolving Fund

- To establish and enforce clear a RDF Policy,
- To establish and enforce clear RDF committee roles,
- To establish and enforce a clear Inspection system.
- To establish and enforce clear supervision tools for RDF.
- Reorganise human resource allocation within MOH
- Implement a training system at all levels
- To establish a Village RDF Policy
- To increase the number of RDF trainers

21.4.5 Traditional Medicine

- To introduce herbal saunas to selected public health facilities（district hospitals and health centres）
- To introduce herb gardens to public health facilities（district hospitals and health centres）
- To disseminate the idea of the rational use of herbs through the mass media.

CHAPTER 22
FRAMEWORK FOR SUBSTANCE ABUSE WITH A FOCUS ON NARCOTICS DRUGS

22.1 INTRODUCTION

The issue of substance abuse in the Lao PDR has been gaining in importance over the past few years, and is now being accorded attention by the highest policy making levels in the country. For the purposes of this framework, the focus is limited to narcotics drugs abuse, namely opium and Amphetamine Type Substances (ATS). In northern Laos, according to the latest statistics (2001) available from the Lao National Commission for Drug Control (LCDC), there are approximately 58,000 opium addicts.[1] People using ATS are mostly found in the larger urban areas of the country, but in border areas to Myanmar and northern Thailand, there are an apparently increasing number of rural people using ATS (in Bokeo, Sayaboury and Luang Namtha, for example). There are no reliable estimates of the number of ATS users in the country, but all evidence suggests steady, sometimes rapid, increases over the past five years.

Other narcotics drugs, such as heroin, cocaine and various psychotropic substances are hardly known or consumed in the Lao PDR. Marijuana is cultivated in Southeast Asia, but seems not to be widely consumed in Laos. Legal substance abuse such as alcohol and tobacco is prevalent (no statistics available) but is given rather little attention. Alcohol and tobacco are generally used more by males than females. There is evidence from studies in urban areas of young people abusing prescription drugs such as sedatives (females more than males), and of young people also abusing inhalants such as glue.[2] Certainly, as part of overall health promotion and prevention strategies, the use and abuse of all substances whether legal or illegal, should be included as part of helping children and young people to avoid risky behaviours. Health education programmes for children must also include age and culturally appropriate prevention curricula for all relevant risk behaviours. Nonetheless, the main focus on this chapter is on narcotics drugs.

The Lao PDR is signatory to two United Nations Conventions on Narcotics Drugs. That is, the 1961 Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. In

[1] According to data available from UNDCP, the Lao PDR is the world's third highest consumer of opium, after Pakistan and Iran.

[2] See series of studies on student drug abuse in Vientiane, Luang Phrabang and Savannakhet by UNDCP.

this regard, the Lao PDR has obligations to adhere to these Conventions, including controlling the production, trafficking and consumption of the drugs listed therein. Therefore, the LCDC was established in 1990, with members appointed from the main ministries, including the Ministry of Health.[3] The steadily increasing political attention accorded to drug issues in the Lao PDR can be seen in the last few years, starting with the Opium Elimination Plan in 1999 (devised with UNDCP assistance), followed by the Prime Minister's Order Number 14 (PMO 14) of November 2000, the resolutions of the 7th Party Congress in 2001 including the decision to eliminate opium production in the Lao PDR by 2005 (instead of 2006 as stipulated under the Opium Elimination Plan), and the establishment in October 2001 of a Central Committee for Drug Control headed by the Prime Minister. The 6th ASEAN Health Ministers Meeting held in March 2002 in the Lao PDR declared a goal of Healthy ASEAN Lifestyles which specifically includes "reducing tobacco consumption [and] controlling alcohol and substance abuse . . ."

The government's political and policy declaration on drug control, in the form of PMO 14, urges *all* Government agencies, mass organisations, projects and the private sector to step up their efforts in solving the country's drug problems. Drug control committees are to be established at all levels, including district and province, and must be multi-sectoral, including, of course, the health sector. However, no significant resources such as additional budgets or personnel have been made available by the Lao government to date to implement PMO 14. There is still a heavy financial reliance on foreign donors to support the implementation of drug policies in the Lao PDR, including in the health sector.

Drug addiction is recognized worldwide as a bio-psycho-social, and chronic, relapsing disorder, with addicts viewed as patients and not as criminals. From within the health sector, drug addiction is generally seen from a mental health perspective. The reasons for a person's addiction always include psychological, or social-psychological, factors although other factors are involved as well[4]. Therefore, within the health sector, drug/substance abuse, as a treatment issue, is normally seen as part of a general framework for mental health, and also as part of health promotion and health education.

Unfortunately, mental health issues have been paid very little attention in the Lao PDR to date (see last section below), although they are being recognized globally as an "emerging issue" requiring higher attention and resource commitments than previously thought.[5] Since addiction is a relapsing disorder and involves psychological factors, it is difficult to treat, and more often than not successful treatment must be seen from a long term perspective; some addicts are never able to quit, others must try various treatment methods, relapsing many times before they are successful. At the opposite extreme, some addicts are able to quit on their own. There is no "easy" treatment course for addiction. A focus on detoxification alone has no prospects for

[3] At first from the Food and Drug Department, but now from the Curative Department.

[4] Factors arising from the person's socio-economic environment.

[5] See WHO Annual Health Report for 2001, *Mental Health: New Understanding, New Hope.*

helping the increasing number of addicts who are seeking treatment options in the Lao PDR. The nature of addiction requires that its treatment also address the various factors which led to the person's addiction in the first place.

Many of the substance abuse problems afflicting the Lao population today could be preventable through actions taken by local people themselves if they would have more awareness on these issues; this is particularly true when substance abuse is a problem of teens and young adults living with their parents. This is also true in communities with intact leadership structures where community leaders can take a role in mobilizing families on substance abuse of all types by creating awareness among them. Given the difficulties of drug abuse treatment—with high relapse rates for virtually all substances, including alcohol and tobacco—"prevention rather than cure" needs to be strongly stressed. In this respect, MOH needs to cooperate closely with other Ministries, especially including the Ministries of Education and Information and Culture. Several Ministries, including Health and Education, now have Drug Control Units which are to plan and coordinate drug control activities within the respective ministries, and may be able to assist with inter-ministerial coordination with assistance from LCDC.

In areas where addiction is a more severe problem for the local population, such as opium addiction in the North, future packages of essential PHC services should also include drug treatment service. Unfortunately, since the district health delivery systems as a whole cannot realistically be significantly improved within five years (see Chapters on Health Facilities and on Primary Health Care), and since addiction is rarely seen as a top priority among cited health problems, it cannot be a realistic goal for the Lao PDR to solve its addiction problems within the next decade, even if opium production is significantly reduced. In the absence of comprehensive prevention programmes, there is a significant risk that ATS use will continue to grow both as a direct and indirect[6] health problem (also in northern communities which currently have opium addiction problems).

22.2 IDENTIFIED ISSUES

22.2.1 Opium and ATS Addicts

Opium users and addicts are generally males (all studies and gender-differentiated surveys which have included consideration of opium addiction show that males outnumber females by a factor of around four to one), living in or near villages which produce opium. Their age range is very broad—from around 20 to old age, with many addicts in the 30 to 50 age range. Over time there has been a tendency toward onset of opium addiction at younger ages, thus leading to greater hardship for families with addicts, especially the non-addicted women.

[6] "Indirect" in the sense that there is a strong correlation between drug taking as a risk behaviour and other risk behaviours, such as having unprotected sex with multiple partners, driving badly, etc.

Considering the decreasing availability of opium in Laos (which strongly affects its price), it may be that the risk group for opium addiction is decreasing in size. However, this does not mean that this same group would not be at risk of addiction of other substances such as ATS or alcohol.

ATS users are generally young men (sometimes only in their teens), often relatively well-educated (high school) and from better off families so that they can afford the ATS. They may also be employed in work places such as factories. These users are generally more urban than rural, although this does not hold true in the northwestern border areas of Laos where ATS is cheaper and rather easily available from neighbouring Myanmar and Thailand.

Although some drug prevention activities have begun in schools, and there are now several schools covered with special, donor-supported drug prevention activities in Vientiane Municipality, there is still a high risk of the spread of ATS use to a growing circle of young people, particularly to those out of school, and to areas beyond the urban settings in Laos.

22.2.2 Addiction and Communities

Communities affected by opium addiction problems are scattered throughout the northern provinces, and largely belong to the highland opium producing groups (examples are Hmong, Akha and Lahu) and upland ethnic groups (ex., Khamu) which live closer to opium production areas. Many of these communities are both remote (Zone 3) and poor with little access to any services. Many of the addicts, in turn, belong to the poorest strata in their respective villages. Practically speaking, all 58,000 opium addicts live in the northern provinces, but including Vientiane and Bolikhamxay Provinces .

If an opium addict causes too much economic hardship for the family, other family members and much less often community leaders, may put pressure on the addict to quit. However, in the absence of regular health services or any kind of treatment services in most areas, the addicts have extremely few and irregular treatment options.

The *positive impacts* of people's traditional beliefs and knowledge have not been deeply explored as discussion points to help local people avoid substance abuse, and to assist with their treatment and rehabilitation should they become addicted. There are opium producing villages in the North which produce opium but which have very few addicts—prevention lessons could be learned from them.

Communities and their representatives participate too little in drug abuse problem-solving discussions either among themselves, or with local health service providers. A significant problem is the general perception of drug abuse as an individual or family problem which does not have an impact on the community, until a "crisis" occurs, such as theft of personal property by addicts.

Local people must also be involved in assisting the addicts in their own communities, but because of the degree of stigma attached to addiction, particularly if the addiction involves younger people and ATS, it is often difficult to mobilize a community to take up drug use as a community health and well-being issue. Community leaders may feel there is a "loss of face" if they openly admit to having drug addicts in the community. Community mobilization is probably easier in smaller, rural communities than in larger, urban ones. Moreover, opium is an issue which has, to date, been considered a more 'normal', if not well-accepted, part of highland village life, making the topic of opium addiction easier to discuss than ATS addiction.

22.2.3 The Current Treatment Situation

The point at which treatment issues may be regularly and systematically dealt with in Laos is still far in the future. However, small beginnings need to be made now in order to deal with drug abuse pro-actively. In the provinces which are confronted with drug abuse problems, particularly the northern provinces where there are many opium addicts, or where there are combinations of opium and ATS use, there are very few trained health personnel available to help. Most of the few who are available have learned how to *detoxify* addicts with the assistance of donor-supported projects,[7] but still lack knowledge or experience in psychological or counselling support after detoxification (aftercare). Relapse rates are generally high (60% up to 100% is common).

Health workers lack the communication skills to motivate or mobilize the communities to provide some aftercare support in their own, traditional/cultural ways. To date, district health offices have relied solely on the budgets of the donor-supported projects to carry out the detoxification sessions, whether in communities, in small treatment centres or in district hospitals. Detoxification of addicts carried out with provincial or district health budgets has virtually not occurred.

In the private, traditional-*cum*-spiritual sector, ceremonies by monks or shamans may be aimed at improving the mental health status of either opium or ATS addicts who come to see them, seeking help to stop their drug use. Sometimes, in addition to performing ceremonies, the monks or shamans will assign further "tasks" which should be completed by the patient to assist his/her recovery. There are, however, no data available either on the incidences of addicts seeking treatment assistance from traditional-*cum*-spiritual healers, nor on the efficacy of the treatment they received.

There is an urgency in improving formal treatment services in two respects. First, in light of the policy to eradicate opium poppy cultivation and opium production by the year 2005. While this

[7] Certain projects, for example, have arranged training courses for provincial and district health workers on community-based treatment in Laos, such as in cooperation with the Psychiatric Unit of Mahasot Hospital. Others have organized study tours to northern Thailand to visit the Northern Drug Dependence Treatment Centre, a government facility where training courses could also be provided to Lao health workers.

goal may be too ambitious, there is no doubt that opium production will be reduced by the year 2005, and opium addicts are already seeking treatment options in larger numbers. However, considering the large number of opium addicts (58,000), the few who live within project areas where treatment services are regularly provided (perhaps 5 - 10%), and the fact that both opium and ATS are widely available in the "Golden Triangle" region as a whole, it will mean that northern Laos will still certainly have opium addiction problems after 2005, not to mention ATS addiction. At present, not more than a few hundred addicts, if that, can be detoxified annually, and not relapse soon afterward.

Second, while less information is available about ATS, given trends in neighbouring countries it is realistic to assume that the problem will get worse in the Lao PDR before it can improve, meaning that action needs to be taken now. At this stage, ATS use has not spread so widely in the country, but it is extremely important to take a pro-active stance and through a combination of health promotion with specific drug prevention messages try to prevent the problem from becoming widespread. There is, therefore, an urgency to the problem requiring actions within the health sector to develop improved treatment skills, especially including counselling and specific youth counselling skills. Ideally, peer counselling should also be developed. With young people it is important to consider ways of preventing initial users from becoming serious drug takers.

DHOs or District Hospitals seldom have basic data on addiction, including local addiction patterns which would assist them to target either treatment or prevention measures more appropriately. [8] Obviously, the health sector cannot work alone on addiction issues—considering ways of integrating them with the already multi-sectoral and community-oriented PHC approach would be a good start.

While the Provincial Health Offices and/or Provincial Hospitals should be able to provide technical support to the DHOs and HCs on drug demand reduction whether for opium, ATS or legal substances such as alcohol, they also lack training and experiences in different aspects of drug treatment and thus cannot provide this support at present.

Treatment Situation for Opium Addiction:

Regular opium treatment services are only available in the context of donor-supported projects in the North. For example, two small treatment centres are being operated in Nam Bak and Xieng Ngeun Districts in Luang Phrabang province and supported by the NGO Consortium. Other donor-supported projects, such as in several districts in Luang Namtha province (NCA, EU, GTZ, EED), have conducted village-based detoxification services on a regular basis over a period of several years. Such services have also been provided less regularly in Bokeo (NCA,

[8] While urban addicts often belong to an underground population of users, rural opium addicts are not, and it is relatively easy to find out where there are greater concentrations of them.

GTZ). Various UNDCP-supported projects or project components (exs., Oudomxay, Xieng Khouang, Houaphan) have also provided detoxification services, as has a US-supported project in Houaphan.

MOH has Treatment Guidelines on Community-Based Treatment of opium addicts which have been drafted, tested and approved. They have already undergone revision, and are the basis for which training is conducted by the Mahasot Hospital Psychiatric Unit Director in some of the northern provinces (especially Bokeo and Luang Namtha).

Various strategies, such as the deployment of District Mobile Teams to conduct community-based detoxification have been, and continue to be, attempted with donor support, but with poor results if the communities have not been adequately involved in the entire process or if there has not been adequate support—physical, psychological, economic—for treated addicts after treatment.

Some VHVs in the northern provinces have been trained by donor-assisted projects to work on supporting drug addicts to recover from their addiction if they have been detoxified, but this number is too few to be insignificant. Moreover, it is too much to expect VHVs to handle this issue on their own in the communities (see below), and there should not be yet another cadre of "vertical" programme VHVs created in Laos.

Some of the donor-assisted projects in the North have used or are using traditional herbs, whether locally produced or bought from China or Vietnam, to detoxify opium addicts during community-based detoxification camps. Other projects use tincture of opium for detoxifying addicts which is made by the Food and Drug Department.

Opium addicts in the North are known to seek the services of *herbalists* on an individual basis to buy traditional medicines which can help them detoxify from opium. Herbalists' services are normally confined to provision of herbal medicines (sometimes mixed with a little opium) which ease the withdrawal symptoms associated with opium detoxification. There is no clear information available as to how many of such traditional health practitioners with an understanding of opium detoxification withdrawal symptoms are practicing in the North.[9]

Without donor support, Health Centres, District and Provincial Hospitals are neither now nor in the foreseeable future in a position to provide drug treatment services on an inpatient basis to local populations. Treatment costs per addict (detoxification alone in a community setting) are estimated at roughly USD25 per addict not including per diems, transportation costs or

[9] A famous herbalist in Oudomxay (staff of PHO) has been selling herbs to assist opium detoxification for at least ten years already. The herbs have been used extensively in the North in place of tincture of opium as a low-cost, readily available means of detoxing addicts. It seems these herbs have been checked by the Traditional Medicine Research Centre and found to be safe for use in the treatment of opium addicts. They remain to be certified by MOH, however.

contributions from villagers,[10] far beyond the means of local health budgets at present. Staffing levels of many northern district health facilities (hospitals or health centres) do not allow there to be enough staff to be available around the clock for groups of addicts.

In projects which support opium detoxification, there has been a strong tendency to provide the detoxification service for free, but threatening relapsing addicts with fines. This practice goes against medical ethics. Addiction in and of itself is not a crime, and addicts should be seen as patients rather than criminals.

Treatment Situation for ATS

No treatment protocols or guidelines have been developed for ATS in Laos.

The Psychiatric Unit at Mahasot Hospital is able to treat a limited number of drug addicts annually; in recent years the main people seeking treatment are young, male ATS addicts (sometimes sent by their families). In 2001, some 100 ATS users were treated at Mahasot.

A treatment centre for ATS has been opened in Vientiane Municipality (Somsa Nga under the Vientiane Municipality Health Department),[11] but since its opening is so recent (June 2002) it cannot be said with any confidence what its actual treatment capacities will be, what kind of staffing it will have, nor what kind of budgets will be allocated for it.

A "Rehabilitation Centre" for juvenile delinquents under the Ministry of Interior also accepts boys who are ATS users (boys there are aged 10 to 16). They do not, however, receive treatment (besides being forced to detoxify in the absence of ATS in the facility) or counselling as such. Most boys in the facility have been brought there by their parents.[12]

As ATS is a "modern" drug, there is no traditional knowledge or medicine which is available to treat its users. In various provinces there have been cases of desperate parents having their sons arrested and sent to the local jail in order to get them detoxified "cold turkey," (no medication to assist with withdrawal symptoms).

As urban areas are more affected than rural in terms of ATS, urban authorities, such as those of Vientiane Municipality, must have increased awareness about ATS issues, while a team of urban-based health professionals must also learn how to treat ATS addicts, including provision of minimal counselling assistance. Because of the nature of ATS users (young men, sometimes delinquent), the nature of its use (underground/illegal), the drugs available for detoxification

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[10] See recent estimates of opium addiction detoxification costs by UNDCP (April 2002).

[11] Donor support via UNDCP was available for the building, but there is no donor support available as a project to run the centre, nor for it to develop and provide training which is how it was originally envisioned: a combination national, treatment and training centre.

[12] Information from unpublished JICA Study Team commissioned study by Yoshimasa Tebayashi on mental health issues in the Lao PDR who had the opportunity to visit this centre in December 2001.

(prescription sedatives) and the nature of the withdrawal symptoms from the drug (deep depression/even suicidal tendencies), community-based treatment methods are less appropriate than for opium.

22.3 OBJECTIVES

(1) A majority of drug addicts in the Lao PDR have regular, affordable and humane treatment options on a voluntary basis.

(2) There is a reduction in the current number of opium and ATS addicts through treatment approaches which are integrated with socio-economic support measures, and which include involvement of the affected communities.

(3) There is a cadre of health professionals available in the Lao PDR able to provide treatment for drug addicts.

(4) Treatment guidelines and protocols for ATS treatment are developed and implemented.

(5) Selected regional and/or provincial hospitals are able to provide regular, socio-medical treatment services for ATS addicts.

(6) Drug abuse prevention measures are integrated with other risk behaviour prevention measures, and with health education in general.

Health Policy Directions

(1) If there is commitment to effective treatment for drug addiction, and other mental health disorder, then there must be a long-term commitment to establishing a cadre of skilled mental health professionals in the Lao PDR. This would require the establishment of both long term and short term HRD measures to build up psychiatrists, psychologists psychiatric nurses and counsellors.

(2) Emphasis must be given to voluntary treatment for addicts, with no punishments for relapse. Forced treatment or punishing addicts for relapse are at odds with codes of medical ethics. Moreover, there should be a policy to maintain addiction as decrimininalised so as not to drive addicts underground and making them harder to reach.

(3) Official recognition should be provided for various treatment methodologies, including locally available herbal treatments.

(4) Drug treatment facilities should be integrated with existing treatment facilities; any other option is too expensive in staffing and other resources required to run separate facilities. Moreover, given the relatively high treatment costs for addicts, cost recovery would be virtually impossible from all but the best off families of addicts (more likely for ATS than for opium, where a majority of addicts come from poorer families).

(5) Health education should include prevention of all risk behaviours, and including all substances (not only the illegal ones).

22.4 KEY DIRECTIONS

The principles of PHC hold for drug demand reduction as well—there should be a stronger emphasis on prevention and promotion through health education, rather than on trying with so few resources to fight the long, uphill battle of addiction treatment. As with general PHC approaches, the emphasis should be on people's own involvement and participation in the issue if it is to be dealt with sustainably.

The drug abuse and treatment situation in the Lao PDR points to a high priority required in the field of Health Education, but recognizing the complexity of having different target audiences, meaning different methods depending on the different age groups, ethnic groups, and types of drug. Especially in terms of ATS use, there is a more urgent need for prevention measures, as the experiences in neighbouring countries have shown that it can spread very rapidly among younger age groups (under 30s). Moreover, drug use among young, urban users is also associated with other high risk behaviours such as having unprotected sex with different partners.

Mental health issues in general, and drug addiction issues in particular, should be eventually integrated with packages of PHC services in the Lao PDR, but this must remain a very long term goal.[13]

Human resource development programmes in Laos must also consider the inclusion of mental health and drug demand reduction.

22.5 KEY MEASURES

22.5.1 Within Communities

Village Health Committees which have been established in northern Health Centre catchments should also be involved in discussions on drug (opium) demand reduction issues in their communities. If there are urban Health Committees, they should be involved in discussions on how best to deal with ATS use in their communities.

Northern province VHVs—particularly in remoter villages which already have, or are at risk of, addiction problems—should be trained and supported to be sensitized on drug use and abuse issues. At the same time, however, it cannot be expected that they are the "answer" to community-based support for addicts who have been detoxified—this would require community-wide consensus on what should be the roles and responsibilities of different community leaders and members, including VHVs.

[13] See the recommendations in the WHO's 2001 Report on Mental Health which explicitly recommends integration of mental health with PHC.

The involvement of "Village-Based Health Providers" whether those with modern or traditional training, in provision of inexpensive opium addiction detoxification should be encouraged by District Health Offices.

Integrated, health-related problem analyses with local communities should take place and include drug issues, whether opium, ATS or other substances. There should be integration with discussions on other "socially difficult" topics such as STDs and HIV/AIDS, as there is a lot of overlapping of the risk groups.

Women in particular should also be helped to have a stronger voice against addiction in their communities, as they are often its victims when their men become addicts.

Village Health Committees in the North should be assisted to relate drug, especially opium, abuse with general health and other issues in the village, such as agriculture and education, and discuss these with women and men in the village.

22.5.2 Various Health Facilities

HCs and DHs, with their currently extremely limited facilities and services--clinical, preventive and promotive—are unlikely to be ready to provide drug treatment services in the near future (without more intense specialized assistance from donors). In areas where it is known there are greater numbers of opium addicts, at a minimum the HCs, DHs and local pharmacies should be supplied with opium detoxification herbs which people can buy and try at home. This is unlikely to help any but the most determined to quit, but at least it provides them an inexpensive opportunity to try.

HCs and DHs, particularly those in remoter areas, cannot try to recover costs fully for opium treatment services, as at a minimum they have to take place over a period of five to seven days for detoxification alone. Many families with addicts belong to the poorer strata of the population—charging full costs for treatment services will increase the barriers to treatment. This means that subsidies would be required for drug detoxification services.

Although full cost recovery could be considered on a case-by-case basis for those seeking opium or ATS treatment, there should at no time be a policy implemented whereby a person who relapses is fined for this. Neither addiction nor relapse are in and of themselves crimes and it goes against medical ethics to punish people for this (punishing the addict is also likely to punish the family which is unfair).

For less severely affected opium addicts (unlikely to experience serious withdrawal symptoms), it would be useful to explore assistance to addicts on an outpatient basis. The addict should be able to buy the necessary herbs for a seven days treatment course (subsidized if necessary), but

receive adequate explanations from the staff regarding how to use the herbs and what kind of withdrawal symptoms to expect.

Outreach services to villages, such as for EPI or EPI Plus, should be used to provide information to Village Health Committees on the limited treatment options which might be available for addicts in the District or even in the Province.

Given the scattered geographical pattern to opium addiction, including the presence of addicts in very remote highland villages, it is not suggested to support provincial or regional treatment centres, as they would be able to assist no more than a very few addicts on either an inpatient or outpatient basis. Such stand-alone treatment centres would represent a major wastage of scarce resources. To the extent possible opium treatment services should be integrated with district health services.

In terms of ATS addicts, treatment centres should not be considered unless adequate skilled personnel are available to assist addicts, and if budgets are available and committed to cover the recurrent costs of such centres. Given the extreme staffing and budgetary constraints in the health sector at present and for the foreseeable future, and the present pattern of ATS addiction, it would be most reasonable to integrate ATS treatment services with existing provincial health facilities, and to seriously consider the provision of treatment services on an outpatient basis wherever possible.[14]

Additional health workers in northern districts who could work on opium addiction issues should be locally recruited or contracted, if possible, from among existing traditional health providers in the area, especially from any experienced and well-trusted herbalists who understand about opium addiction and detoxification (unfortunately there are probably not more than a handful of such persons available in the North.)

22.5.3 Human Resources Development

There should be training on drug demand reduction issues included in curricula for all health workers; at a minimum there should be awareness creation for them on drug prevention and other high risk behaviour prevention, including required communication skills. They should also, at a minimum, be taught to have reasonable attitudes toward addicts; i.e., sympathy and understanding rather than condemnation or contempt.

Key health personnel (such as doctors and nurses from larger, urban hospitals), starting from provinces and regions, should be sent for short term courses in neighbouring countries on drug treatment. They should eventually form a core group which could provide support to others on drug demand reduction.

[14] There would also have to be skills developed for health personnel to be able to assess properly whether an addict could be treated on an outpatient basis or not.

22.6 DISCUSSION OF MAJOR ISSUES:

A Narrow Base to Build From

One of the most serious concerns is the lack of preparedness in the health sector to deal with mental health issues in general, let alone drug issues in particular. A short study[15] commissioned by the JICA Study Team showed that at present there are only two psychiatrists in the whole country, plus three or four general practitioners who also can treat patients with mental health problems. According to the study, not only are there almost no trained mental health professionals (psychologists, psychiatrists, psychiatric nurses, counsellors), there are no facilities or courses at present in the Lao PDR to train anyone to become a mental health professional. It seems that even the Psychology Department of the National University of the Lao PDR does not have a programme for students to major in psychology.[16] There is a lack of treatment protocols for treating mental disorders. The only MOH treatment guidelines available are for the community-based treatment of opium addicts

Treatment Centres and Their Recurrent Costs

Donor funding may be found to support the construction of treatment clinics, but if—as is the case with Health Centres and attendant PHC activities—government budgets and staffing are inadequate to maintain the clinics and their services, then the sustainability of such an endeavour must be called into question. To construct buildings and try to staff them with unskilled health workers would only result in an overall wastage of resources. Moreover, donor support in the field of drug demand reduction in the Lao PDR has been rather meagre over the years, and currently is actively supported by only UNDCP, GTZ and the US Embassy.

Prevention Versus Cure

Unfortunately, drug abuse treatment, in order to be effective, has a fairly long treatment course for the average individual. Even where there are aftercare measures available, there are still strong possibilities of relapse within six months of being detoxified. Experiences with various treatment methodologies in the North, show that relapse rates of 60% to 100% are common. This makes drug addiction relatively expensive to treat on a per person basis. Despite the costs involved, however, there should be no consideration given to fining relapsing addicts. It will be much more cost-effective in the long run to emphasize integrated and appropriate prevention approaches, rather than treatment.

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[15] Unpublished study, "Review for Mental Health Care System in the Lao PDR" by Dr. Yoshimasa Tebayashi (conducted in December 2001).

[16] Although mental health is not included as a framework in the MOH-JICA Master Plan, it should be considered an emerging issue of increasing importance in the Lao PDR.

CHAPTER 23
FRAMEWORK FOR REHABILITATION

23.1 BACKGROUND OF REHABILITATION IN THE LAO PDR[1]

Rehabilitation is an important component of the health services. It can prevent or mitigate disability and reduce the need for medical care at hospitals, which can save resources for the family and for the country as a whole. A good rehabilitation program therefore lead to better health which is the overall goal of health sector development and reform.

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

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

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

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

[1] Interview with Dr. Souphan Inthirat on August 15, 2002 at NRC office.

23.2 IDENTIFIED ISSUES

(1) Insufficient Statistics on Disability

There are no official statistics on disability in Lao PDR. The last population census (1995) contained no question on disability.[2] The only available nation-wide statistics on disability were collected in 1997 by Handicap International (an NGO). However, this survey was limited to people suffering disabilities as a result of UXO accidents.

(2) Weak Organisation of the Rehabilitation Programme

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

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

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

(3) No Regulation of Rehabilitation Services Provided by the Private Sector

The majority of prosthesis and physiotherapy graduates are not employed in the government sector. Recently many have begun working privately as providers of "traditional sauna and massage". However, there is no government control of these businesses other than providing operating permits. Unlike other health services of the private sector such as pharmacies and private clinics, there are no regular inspections of these massage centres.

(4) Lack of Rehabilitation services provided by Professional Staff in hospitals

In principle each provincial hospital has one rehabilitation unit to provide in-house rehabilitation services. The diagram below shows the operation of the rehabilitation unit in the hospital[3]:

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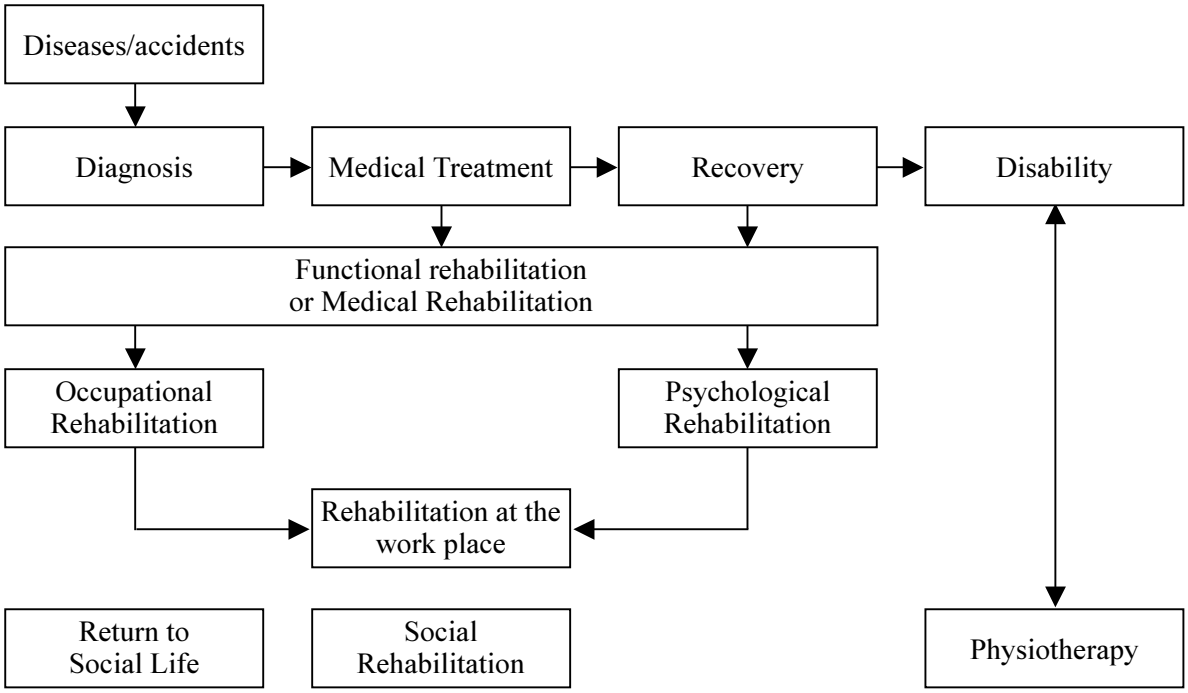
[2] Boddington, M., 2002. Note on Disability and Rehabilitation, POWER/COPE, Laos.

[3] Inthirat, Souphan, 1982. *Organization and Management of the Rehabilitation Program (4 modules*), National rehabilitation Centre, Vientiane.

In practice, however, the hospital rehabilitation units do not function. Patients therefore do not receive appropriate rehabilitation services in hospital, nor do they have access to advice from professional rehabilitation personnel before being discharged.



(5) Unavailability of Rehabilitation Services in Remote Areas

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

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

23.3 KEY DIRECTIONS

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

(1) Better understanding of disability in Lao PDR – number of disabled people, nature of disability and rehabilitation needs;

(2) Systematic teaching on rehabilitation in medical and nursing schools and development of regulation for rehabilitation services;

(3) Reinforcement of complete rehabilitation services at the national and provincial levels;

(4) Availability of rehabilitation services at provincial and district-level hospitals.

(5) Availability of community-based services.

23.4 POSSIBLE MEASURES

(1) Development of Database on People with Disabilities and Their Needs

A nation-wide survey on people with disability should be conducted. The survey will provide GOL with basic socio-economic data on people with disabilities. In addition the survey will enable GOL to identify the real needs of disabled people and thus plan proper rehabilitation services.

The development of a database should be developed from the national survey. It should be updated on a regular basis.

The national census, which is conducted every 5 years, should include a section on disability.

Regular registration of disability should be included in the government administrative structure. The village head should report new cases of disability as part of his or her regular report to the district.

Based on hospital registration, new cases of disability should be reported on the hospital record form.

(2) Reinforcement of the teaching of rehabilitation4 in the schools of medicine, nursing and other health professions and development of national protocols for providing services in rehabilitation

The current curriculum on rehabilitation should be revised, improved and printed. The existing curriculum was developed by the NRC and has been taught at the schools of medicine and nursing. It should be printed and distributed in class.

The teaching of rehabilitation should be extended to other health professionals such as PHC workers or assistant nurses.

There should be enough teachers on rehabilitation to cover teaching at all health/medical schools.

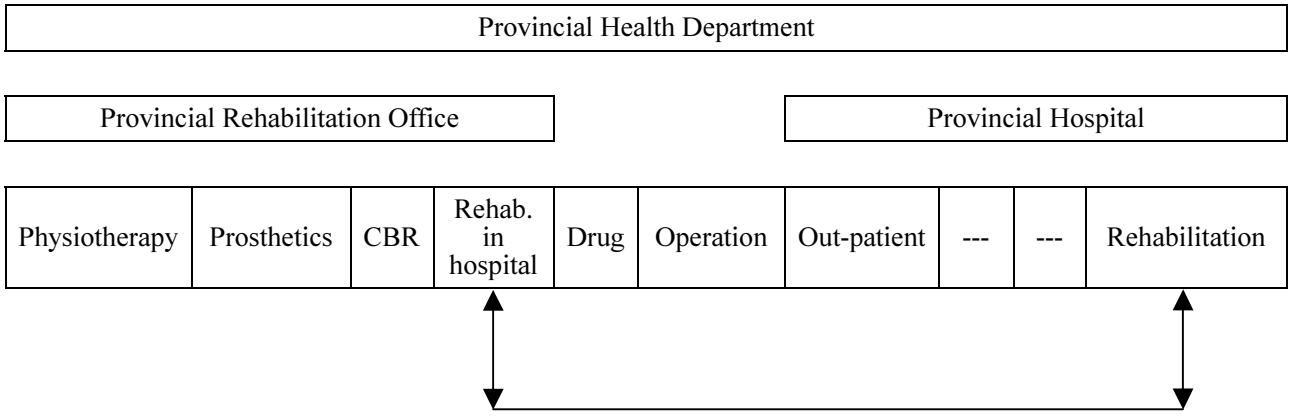
[4] The complete curriculum is available at the National Rehabilitation Centre.

There should be periodic quality control of the services given at health centres for traditional sauna and massage.

(3) Reinforcement of Hospital-Based Rehabilitation Units

Information sessions should be organised for the management of provincial health departments and provincial hospitals so that they understand the importance of rehabilitation services during the time the patients are in hospital. A better understanding will enable them to better allocate resources necessary for the establishment and operation of rehabilitation units within the hospitals.

The rehabilitation unit at the hospital is one of the services of the provincial rehabilitation office. The diagram below shows the relationship between the hospital and the provincial rehabilitation office:



(4) Reinforcement of complete services at the national and provincial levels and extension of services to district level

Complete rehabilitation services should comprise the following units. These services should be available at the national and provincial levels.

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

The NRC should be able to provide training and regular technical assistance to the regional and provincial rehabilitation offices in all the areas listed above. In order to achieve this, the staff of

NRC should be trained in both necessary technical subjects and training methodology. The necessary equipment should be provided in order to allow the specialists to provide good rehabilitation services. A travel budget should also be planned so that technical assistance and supervisory trips can be made to the provinces.

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

(5) Establishment of a Community-Based Rehabilitation Network

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

The district rehabilitation office will be responsible for setting up a community-based rehabilitation programme in the district. A team of qualified staff, means of transportation, training materials[5] and operating budgets should be provided.

[5] With assistance from WHO, the NRC has developed a series of handbooks outlining care and rehabilitation services for people with disabilities at community level. The handbooks are available at the NRC. The Xieng Khouang Provincial Rehabilitation Office has been using this handbook to train district officials. This initiative is part of the Landmines/UXO: Community-Based Rehabilitation Project of Garneau-International with financial support from the government of Canada through the Canadian Landmines Fund.

PART V

FORMATION OF PROGRAMMES

CHAPTER 24
PRIORITY PROGRAMMES

24.1 PRIORITY PROGRAMMES (LONG LIST)

60 programmes are identified based on key directions and possible measures set as frameworks for the health sector. Some programmes comprise several components or projects. A list of all programmes and programme components/projects are shown in Table 24.5. This list is called the Long List.

All listed programmes and programme components/projects in the Long List are recommended for implementation in order to realise the grand design of the Lao health system.

24.2 HIGHLY PRIORITISED PROGRAMMES

24.2.1 Criteria for Selecting Very High and High Priority Programmes

Among identified programmes and programme components/projects, prioritisation has been done using the following criteria:

(1) Criteria related to effectiveness in achieving goals

Efficiency: Efficiency in utilisation of resources (financial and human resources) to achieve goals/ objectives (Programmes that can improve efficiency in achieving equitable health services or quality health services get higher priority.)

Equity: Equity in accessibility to quality health services (paying attention to geographical and economic conditions, socio-cultural barriers, and gender aspects) (Programmes that can improve geographical accessibility, reduce socio-cultural barriers, and/or improve gender inequalities get higher priority.)

Quality: Quality of health services including the skills of health workers in providing those services (Programmes that can improve the quality of health services or of health workers get higher priority.)

(2) Criteria related to practicality of implementing programmes

Precedence: Essential programmes which should be undertaken prior to other programmes, i.e. other programmes depend on them. (Programmes with higher needs of precedence get higher priority.)

Technical Feasibility: Technical difficulty in implementing programmes or getting positive results (Programmes of low technical difficulty get higher priority.)

Low Resource Requirement: Resource requirements for implementing programmes (Programmes of lower resource requirements get higher priority.)

Maturity: Maturity of programme ideas (for example, whether a programme was experimented as a pilot project or not) (Programmes of higher maturity get higher priority.)

24.2.2 Definition of Very High Priority Programmes, High Priority Programmes and Priority Programmes

(1) Very high priority programmes

The very high priority programmes are essential programmes to be initiated as initial steps within 5 years, in accordance with the overall basic strategies, to change/improve the existing situation of Lao health sector.

The very high priority programmes are selected from strategic perspectives, as well as from sector-wide perspectives. The selected very high priority programmes are called the Short List, shown in Table 24.1.

(2) High priority programmes

The high priority programmes are programmes to be undertaken after the very high programmes are started, to raise effectiveness in achieving goals/ objectives, in parallel with the very high priority programmes.

High priority programmes are selected from sector-wide perspectives. The selected high priority programmes are shown together with very high priority programmes as the Medium List. See Table 24.2.

(3) Priority programmes

Priority programmes are selected from sub-sector perspectives. It should be reconsidered whether they should be implemented, after all the very high and high priority programmes have been started.

Figure 24.1 Very High Priority Programmes and Initial Strategic Steps

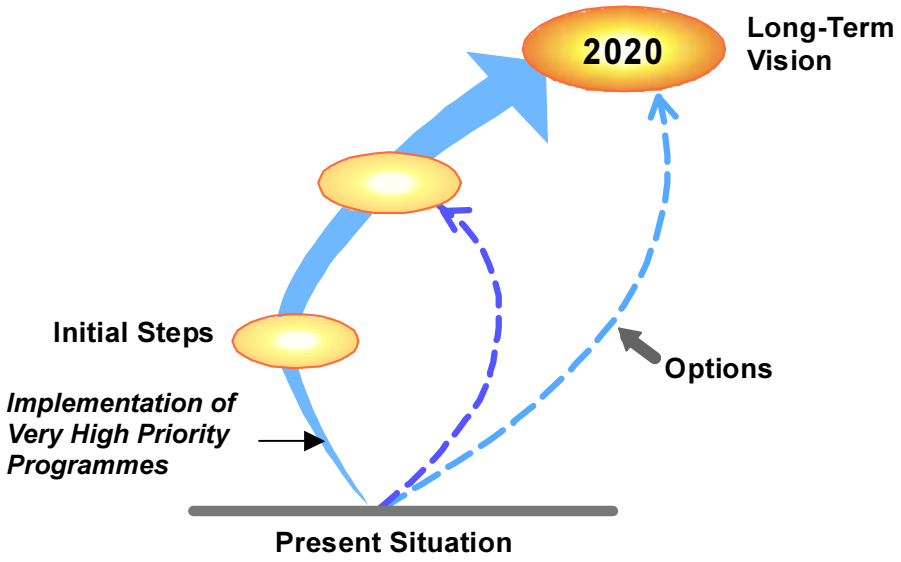


Figure 24.2 Selection of Highly Prioritised Programmes

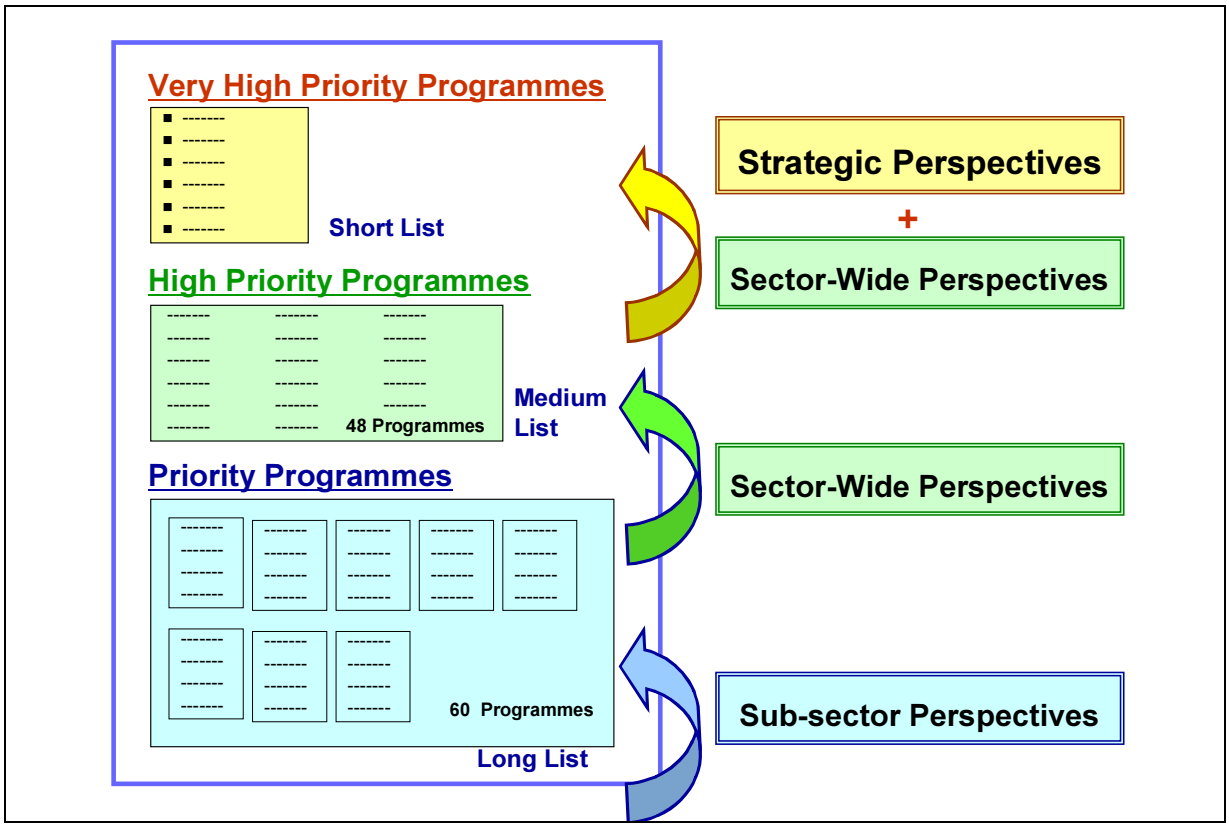
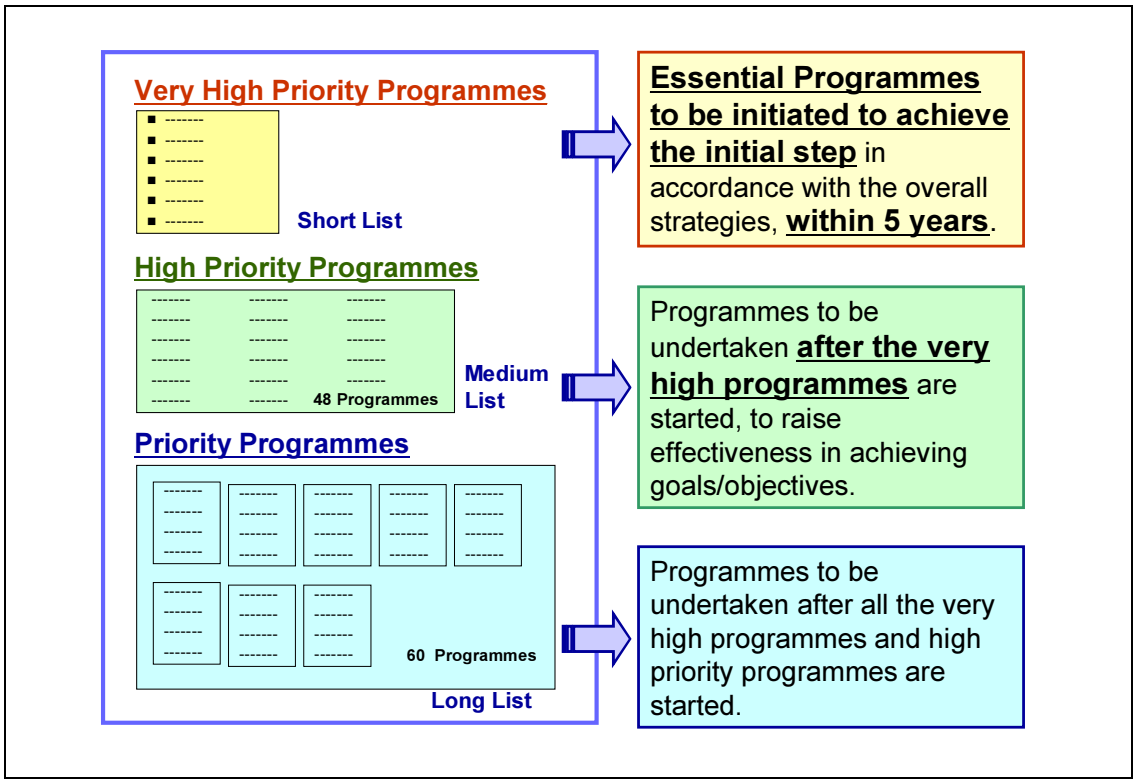


Figure 24.3 Very High Priority, High Priority and Priority Programmes



24.2.3 Selected Priority Programmes

(1) Very High Priority Programmes

The list of very high priority programmes (Short List) is shown in Table 24.1. Relation between Overall Basic Strategies (1) and Very High Priority Programmes is shown in Table 24.3.

Table 24.1 List of Very High Priority Programmes (Short List)

PLANNING AND MANAGEMENT

(1) PM-1 Sector-Wide Coordination Programme
(2) PM-2 Capacity Building Programme for Health Management and Health Information System

HUMAN RESOURCES DEVELOPMENT

(3) HR-2 Programme for Improving Management, Allocation, and Motivation of Health Personnel
(4) HR-3 Programme of Reforming Job Descriptions and Titles of Health Personnel and Organization Structure of the Government Health Sector
(5) HR-4 Programmes for Strengthening Regional and Provincial Education and Training Institutions for Health Workers
(6) HR-5 Programme for Reformulating Nurse Education Policies
(7) HR-9 Programme for Improving Quality of Teachers for Health Worker Education/Training
(8) HR-10 Programme for Reformulating Medical Doctor Education Policies
(9) HR-13 Textbook Development Programme for Nurse Education in Lao Language

HEALTH FINANCE

(10) HF-1 Financial Management Improvement Programme for the Health Sector
(11) HF-2 Programme for Reforming the Revolving Drug Fund and User Fee Systems

HEALTH EDUCATION

(12) ED-1 Radio Broadcasting Programme for Health Education
(13) ED-3 Programme for Promoting IEC Activities at District Hospitals

INFECTIOUS DISEASE CONTROL

(14) ID-2 Programme of Improving Skills in Diagnosis and Care/Treatment of Infectious Diseases at District Hospitals and Health Centres
(15) ID-4 Programme for Integrating EPI and Other Health Services
(16) ID-6 Programme of Strengthening Control of HIV/AIDS and STDs
(17) ID-7 Programme for Strengthening Malaria Control and other PHC Activities

PRIMARY HEALTH CARE

(18) PH-1 Programme for Supporting the Operationalisation of the "Policy of Primary Health Care"
(19) PH-2 Programme to Develop and Adapt Flexible National Guidelines and Regulations for Strengthening District Health Systems based on the PHC Approach
(20) PH-3 Programme of Implementing the PHC Approach to Strengthen District Health Systems

MATERNAL AND CHILD HEALTH

(21) MC-1 MCH Networking and Coordination Programme
(22) MC-2 Programme for Strengthening and Promotion of MCH

(23) MC-3 Programme for Strengthening Family Planning

NUTRITION

(24) NT-1 Programme of Developing a Core Organization for Providing Support and Oversight to Nutrition Activities

(25) NT-3 Nutrition Information/Education Programme

HOSPITAL SERVICES

(26) HS-1 District Hospital Improvement Programme

(27) HS-2 National Programme for Strengthening the Maintenance System of Health Facilities by Establishing Provincial Maintenance Units

(28) HS-3 Hospital Management Improvement Programme

MEDICAL LABORATORY TECHNOLOGY

(29) ML-1 Programme for Strategy Formulation and Capacity Building for Health Technology-Based Medicine

ESSENTIAL DRUGS

(30) DR-2 Rational Use of Drugs Programme

(31) DR-4 Village-Level Revolving Drug Fund (RDF) Programme

Summaries of Very High Priority Programmes are shown below:

PM-1 Sector-Wide Coordination Programme

PM-1 intends to start coordination among MOH and health donors/NGOs by conducting informal sharing of information, as well as by continuing national-level health forums. PM-1 also covers coordination efforts at the provincial level. The Department of Planning and Budgeting in the MOH should take the lead in this sector-wide coordination, with the support of a small group of donor/NGO people.

PM-2 Capacity Building Programme for Health Management and Health Information System

PM-2 is aimed at addressing the need for a more effective and efficient system of managing scarce resources for health. It proposes to equip selected key personnel at the central MOH and management teams of PHOs and DHOs with basic and useful management skills. It intends to develop a pool of MOH management experts who will be master trainers and facilitate systems improvement during initial and nationwide programme implementation. In the end, PM-2 will prepare the health system to do more with less.

HR-2 Programme for Improving Management, Allocation, and Motivation of Health Personnel

HR-2 aims at allocating more health personnel to the district level (district health offices, district hospitals and health centres) and developing a scheme to encourage high motivation towards their work, for an effective and efficient district health system. Programme components include: 1) formulation of health personnel distribution and allocation plan; 2) preparation of motivation scheme; 3) pilot project implementation and evaluation; and 4) full-scale implementation of motivation scheme and re-allocation of the health personnel.

HR-3 Programme of Reforming Job Descriptions and Titles of Health Personnel and Organisation Structure of the Government Health Sector

The main objectives of HR-3 are to ensure that health workers have a clear understanding of their own duties and a high sense of responsibility towards their work, and to increase organisational efficiency in the government health sector. The major components of the programme are 1) development of job descriptions, 2) reform of the organisation structure of the government health sector, and 3) establishment and implementation of the system to monitor the performance of health personnel.

HR-4 Programme for Strengthening Regional Education and Training Institutions for Health Workers

HR-4 tries to strengthen the three functions of public health schools in the regions: namely 1) pre-service training for nurses, 2) in-service training for health workers at the provincial, district and health centre levels, and 3) pre-service training of PHC workers for health centres.

HR-4 shall include technical assistance, physical development and equipment improvement, targeting all public health schools and nursing schools in Champasak province, Savannakhet province, Khammuane province, Vientiane province, Luangphabang province, and Oudomxay province.

HR-5 Programme for Reformulating Nurse Education Policies

HR-5 intends to facilitate the Lao health sector to emphasise the importance of the roles of nurses at the health centre and community levels as well as their independent and professional roles in hospitals. This change of emphasis shall be reflected in policy formulation and an action plan to improve nurse education and its actual implementation in public health schools and nursing schools in the regions and Vientiane Municipality.

HR-9 Programme for Improving Quality of Teachers for Health Worker Education/Training

The improvement of the quality of teachers is essential to improve the quality of pre-service training and in-service training of health workers. HR-9 includes 1) policy and action plan formulation to provide more education and training opportunities inside/outside the country for both the existing teaching staff and prospective teachers and trainers, and 2) actual implementation of the policy and action plan.

HR-10 Programme for Reformulating Medical Doctor Education Policies

HR-10 aims to review medical doctor education policies and to reform the education system for medical doctors in order to improve their quality. The action plan, which will be developed in HR-10, shall include 1) introducing new systems such as internships in hospitals, a licensing system, and continuing education, 2) promoting international and domestic learning and exchange programmes, and 3) encouraging the active participation of medical doctors in teaching and training health workers.

HR-13 Textbook Development Programme for Nurse education in Lao Language

HR-13 shall develop and publish textbooks in Lao mainly for pre-service nurses and PHC workers, and in-service health workers serving at provincial, district, and village levels. The programme will contribute to improving the efficiency of pre-service education and will enable pre- and in-service health workers, who have few opportunities and little time to study foreign languages, to learn by themselves in order to brush up their knowledge and skills.

HF-1 Financial Management Improvement Programme for the Health Sector

In order to improve the health financial situation in increased budget allocation to the health sector, adequate utilization of health government budgets and efficient utilization of allocated budgets, HF-1 emphasises a system reform and capacity building of budgeting and recording expenditure at the national, provincial and district levels. Based on this financial

management improvement, HF-1 proposes the introduction of a simplified national health account system to the Lao PDR.

HF-2 Programme for Reforming the Revolving Drug Fund and User Fee Systems

HF-2 aims at standardising the RDF, user fee and exemption systems at health facilities, so that government budget allocated for exemption for the poor and collected user fees can be used properly and transparently at the health facilities. HF-2 also aims at standardising and strengthening the management system of RDFs by centralising drug supply and purchase through PHOs, in order to control the quality of drugs and to provide drugs at the same prices throughout each province.

ED-1 Programme for National Radio Broadcasting

ED-1 intends to develop radio programming as a vehicle for health messages, to be used in reinforcing behaviour change campaigns. This programme will also focus on the development of key health messages for creating health awareness for both Lao Loum and ethnic minority people. The programme implementation will be based on collaboration between Ministry of Health, Ministry of Information and Ministry of Education. Encouraging communities to listen to radio programmes through Community Learning Centre activities will also be considered.

ED-3 Programme for Promoting IEC Activities at District Hospitals

Aimed at improving the quality of health services in district hospitals, ED-3 will emphasise the promotion of IEC activities, including possibly advertising the potential of district hospitals in order to increase utilization. In addition, this programme will aim to reduce preventable infectious diseases in communities by organising outreach activities.

ID-2 Programme of Improving Skills in Diagnosis and Care/Treatment of Infectious Diseases at District Hospitals and Health Centres

ID-2 aims to provide in-service training on making working diagnosis and care/treatment for infectious diseases for health workers at the district and health centre levels. Working Diagnosis, using an approach by syndromes, appears to be the most appropriate strategy given available medical facilities at the district and health centre levels. Working Diagnosis does not imply sophisticated biological or paramedical test but requires a more advanced knowledge of clinical examination, semiology and epidemiology of the infectious diseases.

ID-4 Programme for Integrating EPI and Other Health Services

ID-4 aims at examining the technical and financial feasibility of this idea of integrating EPI and other health services by conducting case studies in selected provinces of different organisational capacities, and by implementing pilot projects in some provinces with advanced organisational capacities. Other health services might include health education (hygiene and nutrition) and monitoring village-level revolving drug funds.

ID-6 Programme of Strengthening Control of HIV/AIDS and STDs

Although HIV-AIDS prevalence appears to be limited in space (mainly urban areas) and circulating at a very low level within the entire country, Sexually Transmitted Diseases (STDs) have a high incidence and are of major public health concern. Because of the exceptionally low incidence of HIV/AIDS across the country, besides the benefit for HIV/AIDS of the STD programme, specific action also needs to be taken against a possible expansion of HIV among risk populations and areas. First of all, it is necessary to conduct a second-generation surveillance of HIV/AIDS and STDs for formulating necessary action plans. It is also a necessity to develop a comprehensive, sustainable communication strategy in order to reach groups at risk including service workers, young people, partners, drug addicts, migrants and tourists.

ID-7 Programme for Strengthening Malaria Control and other PHC Activities

Malaria critically affects the development process, having high rates of mortality and morbidity. There is severe anti-malarial drug resistance in Laos and malaria control needs to be addressed jointly with other countries at the regional level. In the last several years, a variety of donors/NGOs have assisted in malaria control programmes. ID-7 aims to continue to guide malaria control and prevention measures (community based and vector control) and to improve the treatment of malaria. ID-7 also pays attention to how to integrate malaria control with other PHC activities at the district and health centre levels.

PH-1 Programme Supporting the Operationalisation of the "Policy on Primary Health Care"

PH-1 takes the Primary Health Care Policy another step further towards full operationalisation in Lao PDR. Considering that the developmental approach of PHC is a paradigm shift from the welfare approach, it recommends a re-orientation of attitudes of decision-makers at the central MOH, PHO, and DHO as well as those of the provincial and district governors, after which the process of formulating the "MOH Strategic Plan to Operationalise PHC" commence.

PH-2 Programme to Develop and Adapt Flexible National Guidelines and Regulations for Strengthening District Health Systems based on the PHC Approach

PH-2 aims at supporting and facilitating the strengthening of District Health Systems based on the PHC approach by providing flexible national guidelines and regulations. The guidelines/regulations cover the following components of the District Health Systems: 1) District health offices and district hospitals, 2) District health committees, 3) Health centres and health centre networks, 4) VHVs/TBAs and VHV/TBA networks, 5) Village Health Committees, 6) Village Health Providers.

PH-3 Programme of Implementing the PHC Approach to Strengthen District Health Systems

The district is where the top and bottom meet, where policy becomes reality. Whereas PH-1 transforms the "Policy on Primary Health Care" into the "MOH Strategic Plan to Operationalise PHC", and PH-2 lays down flexible national guidelines and regulations, PH-3 describes activities to actually strengthen the four components of a district health system: the district hospital based services, outreach services from the district level, health centre based services, and community-based activities of village health volunteers. It underscores the importance of rationalising and clarifying the organisation, improving management systems, and building capacities of staff to be generalists and take a holistic approach. It emphasises the empowerment of communities to take responsibility for their own health. PH-3 proposes the participation of NGOs or consultancy groups as catalyst of change in implementing PHC.

MC-1 MCH Networking and Coordination Programme

MC-1 seeks to facilitate coordination and, whenever possible, integration of the various maternal and child health care programmes internally within the Centre of Maternal and Child Health and the Ministry of Health and between MOH and donors. Venues for coordination will be created through the establishment of a functional network and the setting up of a coordination centre.

MC-2 Programme for Strengthening and Promotion of MCH

MC-2 aims to expand the zone-zero strategy from immunisation to a package of integrated MCH services at zone-zero facilities. This will be implemented in selected pilot areas where MCH services will also be actively promoted through an intensified antenatal care campaign with health workers going out of the facilities to communities to reach pregnant women. MC-2 also intends to improve and expand outreach services. A package of MCH services that can be delivered through the outreach programme will be developed including protocols and kits. Training of health workers before the implementation of the above stated activities is an essential component of the programme.

MC-3 Programme for Strengthening Family Planning

MC-3 intends to improve logistics management of Family Planning (FP) commodities and strengthen the capacity of the FP Programme to establish an adequate and steady supply of contraceptives. It also aims to improve the quality of services by improving the training of health workers on FP; reviewing and amending policy and procedures to facilitate the delivery of FP services; and finding ways to expand FP services by piloting the inclusion of contraceptives in the revolving drug fund and the inclusion of the injectable hormonal contraceptive method in MCH outreach.

NT-1 Programme of Developing a Core Organisation for Providing Support and Oversight to Nutrition Activities

The objectives of NT-1 are to establish a focal point for nutrition activities within the Ministry of Health and to create venues for the coordination of various nutrition activities.

NT-3 Nutrition Information/Education Programme

NT-3 intends to develop training curricula and train health workers and village volunteers. The training curriculum for health workers will focus on basic nutrition information and messages that will be useful in the delivery of MCH services. The village health volunteer training will cover information and messages on proper maternal and child nutrition and feeding.

HS-1 District Hospital Improvement

HS-1 focuses on the development of District Hospitals as the core of the District Health System. District Hospitals will be classified, and criteria for classification will be set. An Initial Standard for each type of District Hospital will be formulated, based on the identification of standards for health facilities at all levels. The Initial Package for upgrading District Hospitals to meet the Initial Standard will be prepared, and implementation will take place first in selected priority District Hospitals.

HS-2 National Programme for Strengthening the Maintenance System of Health Facilities by Establishing Provincial Maintenance Units

HS-2 emphasises the importance of proper property management and maintenance in order to make effective use of existing infrastructure and equipment. Main components of HS-2 are to strengthen the national maintenance and property management systems, and to establish a Provincial Maintenance Unit in each province to take care of all health facilities within the province. Training for the technical staff in Provincial Maintenance Units will be provided by the central level.

HS-3 Hospital Management Improvement Programme

In cooperation with its partners, the MOH has built, upgraded and equipped an extensive hospital network nationwide. It has organised off-site capacity-building programmes to enhance technical and, a few times, managerial skills of its personnel. HS-3 recommends on-site training for all members of the hospital management teams. To improve the efficient use of resources, HS-3 emphasises a combination of other factors: setting of standards; clarifying job descriptions; recognising best practices through the establishment of Minister's Awards; and the development of management systems.

ML-1 Programme for Strategy Formulation and Capacity Building for Health Technology-Based Medicine

ML-1 emphasises the importance of health technology-based medicine for improving the quality of health services. The concept of health technology-based medicine will be disseminated and the knowledge and skills of medical doctors and health technologists will be improved. Strategy and guidelines for Health Technology-Based Medicine will be formulated. Training of medical doctors and health technologists will be provided.

DR-2 Rational Use of Drugs Programme

Although the supply and availability of drugs has been greatly improved in the last several years, the irrational use of drugs has become prevalent by health workers at all levels of health facilities, as well as in communities. DR-2 aims to create conditions in which the rational use of drugs is promoted by preparing essential drug lists and treatment guidelines that are suitable for health workers of different levels, training health workers in terms of the rational use of drugs (potential danger of antibiotic drugs and injections) and training health workers on how to detect false or poor quality drugs.

DR-4 Village-Level Revolving Drug Fund (RDF) Programme

MOH has started a project to unify the RDF system and to expand village-level RDFs nationally, targeting all villages in remote areas (5,400 villages) by 2005. DR-4 intends to assess the progress of the implementation of the projects and redesign the system in order to improve the already begun village-level RDFs, to continuously support DHOs in management and monitoring, and to expand gradually to remoter areas.

(2) High Priority Programmes

The selected high priority programmes are shown together with very high priority programmes as the Medium List in Table 24.2. Relation between Overall Basic Strategies (2) and Very High and High Priority Programmes is shown in Table 24.4.

Table 24.2 List of Very High and High Priority Programmes (Medium List)

PLANNING AND MANAGEMENT

(1) PM-1 Sector-Wide Coordination Programme
(2) PM-2 Capacity Building Programme for Health Management and Health Information System

HUMAN RESOURCES DEVELOPMENT

(3) HR-1 Health Personnel Rotation System Programme
(4) HR-2 Programme for Improving Management, Allocation, and Motivation of Health Personnel
(5) HR-3 Programme of Reforming Job Descriptions and Titles of Health Personnel and Organization Structure of the Government Health Sector
(6) HR-4 Programmes for Strengthening Regional and Provincial Education and Training Institutions for Health Workers
(7) HR-5 Programme for Reformulating Nurse Education Policies
(8) HR-6 Programme for Enhancing Communication Skills of Health Workers
(9) HR-8 Continuing Education Programme for Health Workers
(10) HR-9 Programme for Improving Quality of Teachers for Health Worker Education/Training
(11) HR-10 Programme for Reformulating Medical Doctor Education Policies
(12) HR-13 Textbook Development Programme for Nurse Education in Lao Language

HEALTH FINANCE

(13) HF-1 Financial Management Improvement Programme for the Health Sector
(14) HF-2 Programme for Reforming the Revolving Drug Fund and User Fee Systems

HEALTH EDUCATION

(15) ED-1 Radio Broadcasting Programme for Health Education
(16) ED-2 School Health Programme
(17) ED-3 Programme for Promoting IEC Activities at District Hospitals

INFECTIOUS DISEASE CONTROL

(18) ID-2 Programme of Improving Skills in Diagnosis and Care/Treatment of Infectious Diseases at District Hospitals and Health Centres
(19) ID-3 Programme for Developing Early Warning System for Outbreak of Infectious Diseases based on Working Diagnosis
(20) ID-4 Programme for Integrating EPI and Other Health Services
(21) ID-5 Programme for Improving Childhood Infectious Disease Control (integrated into IMCI)

(22) ID-6 Programme of Strengthening Control of HIV/AIDS and STDs
(23) ID-7 Programme for Strengthening Malaria Control and other PHC Activities
(24) ID-8 Tuberculosis Control Improvement Programme

PRIMARY HEALTH CARE

(25) PH-1 Programme for Supporting the Operationalisation of the "Policy of Primary Health Care"
(26) PH-2 Programme to Develop and Adapt Flexible National Guidelines and Regulations for Strengthening District Health Systems based on the PHC Approach
(27) PH-3 Programme of Implementing the PHC Approach to Strengthen District Health Systems

MATERNAL AND CHILD HEALTH

(28) MC-1 MCH Networking and Coordination Programme
(29) MC-2 Programme for Strengthening and Promotion of MCH
(30) MC-3 Programme for Strengthening Family Planning
(31) MC-4 Mother-Baby Friendly Hospital Programme
(32) MC-6 MCH Training Programme for Village Health Volunteers (VHV) and Traditional Birth Attendants (TBA)

NUTRITION

(33) NT-1 Programme of Developing a Core Organization for Providing Support and Oversight to Nutrition Activities
(34) NT-2 Programme for Improving Nutritional Status of Prenatal/Lactating Mothers and Under-5 Children
(35) NT-3 Nutrition Information/Education Programme

HOSPITAL SERVICES

(36) HS-1 District Hospital Improvement Programme
(37) HS-2 National Programme for Strengthening the Maintenance System of Health Facilities by Establishing Provincial Maintenance Units
(38) HS-3 Hospital Management Improvement Programme
(39) HS-5 Programme for Upgrading Provincial, Regional and Central Hospitals to Meet Minimum Standards

MEDICAL LABORATORY TECHNOLOGY

(40) ML-1 Programme for Strategy Formulation and Capacity Building for Health Technology-Based Medicine
(41) ML-4 Programme for Capacity Building of Medical Laboratory Technologists

ESSENTIAL DRUGS

(42) DR-1 Programme for Strengthening Quality Check Systems of Drugs
(43) DR-2 Rational Use of Drugs Programme
(44) DR-3 Programme of Training Private Pharmacies' Staff

(45) DR-4 Village-Level Revolving Drug Fund (RDF) Programme

(46) DR-5 Programme for Promoting Traditional Medicine at District Hospitals, Health Centres and Village Levels

GENDER

(47) GR-1 Programme for Mainstreaming Gender Issues in the Health Sector

HEALTH RESEARCH

(48) RR-1 Programme to Develop Capacities for Health Research

SUBSTANCE ABUSE

(49) SA-1 Programme to Develop Treatment Guidelines and Related Capacities for ATS with Perspective on Mental Health

Table 24.3 Relation between Overall Basic Strategies (1) and Very High Priority Programmes

	Overall Basic Strategies (1)	Very High Priority Programmes
1	To Promote Sector-Wide Coordination at National, Provincial and District Levels	PM-1, MC-1, NT-1, ML-1
2	To Reform the Health Financial System and to Strengthen the Financial Management Capacity of MOH, PHO and DHO	HF-1, HF-2
3	To Improve the Quality of Health Worker Training and To Allocate and Motivate Well-Trained Health Workers in Districts and Health Centres	HR-2, HR-3, HR-4, HR-5, HR-9, HR-10, HR-13, ID-2, NT-3
4	To Build the System and Capacity of Health Management in Decentralised Contexts	PM-2
5	To Implement Infectious Disease Control Efficiently and Effectively	ID-2, ID-4, ID-6, ID-7
6	To Implement the PHC Approach to Strengthen District Health Systems	
	(6-a) To Promote the PHC Approach	PH-1, PH-2, PH-3
	(6-b) To Strengthen the Function of District Hospitals and District Health Office	PM-2, HS-1, ID-2
	(6-c) To Sustain Village-RDFs	DR-4
	(6-d) To Integrate and to Decentralise PHC Components (EPI, Other Infectious Disease Control, and Family Planning)	ID-4, ID-7, MC-3
	(6-e) To Strengthen PHC Components (MCH and Nutrition)	MC-2, NT-3
	(6-f) To Promote Health Education	ED-1, ED-3
7	To Operate Central and Provincial Hospitals Efficiently	HS-2, HS-3, ML-1
8	To Increase the Availability and Affordability of Essential Drugs and to Promote Rational Drug Use	DR-2, DR-4

Table 24.4 Relation between Overall Basic Strategies (2) and Very High and High Priority Programmes

	Overall Basic Strategies (2)	Very High Priority Programmes	High Priority Programmes
1	To Continue Sector-Wide Coordination at National, Provincial and District Levels and to Promote Inter-Sectoral Coordination for Health Sector Development and Reform	PM-1, MC-1	-
2	To Continue and Strengthen the Reform of the Health Financial System and the Capacity Building of Financial Management of MOH, PHO and DHO	HF-1	-
3	To Improve the Quality of Health Worker Training covering not only Nurses, but also Medical Doctors and Other Paramedical, and to Continue the Allocation and Motivation of Well-Trained Health Workers in Districts and Health Centres	HR-2, HR-3, HR-4, HR-13, ID-2, NT-3	HR-1, HR-6, HR-8
4	To Continue the Capacity Building of Health Management in Decentralised Contexts	PM-2	-
5	To Strengthen Infectious Disease Control under District Health Systems	ID-2, ID-4, ID-6, ID-7	ID-3, ID-5, ID-8
6	To Implement the PHC Approach to Reconstruct Integrated District Health Systems (by re-integrating various PHC components under the District Health Systems, including the promotion of school health activities)		
	(6-a) To Promote the PHC Approach	PH-2, PH-3	ED-2
	(6-b) To Strengthen the Function of District Hospitals and District Health Office	PM-2, HS-1, ID-2	MC-4
	(6-c) To Sustain Village-RDFs	DR-4	-
	(6-d) To Integrate and to Decentralize PHC Components (EPI, Other Infectious Disease Control, and Family Planning)	ID-4, ID-7, MC-3	-
	(6-e) To Strengthen PHC Components (MCH and Nutrition)	MC-2, NT-3	MC-6, NT-2
	(6-f) To Promote Health Education	ED-1, ED-3	-

7	To Continue the Promotion of Efficient Operation of Central and Provincial Hospitals and to Upgrade the Service Level of Central and Provincial Hospitals (by conducting trainings of specialist medical doctors and improving laboratory technology)	HS-2, HS-3, ML-1	HS-5, ML-4
8	To Continue to Increase the Availability and Affordability of Essential Drugs and to Promote Rational Drug Use, and furthermore to Strengthen the System of Drug Quality Control	DR-2, DR-4	DR-1, DR-3, DR-5
9	To Promote Effective Participation of Informal Village Health Providers and Villagers' Participation in Health Sector Development and Reform	PH-2, PH-3	-
10	To Promote Gender Perspectives in Health Programmes	-	GR-1
11	To Promote Research to Get Policy Implications	-	RR-1
12	To Strengthen Curative Aspects (including Mental Health) of Drug Abuse	-	SA-1
13	To Strengthen Rehabilitation Services in Hospitals	-	HS-5

(3) Precedent Programmes and Expansion Programmes

Precedent Programmes

It is difficult to start all 31 very high priority programmes at the same time. Seven programmes are therefore to be implemented first, as shown below. These are the programmes to prepare the basic conditions for starting the reform of the health sector in Lao PDR.

PM-1 Sector-Wide Coordination Programme

This programme aims to start continuous coordination among MOH and health donors/NGOs. The programme will prepare the basic conditions for promoting the reform of the Lao health sector by all actors in the same direction.

HR-5 Programme for Reformulating Nurse Education Policies

This programme aims to emphasise the importance of the roles of nurses and to reform nurse education. The programme will prepare the basic conditions for improving the training of nurses and will contribute especially to health services at the health centre and community levels.

HF-2 Programme for Reforming the Revolving Drug Fund and User Fee Systems

This programme aims at standardising the RDF, user fee and exemption systems from the point of view of public services. The programme will prepare conditions for providing safe and properly priced drugs nationwide from hospital level to community level.

ID-4 Programme for Integrating EPI and Other Health Services

This programme will examine the technical and financial feasibility of the idea of integrating EPI and other health services. The programme will prepare the basic conditions to integrate various vertical programmes and to provide comprehensive health services based on the PHC approach at district level in the future.

PH-2 Programme to Develop and Adapt Flexible National Guidelines and Regulations for Strengthening District Health Systems based on the PHC Approach

This programme aims at providing flexible national guidelines and regulations regarding district health systems. The programme will prepare the basic conditions for developing district health systems based on the PHC approach in the future.

MC-1 MCH Networking and Coordination Programme

This programme seeks to facilitate the coordination and integration of the various maternal and child health care programmes. The programme will prepare the basic conditions for strengthening activities on MCH, which is currently one of the weaker areas in the Lao health sector.

NT-1 Programme of Developing a Core Organisation for Providing Support and Oversight to Nutrition Activities

The objectives of this programme are to establish a focal point for nutrition activities within MOH. The programme will prepare the basic conditions for promoting activities on nutrition, which is another weaker area in the Lao health sector.

Expansion Programmes

Among the very high priority programmes, the seven programmes identified below are to be implemented nationwide, aimed at making substantial progress towards achieving the initial step guided by the overall basic strategies (1). The Lao government must make continuous efforts to implement those programmes by allocating sufficient budgets for sufficient periods in order for the programmes to have a substantial impact.

PM-2 Capacity Building Programme for Health Management and Health Information System

This programme is aimed at building the capacities of MOH, PHOs and DHOs for health management and to improve the health information system. The programme will promote the fourth of the overall basic strategies (1).

HR-4 Programme for Strengthening Regional Education and Training Institutions for Health Workers

This programme tries to strengthen the functions of public health schools in the regions. The programme will promote the third of the overall basic strategies (1).

HF-1 Financial Management Improvement Programme for the Health Sector

This programme emphasises a reform of the health finance system at the national, provincial and district levels in order to utilise government budgets effectively and efficiently. The programme will promote the second of the overall basic strategies (1).

PH-3 Programme of Implementing the PHC Approach to Strengthen District Health Systems

This programme aims at strengthening the four components of a district health system: the district hospital-based services, outreach services, health centre-based services, and community-based activities. The programme will promote the sixth of the overall basic strategies (1).

MC-2 Programme for Strengthening and Promotion of MCH

This programme aims to expand the zone-zero strategy from immunisation to a package of integrated MCH services. The programme will promote the sixth of the overall basic strategies (1).

HS-1 District Hospital Improvement

This programme focuses on the development of District Hospitals as the core of the District Health System. The programme will promote the sixth of the overall basic strategies (1).

HS-2 National Programme for Strengthening the Maintenance System of Health Facilities by Establishing Provincial Maintenance Units

This programme aims to strengthen the national maintenance and property management systems, and to establish Provincial Maintenance Units for the more effective use of infrastructure and equipment. The programme will promote the seventh of the overall basic strategies (1).

(4) Priority Programmes

A list of all identified programmes and programme components/projects (Long List) are shown in Table 24.5.

Table 24.5 List of Priority Programmes (Long List)

No.	Title of Programme/ Title of Programme Component	Type of Programme Component	Concern with Peripheral Areas	Priority Very High : ☆☆ High : ☆
PLANNING AND MANAGEMENT				
PM-1	**Sector-Wide Coordination Programme**	**-**	-	☆☆
PM-1(1)	Sector-Wide Coordination at the National Level	Coordination		
PM-1(2)	Sector-Wide Coordination at the Provincial Level	Coordination		
PM-2	**Capacity Building Programme for Health Management and Health Information System**	**-**	-	☆☆
PM-2(1)	Capacity Building on Health Management at the Central MOH	Training		
PM-2(2)	Study and Initial Project: On-site Capacity Building on Health Management for Selected PHOs and DHOs	Study Pilot-test		
PM-2(3)	Capacity Building on Health Management for all PHOs and DHOs	Training		
HUMAN RESOURCES DEVELOPMENT				
HR-1	**Health Personnel Rotation System Programme**	**-**		☆
HR-1(1)	Study Project on Health Personnel Rotation Schemes	Study Institutional Reform		
HR-1(2)	Establishment of Provincial Health Personnel Rotation System	Institutional Reform	✓	
HR-1(3)	Establishment of Central-Provincial Health Personnel Rotation System	Institutional Reform		
HR-1(4)	Establishment of Different Career Paths for Health/Medical Practitioners and Health Managers/Administrators	Institutional Reform		
HR-2	**Programme for Improving Management, Allocation and Motivation of Health Personnel**	**-**		☆☆
HR-2(1)	Formulation at the Health Personnel Distribution and Allocation Plan	Institutional Reform	✓	

HR-2(2)	Implementation of the Decree on "Promoting Health Personnel in Remote Rural Areas" and Personnel Re-allocation	Institutional Reform	✓	
HR-2(3)	Development of Other Schemes to Improve the Motivation of Health Personnel	Study System Design Pilot Project Institutional Reform	✓	
HR-3	**Programme of Reforming Job Descriptions and Titles of Health Personnel and Organisation Structure of the Government Health Sector**	-		☆☆
HR-3(1)	Development of Job Descriptions and Health Worker's Titles	Institutional Reform		
HR-3(2)	Reformulation of Organisation Structure in the Government Health Sector	Institutional Reform		
HR-3(3)	Establishment of the System to Monitor the Performance of Health Personnel	System Design Training Institutional Reform		
HR-4	**Programmes for Strengthening Regional and Provincial Education and Training Institutions for Health Workers**	-		☆☆
HR-4(1)	Upgrading of Existing Public Health Schools and Auxiliary Nursing Schools	Training, Construction, Equipment	✓	
HR-4(2)	Development and Production of Textbooks for Nurse Education in Lao Language (HR-13)	(Refer to HR-13)	✓	
HR-4(3)	Establishment of PHC Worker Training Course at Public Health Schools and Auxiliary Nursing Schools	Textbook Development(HR-13), Training Construction, Equipment	✓	
HR-4(4)	Establishment of Resource Centres at Public Health Schools and Auxiliary Nursing Schools	Training Construction, Equipment		
HR-4(5)	Establishment of In-Service Training Courses at Public Health Schools or Auxiliary Nursing Schools	Curriculum and Material Development Training Construction, Equipment		
HR-5	**Programme for Reformulating Nurse Education Policies**	-		☆☆
HR-5(1)	Assessment of the Present Situation and Redefine the Role of Nurses	Study		
HR-5(2)	Defining the Job Description of Nurse(HR-3)	(Refer to HR-3)		
HR-5(3)	Reformulation of the Nurse Education System	System Design Institutional Reform	✓	

HR-5(4)	Formulation of a Policy and Action Plan toward 2020	Planning	✓	
HR-6	**Programme for Enhancing Communication Skills of Health Workers**	**-**		☆
HR-6(1)	Emphasis of Communication Skill Training in In-Service Training	Curriculum and Material Development Training		
HR-6(2)	Emphasis of Communication Skill Training in Pre-Service Education	Curriculum and Material Development Training		
HR-7	**Programme of Upgrading Medical Assistances to Medical Doctors Through Continuing Education**	Institutional Reform Curriculum Development Training		
HR-8	**Continuing Education Programme for Health Workers**	-		☆
HR-8(1)	Establishment of Standardized Menu of Continuing Education	System Design Institutional Reform Curriculum Development		
HR-8(2)	Development at a Multilevel Evaluation System	System Design Institutional Reform		
HR-8(3)	Establishment of Pre-evaluation System of Education and Training Courses	System Design Institutional Reform		
HR-9	**Programme for Improving Quality of Teachers for Health Worker Education/Training**	-		☆☆
HR-9(1)	Formulation of a Policy and Action Plan toward 2020	Study System Design Planning		
HR-9(2)	Starting Implementation of the Policy and Action Plan	Education Training		
HR-10	**Programme for Reformulating Medical Doctor Education Policies**			☆☆
HR-10(1)	Assessment of the Present Situation of Medical Doctors	Study		
HR-10(2)	Defining the Job Description of Medical Doctor(HR-3)	(Refer to HR-3)		
HR-10(3)	Reformulation of the System of Medical Doctor Education	System Design Institutional Reform		
HR-10(4)	Formulation of a Policy and Action Plan toward 2020	Planning		
HR-11	**Programme for Horizontal Networks of Health Workers and Promoting International and Domestic Exchange**	Organization Development		

HR-12	**Programme for Developing Textbooks for Medical Doctor and Paramedical Professional Education in Lao Language**	Study Textbook Development Printing and Publishing	✓	
HR-13	**Textbook Development Programme for Nurse Education in Lao Language**	Study Textbook Development Printing and Publishing	✓	☆☆
HEALTH FINANCE				
HF-1	**Financial Management Improvement Programme for the Health Sector**	-		☆☆
HF-1(1)	Study of Cost-Effectiveness of Health Interventions	Study		
HF-1(2)	MOH Financial Management System Improvement and Capacity Building Project	System Design Training		
HF-1(3)	Provincial Financial Management System Improvement and Capacity Building Project	System Design Training	✓	
HF-1(4)	District Health Financial Management System Improvement and Capacity Building Project	System Design Training	✓	
HF-1(5)	Project of Developing A Simplified National Health Account System	System Design Training		
HF-2	**Programme for Reforming the Revolving Drug Fund and User Fee Systems**	-		☆☆
HF-2(1)	Establishment of a Task Force for Reforming the Revolving Drug Fund and User Fee/Exemption Systems	Institutional Reform		
HF-2(2)	Study Project for Re-designing RDF Systems and User Fee/Exemption Policies/Systems	Study Institutional Reform		
HF-2(3)	Implementation of the Revised Policies and Standardized Systems of RDF and User Fee/Exemption	Curriculum Development, Training	✓	
HF-3	**Health Insurance Schemes Coordination Programme**	Institutional Reform		
HEALTH EDUCATION				
ED-1	**Radio Broadcasting Programme for Health Education**	Institutional Reform Study, Training, Service Expansion	✓	☆☆
ED-2	**School Health Programme**	-		☆
ED-2(1)	Expansion of Deworming Activities	System Development Service Expansion	✓	

ED-2(2)	Strengthening of Health Education at Primary Schools	System Development Service Expansion	✓	
ED-3	**Programme for Promoting IEC Activities at District Hospitals**	Study Material Development Service Expansion	✓	☆☆
INFECTIOUS DISEASE CONTROL				
ID-1	**Programme for Training on General Health Practice and Community Based Infectious Disease Control**	-		
ID-1(1)	Training on specific majors ID for working diagnosis (cf ID-2), clinical and biological diagnostic epidemiology, treatment and prevention.	Training Service Development		
ID-1(2)	Organizing seminars/sessions on a specific ID actually active.	Training		
ID-2	**Programme of Improving Skills in Diagnosis and Care/Treatment of Infectious Diseases at District Hospitals and Health Centres**	-		☆☆
ID-2(1)	Curriculum Development for Training for Skill Improvement	Curriculum Development		
ID-2(2)	Training of Trainers for Skill Improvement both in Making working Diagnosis and Care/Treatment targeted at District Hospitals and Health Centres	Training		
ID-2(3)	Training for Skill Improvement both in Making Working Diagnosis and Care/Treatment	Training	✓	
ID-3	**Programme for Developing Early Warning System for Outbreak of Infectious Disease based on Working Diagnosis**	Service Development	✓	☆
ID-4	**Programme for Integrating EPI and Other Health Services**	-		☆☆
ID-4(1)	Study for Assessment and Improvement of the Present Immunization Programme (EPI)	Study		
ID-4(2)	Pilot Projects for Integration of EPI with other Health Services	Pilot Projects Institutional Reform	✓	
ID-5	**Programme for Improving Childhood Infectious Disease Control (integrated into IMCI)**	Service Expansion		☆
ID-6	**Programme of Strengthening Control of HIV/AIDS and STDs**			☆☆
ID-6(1)	HIV/AIDS and STD surveillance	Study		
ID-6(2)	Training of Health Workers on STDs	Training		

ID-6(3)	Ensuring the Availability of STD Drugs	Service Expansion		
ID-6(4)	Piloting Special Services for Service Women	Pilot Project		
ID-6(5)	Strengthening Information/Education on STDs and HIV-AIDs	Service Development		
ID-6(6)	Voluntary HIV Testing	Service Development		
ID-7	**Programme for Strengthening Malaria Control and other PHC Activities**			☆☆
ID-7(1)	Extending Positive Diagnostic Delivery	Service Development		
ID-7(2)	Expending the Vector Control Strategy	Service Development	✓	
ID-7(3)	Sustaining Community Based Control	Service Development	✓	
ID-8	**Tuberculosis Control Improvement Programme**	Service Development	✓	☆
PRIMARY HEALTH CARE				
PH-1	**Programme for Supporting the Operationalisation of the "Policy of Primary Health Care"**	**-**		☆☆
PH-1(1)	Reorientation of Attitudes toward the More Developmental Approach of PHC	Study Material Production System Development	✓	
PH-1(2)	Formulation of the MOH Strategic Plan to Operationalise PHC	System Development	✓	
PH-2	**Programme to Develop and Adapt Flexible National Guidelines and Regulations for Strengthening District Health Systems based on the PHC Approach**	**-**		☆☆
PH-2(1)	Assessment of On-Going and Past PHC Projects in the last ten years	Study		
PH-2(2)	Development of Flexible National Guidelines and Regulations for Strengthening District Health Systems based on a PHC Approach	Study System Development Curriculum Development	✓	
PH-3	**Programme of Implementing the PHC Approach to Strengthen District Health Systems**	**-**		☆☆
PH-3(1)	Initial Project to Strengthen District Health Systems	System Development Service Expansion	✓	
PH-3(2)	Institutionalisation of District Health Systems Nationwide	System Development Service Expansion	✓	
MATERNAL AND CHILD HEALTH				
MC-1	**MCH Networking and Coordination Programme**	**-**		☆☆
MC-1(1)	Networking and Coordination between Donors and MOH/MCH	Coordination		

MC-1(2)	Establishment of a Coordination Centre for MCH	Coordination System Development		
MC-2	**Programme for Strengthening and Promotion of MCH**	**-**		☆☆
MC-2(1)	Expanding the Zone-0 Strategy from Immunization to MCH	System Development Training		
MC-2(2)	Intensified Antenatal Care Campaign	Service Expansion	✓	
MC-2(3)	Improvement of MCH Outreach Service	System Development Training Service Expansion	✓	
MC-2(4)	Training for MCH	Training	✓	
MC-2(5)	MCH Information/education campaign	Campaign	✓	
MC-2(6)	Programme Management	Management	✓	
MC-3	**Programme for Strengthening Family Planning**	**-**		☆☆
MC-3(1)	Ensuring a steady supply of contraceptive commodities	Training Service Expansion		
MC-3(2)	Improvement in the training for family planning service	Training Service Expansion	✓	
MC-3(3)	Liberalizing procedures to facilitate service delivery	Service Expansion		
MC-3(4)	Piloting the inclusion of family planning commodities in the Village Drug Revolving Fund	Study Service Expansion	✓	
MC-3(5)	Piloting the inclusion of the Injectable Hormonal Contraceptive Method in MCH Outreach	Study Service Expansion	✓	
MC-4	**Mother-Baby Friendly Hospital Programme**	**-**		☆
MC-4(1)	Diffusing the concept of Mother-Baby Friendly Hospitals	System Development	✓	
MC-4(2)	Training for Mother-Baby Friendly Hospitals	Training	✓	
MC-4(3)	Remodelling of Delivery Rooms in Hospitals	Construction Equipment	✓	
MC-5	**Maternity Waiting Home Programme**	**-**		
MC-5(1)	Piloting Maternity Waiting Home, Improving Maternal Care Service and Promoting Community Support	Study Service Expansion	✓	
MC-5(2)	Promoting Maternity Waiting Home at Remote District	Service Expansion	✓	
MC-6	**MCH Training Programme for Village Health Volunteers (VHV) and Traditional Birth Attendants (TBA)**	**-**		☆

MC-6(1)	Redefining the roles of VHVs and TBAs	Study System Development		
MC-6(2)	Developing guidelines for the Recruitment of VHVs and TBAs	Study System Development	✓	
MC-6(3)	Training of VHVs and TBAs	Curriculum Development Training	✓	
NUTRITION				
NT-1	**Programme of Developing a Core Organisation for Providing Support and Oversight to Nutrition Activities**	**-**		☆☆
NT-1(1)	Development of a Core Organization for Nutrition within MOH	Organizational Development		
NT-2	**Programme for Improving Nutritional Status of Prenatal/Lactating Mothers and Under-5 Children**	**-**		☆
NT-2(1)	Micro-nutrient supplementation drive	Service Expansion	✓	
NT-2(2)	Movement for breastfeeding and child weaning	Service Expansion	✓	
NT-3	**Nutrition Information/Education Programme**	**-**		☆☆
NT-3(1)	Nutrition Training for Health Workers	Curriculum Development Training	✓	
NT-3(2)	Training on Nutrition for Village Volunteers	Curriculum Development Training	✓	
NT-3(3)	Implementation of Nutrition Information/Education Activities	Service Development	✓	
NT-4	**Programme for Promoting Marketing of Supplemental Food**	System Development Training		
HOSPITAL SERVICES				
HS-1	**District Hospital Improvement Programme**	**-**		☆☆
HS-1(1)	Establishment of Initial Standards for District Hospitals and Formulation of Initial Package Project	System Development		
HS-1(2)	Initial Package Project for District Hospital Improvement	Design, Construction, Equipment, Training	✓	
HS-1(3)	Contracting Out Project of Understaffed Poor-Performing District Health System	System Development Institutional Reform	✓	
HS-2	**National Programme of Strengthening the Maintenance System of Health Facilities by Establishing Provincial Maintenance Units**	**-**		☆☆

HS-2(1)	Formulation of Action Plan to strengthen the property management and maintenance systems and to establish Provincial Maintenance Units	System Development Institutional Reform		
HS-2(2)	Formulation of Guidelines/Standards for the Provincial Maintenance Unit and Job Descriptions for the Maintenance Engineers/Technicians	System Development		
HS-2(3)	Curriculum Development and Implementation of Training for the Provincial Maintenance Engineers / Technicians	Curriculum Development Training		
HS-2(4)	Establishment of Provincial Maintenance Unit	System Development		
HS-3	**Hospital Management Improvement Programme**	**-**		☆☆
HS-3(1)	Establishment of Minister Awards for Best Practices of Hospitals	System Development		
HS-3(2)	Formulation of Standard Services for All Health Facilities and Job Description for All Staff	System Development		
HS-3(3)	Study Project on Hospital Management Improvement Efforts	Study System Development		
HS-3(4)	Project of Enhancing Management Capacity of Hospitals though Team Approach	Institutional Reform System Development Training		
HS-4	**National Programme of Patient Friendly Hospitals**	**-**		
HS-4(1)	Project of Hospital Improvement for Making Hospitals Comfortable and Friendly	System Development Training		
HS-4 (2)	Introduction of Patient-Friendly Information on Drug Packages	System Development Training		
HS-5	**Programme for Upgrading Provincial, Regional and Central Hospitals to Meet Minimum Standards**	Study, Design, Construction, Equipment, Training		☆
MEDICAL LABORATORY TECHNOLOGY				
ML-1	**Programme for Strategy Formulation and Capacity Building for Health Technology-Based Medicine**	**-**		☆☆
ML-1(1)	Establishment of a Focal Group for Health Technology in MOH	Organization Development		
ML-1(2)	Formulation of Strategies for Health Technology-Based Medicine	Study System Development		

ML-1(3)	Training for Health Technology-Based Medicine utilizing Health Technologies	Curriculum Development Training		
ML-2	**Programme for Preparing Conditions Conducive to Good Laboratory Practice**	Study System Development Institutional Reform		
ML-3	**Programme of Establishing Internal and External Evaluation Systems of Medical Laboratory at Hospitals**	Study System Development		
ML-4	**Programme for Capacity Building of Medical Laboratory Technologists**	Study, Curriculum Development Training		☆
ML-4(1)	Assessment of quality of medical laboratory tests in hospitals	Study		
ML-4(2)	Curriculum Development of training on Medical Laboratory Technology	System Development		
ML-4(3)	Training for Medical Laboratory Technicians.	Training		
DRUGS				
DR-1	**Programme for Strengthening Quality Check Systems of Drugs**	-		☆
DR-1(1)	Establishment of Protocol of Drug Quality Check	System Development Institutional Reform		
DR-1(2)	Establishment of Regulations/Laws on Drug Quality including Penalties to Violators	Institutional Reform		
DR-1(3)	Establishment of Procedure of Reporting Violation and Violators of Drug Regulations/Laws	System Development Institutional Reform		
DR-2	**Rational Use of Drugs Programme**	-		☆☆
DR-2(1)	Establishment of Essential Drug Lists and Treatment Guidelines varying according to Qualifications of Health Workers and Village Health Volunteers	System Development		
DR-2(2)	Diffusion of Knowledge and Information on Rational Drug Use to Medical Doctors, Other Health Workers, Pharmacies' Staff and Health Volunteers	Curriculum Development Training		
DR-2(3)	Diffusion of Knowledge and Information on Rational Drug Use to Drug Consumers	Service Expansion		
DR-2(4)	Strengthening of Supervision of the Prescription of Drugs by Health Centre Staff	System Development Training		
DR-2(5)	Strengthening of Law Enforcement on Those Prescribing and Selling Drugs	System Development Service Expansion		

DR-3	**Programme of Training Private Pharmacies' Staff**	-		☆
DR-3(1)	Establishment and Operation of Model Pharmacies by MOH and PHO	System Development Training		
DR-3(2)	Development of Training Courses of Advising to Patients or Shoppers at Pharmacies	Curriculum Development Training		
DR-3(3)	Training of Private Pharmacies' Staff and Students of Pharmacy	Curriculum Development Training		
DR-4	**Village-Level Revolving Drug Fund (RDF) Programme**	-		☆☆
DR-4(1)	Establishment of a Task Force for Village –Level RDFs	Organizational Development		
DR-4(2)	Review of Existing Village-Level RDFs and Redesign of the Village-Level RDF System	System Development	✓	
DR-4(3)	Capacity Building for Improving the Village-Level RDF Systems	Curriculum Development Training	✓	
DR-4(4)	Improvement of Existing Village-RDFs and Expansion to Remoter Areas	Pilot Project System Development	✓	
DR-5	**Programme for Promoting Traditional Medicine at district hospitals, Health Centres and Village Levels**	System Development	✓	☆
GENDER				
GR-1	**Programme for Mainstreaming Gender Issues in the Health Sector**	-		☆
GR-1(1)	Sensitisation of MOH Decision-Makers and High Level Officers on the Necessity for Integrating Gender Issues in Health Policies and Programmes	System Development Institutional Reform Training		
GR-1(2)	Introduction of Gender-Differentiated Monitoring of Impacts of Selected MOH Policies	Pilot Project System Development		
GR-1(3)	Introduction of Gender Differentiated Statistics in Health Information Systems at all levels	System Development		
GR-1(4)	Sensitisation of Health Researchers so that they include gender differences as part of health Research Designs	System Development Training		
HEALTH RESEARCH				
RR-1	**Programme to Develop Capacities for Health Research**	-		☆
RR-1(1)	Project to Develop Management Capacities for Health Research	Training System Development		

RR-1(2)	Project to Develop Researchers' Capacities, including Researchers' Network for Health Research	Training		
SUBSTANCE ABUSE				
SA-1	**Programme to Develop Treatment Guidelines and Related Capacities for ATS with Perspective on Mental Health**	-		☆
SA-1(1)	Project to Develop Treatment Protocols and Guidelines for ATS	Study System Development		
SA-1(2)	Project to Develop ATS Treatment Capacities Among Existing Health Facilities and Professionals in the Lao PDR.	Training Service Development		
SA-1(3)	Project to Disseminate Risk Behaviour Prevention Curricula Integrated with Health Education	Curriculum Development Service Expansion Training		
SA-1(4)	Long Term Project to Develop Mental Health Professionals in the Lao PDR.	Study Curriculum Development System Development		
SA-2	**Programme to Develop Capacities for Drug Abuse Treatment in Northern Provinces**	Training		