Success Factors for Women’s and Children’s Health

LAO PDR
Ministry of Health, Lao PDR
“Success factors for women’s and children’s health: Lao PDR” is a document of the Ministry of Health, Lao PDR. This report is the result of a collaboration between the Ministry of Health and multiple stakeholders in Lao PDR, supported by the Partnership for Maternal, Newborn and Child Health (PMNCH), the World Health Organization, other H4+ and health and development partners who provided input and review.

Success Factors for Women's and Children's Health is a three-year multidisciplinary, multi-country series of studies coordinated by PMNCH, WHO, World Bank and the Alliance for Health Policy and Systems Research, working closely with Ministries of Health, academic institutions and other partners. The objective is to understand how some countries accelerated progress to reduce preventable maternal and child deaths. The Success Factors studies include: statistical and econometric analyses of data from 144 low- and middle-income countries (LMICs) over 20 years; Boolean, qualitative comparative analysis (QCA); a literature review; and country-specific reviews in 10 fast-track countries for MDGs 4 and 5a.1, 2 For more details see the Success Factors for Women's and Children's health website: available at http://www.who.int/pmnch/successfactors/en/
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1. Executive Summary

Overview

Lao People’s Democratic Republic (PDR) has made significant progress in improving the health of women and children and is on track to achieve Millennium Development Goals (MDGs) 4 (to reduce child mortality) and 5a (to reduce maternal mortality). This review provided an opportunity for the Ministry of Health (MOH) in Lao PDR to synthesize and document how these improvements were made, focusing on policy and programme management best practices.

Under 5 child mortality

Reductions in mortality are associated both with improved coverage of effective interventions to prevent or treat the most important causes of child mortality – in particular essential immunizations, malaria prevention and treatment, vitamin A supplementation, birth spacing, early and exclusive breastfeeding – and with improvements in socioeconomic conditions. The rate of decline in newborn mortality has been considerably slower than that of under 5 mortality and in 2012 represented 38% of all under 5 mortality. Mortality declines are much slower among the poor, less educated and rural populations. This equity gap remains an important challenge.

Maternal mortality

Declines in maternal mortality are associated with a halving of the total fertility rate between 1990 and 2012 – from six to three – and associated increases in birth interval. Fertility declines are associated with improvements in the contraceptive prevalence rate and with socioeconomic and educational improvements. Although important increases in the proportion of women delivering with a skilled birth attendant and delivering at health facilities are noted, antenatal care coverage has shown little improvement; and coverage for interventions around delivery remains below 50%. Much of the decline in maternal mortality is therefore likely to be associated with the decline in fertility and other socioeconomic improvements.
Health sector initiatives and investments

Lao PDR has put in place policies and programmes in three areas to improve delivery of key reproductive, maternal, newborn and child health (RMNCH) interventions for women and children. These consist of: laws, standards and guidelines; essential health systems; and improved delivery strategies. Laws, standards and guidelines have focused on supporting universal coverage with a package of effective interventions, on developing technical standards, and on mechanisms for improving coordination. Systems, policies and programme inputs have focused on improving health care financing, the health workforce, availability of essential medicines and use of data for tracking progress. Health financing efforts have focused on increasing government allocations to health, expanding health insurance schemes, and supporting free health care for pregnant women and children. Health workforce policy efforts have focused on improving numbers, capacity and distribution of workers, particularly midwives. Methods used included improved training, accreditation systems, and incentives for remote placement. Key delivery strategies have included implementation of an integrated routine system through provinces and districts, vertical programmes for immunizations and malaria, selective use of campaigns, and partnerships with development partners, NGOs and other civil society groups to support activities across the country.

Initiatives and investments outside the health sector

Sectors outside of health have been central to mortality declines and improvements in health. Lao PDR has seen improvements in education (primary school enrolment, time spent in school, literacy), and access to improved water and sanitation. A 40% reduction in poverty has been seen across all population groups in the last 20 years. Policy and programme inputs in these areas have included: increased resource allocation and partnerships with development partners, NGOs and civil society; clear policies and strategies; identification and targeting of high risk groups and populations, with an emphasis on reaching the poor; and use of data for making programme decisions.

Political economy

Lao PDR is a single party socialist country and is governed through decrees. This contributes to a strong policy and strategy environment. Lao has implemented initiatives to enable civic participation and improve accountability to the public. Between 1990 and 2003 the proportion of women members in the national legislature tripled; by 2011, one quarter of the lower/single house of parliament was made up of women. Improved political participation by women is believed to be important to improve and sustain government commitment to women's and children's health. In addition, nationally, there is a commitment to improving gender equality and rights for women – strategies that are also believed to improve demand and support for health more generally.
Governance and leadership

Direction is set at the highest level by establishing clear development goals. The Lao PDR Government has a long-standing goal to graduate from Least Developed Country status by 2020. Lao PDR aims to achieve universal access to health care by 2020 and has a clear vision for health system reform to help meet this goal, outlined in the Seventh Five-year Health Sector Development Plan (2011–2015). A number of mechanisms support leadership including a Sector Wide Coordination (SWC) mechanism for health to align and direct the contribution and activities of the Development Partners, a MOH Steering Committee, a Maternal and Child Health (MCH) Technical Working Group coordinated by the Centre for Maternal and Child Health, close links with provincial and district levels, and engagement of civil society organizations such as the Lao Women’s Union and the Lao Red Cross.

Challenges

Inequity is a key challenge which must be addressed to ensure that all population groups in the country see health gains. Technical priorities are improving maternal and child nutrition, preventing newborn deaths and improving the quality of care at all levels, with an emphasis on the quality of intrapartum and essential newborn care.

Priority areas for future action include:
1. Increasing state health financing and expanding free health care for women and children;
2. Strengthening human resources for health, with an emphasis on midwifery capacity;
3. Improving emergency obstetric and neonatal care; and
4. Increasing deliveries attended by skilled birth attendants.
2. Introduction

Lao PDR has made considerable progress in improving health in the last 20 years and is on track to achieve MDGs 4 (to reduce child mortality) and 5a (to reduce maternal mortality). This review provided an opportunity for the Ministry of Health (MOH) in Lao PDR to synthesize and document how the country achieved these health gains. The aim was to use findings to inform programming and future priorities in the country.

The primary objective of the review was to identify factors both within and outside the health sector that have contributed to reductions in maternal and child mortality in Lao PDR, focusing on how improvements were made and emphasizing policy and programme management best practices. Plausibility criteria for defining success factors were developed based on an impact model which linked policy and programme inputs with potential mortality reductions (Annex 1).

Establishing causal links between policy and programme inputs and health impact is limited by a lack of data on the mechanisms by which different factors influence programmes. Consensus between stakeholders working at all levels was therefore critical to identifying the most important factors. Further research in this area may help quantify links between policies, programmes and health outcomes and allow the analysis to be further refined.

The review included both quantitative and qualitative methods. The first draft was developed by local and international experts. One-on-one interviews and group meetings with stakeholders were conducted between February and April 2014 to further review, revise and get consensus on findings. Findings were presented and discussed at the annual national Maternal and Child Health review meeting on 24 February 2014. A final draft was developed and approved by the MOH in April 2014.

Methods used for the Success Factor Study in Lao PDR

A literature review based on peer-reviewed and grey literature, policy documents, programme evaluations and sector strategies and plans. A review of quantitative data from population-based surveys, routine data systems, international databases and other sources. One-on-one interviews and meetings with key stakeholders to inform and help validate findings and to identify factors based on local knowledge and experience. A review of the draft document by stakeholders and local experts to finalize findings.

Defining criteria for success factors

To be included as key factors, policy and programme inputs had to meet four plausibility criteria including:

- Potential impact (likely to have contributed to mortality reduction based on an impact framework and available data);
- Temporal association (had been implemented long enough to have influenced mortality);
- Scale (had reached a large enough target population to influence mortality); and
- Consensus (broad agreement between key stakeholders within and outside the health sector)
3. Country Context

Overview

Lao PDR is a landlocked, mountainous country in South-East Asia. Over one third of the population is under 15 years of age, and around two thirds live in rural areas. Many rural areas do not have paved roads and are difficult to access.\(^3,4\)

Lao PDR is one of the most ethnically diverse countries in the world, with 49 official ethnic groups. Each group has its own dialect, customs, beliefs and health behaviours (including the use of traditional or herbal medicine). Ethnic minorities mostly live in the highlands whereas ethnic Lao, which make up over half the population, predominantly inhabit the lowlands.\(^3,5\)

Lao PDR has significant natural resources, including forestry and minerals, as well as hydropower potential.\(^4\) Increased foreign direct investment in these industries, following a shift to a market-oriented economy in line with the New Economic Mechanism (1986), has been a key driver for a decade of unparalleled growth: gross domestic product has grown on average 8% per annum.\(^4\) The gross domestic product per capita (purchasing power parity, PPP, Int$) increased from $933 in 1990 to $2522 in 2012. Lao PDR has recently been reclassified as a lower-middle income country; however, it ranked 138 out of 186 countries on the Human Development Index in 2012.\(^6\) Agriculture is one of largest sectors in the economy, contributing to around one third of gross domestic product and employing nearly 80% of the labour force.\(^5\)
## Table 1: Key country indicators – health and development

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Population</strong></td>
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<td><strong>Health Financing</strong></td>
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<tr>
<td><strong>Economic Development</strong></td>
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<td></td>
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</tr>
<tr>
<td>GINI INDEX (0 equality to 100 inequality income distribution)</td>
<td>35 (1997)</td>
<td>33 (2002)</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Health Workforce</strong></td>
<td></td>
<td></td>
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<tr>
<td>PHYSICIANS (per 1000 population)</td>
<td>0.23 (1990)</td>
<td>0.35 (2004)</td>
<td>0.27 (2010)</td>
</tr>
<tr>
<td>NURSES AND MIDWIVES (per 1000 population)</td>
<td>N/A</td>
<td>0.97 (2004)</td>
<td>0.97 (2010)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADULT LITERACY RATE (% of males (M) and % females (F) aged 15 and above)</td>
<td>73(M) 48(F) (1995)</td>
<td>81(M) 58(F) (2000)</td>
<td>77 (M) 69 (F) (2011)</td>
</tr>
<tr>
<td><strong>Environmental Management</strong></td>
<td></td>
<td></td>
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<tr>
<td>ACCESS TO CLEAN WATER (% of population with access to improved source)</td>
<td>40 (1994)</td>
<td>46 (2000)</td>
<td>70 (2011)</td>
</tr>
<tr>
<td><strong>Urban Planning/Rural Infrastructure</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>ELECTRIC POWER CONSUMPTION (kilowatt hours per capita)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Human Development Index</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VALUE (reported along a scale of 0 to 1; values nearer to 1 correspond to higher human development)</td>
<td>.38 (1990)</td>
<td>.45 (2000)</td>
<td>.54 (2012)</td>
</tr>
<tr>
<td>COUNTRY RANK (2012)</td>
<td></td>
<td></td>
<td>138</td>
</tr>
<tr>
<td><strong>Good Governance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTROL OF CORRUPTION (extent that public power is used for private gain)</td>
<td>-0.47 (1996)</td>
<td>-0.78 (2000)</td>
<td>-1.04 (2012)</td>
</tr>
</tbody>
</table>

*See Table 2 for data on coverage of key RMNCH indicators
+Source: World Development Indicators, UNDP, World Bank (Worldwide Governance Indicators)
Table 2: Coverage indicators for maternal and child health

<table>
<thead>
<tr>
<th>CONTINUUM OF CARE</th>
<th>INDICATOR</th>
<th>COVERAGE*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2006</td>
</tr>
<tr>
<td>Prepregnancy</td>
<td>DEMAND FOR FAMILY PLANNING SATISFIED</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>% of women 15-49 with unmet need for family planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CONTRACEPTIVE PREVALENCE RATE (modern method)</td>
<td>29 (LRHS 2000)</td>
</tr>
<tr>
<td>Pregnancy, delivery and immediate postpartum</td>
<td>ANTEPARTUM CARE (% of women attended at least four times during pregnancy by any provider)</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>NEWBORNS PROTECTED AGAINST NNT AT BIRTH (as % of total births)</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>SKILLED ATTENDANCE AT BIRTH</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>EARLY NEWBORN CARE (babies breastfed in the first hour of life)</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>ANTIRETROVIRALS FOR WOMEN (HIV-Positive pregnant women to reduce mother-to-child transmission)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>POSTNATAL CARE FOR MOTHERS AND NEWBORNS (for mothers and newborns received care within two days of childbirth)</td>
<td>-</td>
</tr>
<tr>
<td>Newborn and childhood</td>
<td>INFANT FEEDING (Exclusive breastfeeding for first six months)</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>IMMUNIZATION (Children ages 12-23 months receiving DTP3)</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>VITAMIN A Children receiving a dose in the previous six months</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>PNEUMONIA (Antibiotic treatment for pneumonia)</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>DIARRHEA (ORT with continued feeding for diarrhoea)</td>
<td>49</td>
</tr>
</tbody>
</table>

*All data from the 2006 LMICS and the 2011/12 LSIS unless otherwise specified.*
4. Key Trends, Timelines and Challenges

Under 5 child deaths

Between 1990 and 2012 under 5 child mortality in Lao PDR declined 56% (from 163/1000 live births to 72/1000 live births). During this period the average annual rate of mortality reduction was estimated to be 3.7%. Lao PDR is on track to achieving both its global MDG goal (54/1000 live births) and its national MDG goal (70/1000 live births) (Figure 1).

The rate of decline in newborn mortality has been considerably slower than that of under 5 mortality. For this reason, the proportion of under 5 deaths occurring in the newborn period has risen steadily – and in 2012 represented 38% of all under 5 mortality. Since a high proportion of newborn deaths occur around delivery and in the first 24 hours of life, these findings highlight the challenge of providing effective interventions to mothers and newborns during delivery and in the early postnatal period. Mortality declines are much slower among the poor, less educated and rural populations. This equity gap remains an important challenge, for example, children in the poorest quintile are 3.6 times more likely to die before their fifth birthday than those in the wealthiest quintile. Children born in the Phongsaly Province have a five times higher risk of dying before 5 years than a child born in Vientiane City. Reaching high-risk populations will be essential for continuing mortality declines into the future.

Reductions in mortality are associated both with improved coverage of effective interventions to prevent or treat the most important causes of child mortality and with improvements in socioeconomic conditions. Childhood nutritional status has not made major gains during this period and is not believed to have played a major role in mortality declines; although improved rates of exclusive breastfeeding, early breastfeeding and coverage with vitamin A supplements may have contributed.

Figure 1: Trends in under 5 and newborn mortality, 1990-2012

2015 MDG targets: MDG 54, LMDG70.

Source: World Development Indicators/IGME.
**Maternal mortality**

Between 1990 and 2012 maternal mortality fell with an estimated annual rate of decline of 5.9% and is considered to be on track against the global rate of reduction threshold (5.5% annual rate of reduction or higher). Using global data, the country has achieved its MDG target of 260 deaths per 100,000 live births (Figure 2).9

Declines in maternal mortality are associated with a halving of the total fertility rate between 1990 and 2012 – from six to three – and associated increases in birth interval. Fertility declines are associated with improvements in the contraceptive prevalence rate, along with socioeconomic and educational improvements.

Although increases in the proportion of women delivering with a skilled birth attendant and delivering at health facilities are noted, antenatal care coverage has shown little improvement. Coverage for interventions around delivery remains below 50%. A majority of women continue to deliver at home and receive limited care during this period for a number of reasons, including limited access to services, cultural beliefs, perceived poor quality at facilities and other barriers.10, 11, 12 Available data also suggest that the quality of routine antenatal, delivery and postpartum care; and of basic and comprehensive Emergency Obstetric and Newborn Care (EmONC) needs improvement. Much of the decline in maternal mortality is therefore likely to be associated with the decline in fertility and other socioeconomic improvements.

**Table 3: Factors associated with mortality declines, 1990-2012**

<table>
<thead>
<tr>
<th>Improved coverage of effective interventions to prevent or treat the most important causes of maternal and child death</th>
<th>Economic, environmental and educational improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Essential immunizations</td>
<td>• Proportion of the population that is below the poverty line (48% in 1992 to 28% in 2008)</td>
</tr>
<tr>
<td>• Vitamin A supplementation</td>
<td>• Per capita income ($933 in 1990 to $2,522 in 2011)</td>
</tr>
<tr>
<td>• Exclusive breastfeeding</td>
<td>• Female literacy (48% in 1995 to 69% in 2011)</td>
</tr>
<tr>
<td>• Early breastfeeding (within one hour or birth)</td>
<td>• Net enrolment in primary education (59% in 1992 to 96% in 2012)</td>
</tr>
<tr>
<td>• Use of bed nets – children under 5 – and reductions in malaria prevalence and in malaria deaths</td>
<td>• Access to clean water (40% in 1994 to 70% in 2011)</td>
</tr>
<tr>
<td>• Birth spacing</td>
<td>• Access to improved sanitation (20% in 1994 to 62% in 2011)</td>
</tr>
<tr>
<td>• Improved contraceptive prevalence</td>
<td>• Coverage for many core interventions remains below 50% with limited improvements in treatment practices for pneumonia and diarrhea. Zinc not widely used for management of diarrhea.</td>
</tr>
<tr>
<td>• Increased median birth interval to 34 months</td>
<td>• Wide variations in coverage and nutritional status by geographic area; and reduced coverage in poor, less educated and rural populations.</td>
</tr>
<tr>
<td>• Some improvements in deliveries with SBAs, facility deliveries, PNC</td>
<td>• Quality of care for routine delivery, immediate postpartum and postnatal care needs improvement.</td>
</tr>
<tr>
<td>• Coverage for many core interventions remains below 50% with limited improvements in treatment practices for pneumonia and diarrhea. Zinc not widely used for management of diarrhea.</td>
<td>• Inequities in income, infrastructure and availability of education continue; remote, rural and less educated populations are more difficult to reach.</td>
</tr>
</tbody>
</table>

**Figure 2: Trends in maternal mortality and fertility, 1990-2013**

Nutrition

Rates of stunting and underweight have shown modest declines since 1990, but between 30% and 40% of children remain stunted or underweight – and rates of stunting have been static since 2000. A high proportion of the population continues to live under the food poverty line (25% in 2008).\(^{13}\) The prevalence of iron deficiency anaemia is high in children under 5 and was estimated to be 41% in 2006, with rates in some provinces over 50%.\(^{14}\) Although rates of exclusive breastfeeding have shown improvements, complementary feeding practices around weaning and in the first two years of life continue to need improvement. In addition, young children living in households without access to improved water and sanitation sources have a higher prevalence of diarrhoea, underweight and stunting\(^{8}\) – highlighting the importance of improving infrastructure in high risk areas to improve nutritional status. These data suggest that mortality improvements have been made without significant improvements in nutritional status of children. Undernutrition including fetal growth restriction, stunting, wasting, and deficiencies of vitamin A and zinc along with suboptimal breastfeeding accounted for 45% of all child deaths globally in 2011.\(^ {30}\) Improving nutrition is critical for driving further mortality reductions.

Figure 3: Trends in childhood stunting and underweight, 1994-2012

2015 MDG targets: 34% for stunting, 22% for underweight.

5. Health Sector Initiatives and Investments

Health sector advances have been driven by policy and programme inputs in three areas: laws, standards and guidelines; health systems; and delivery strategies.

5.1 Laws, standards and guidelines to support implementation of RMNCH interventions

**Focusing on universal coverage with a package of high-impact interventions**

The MOH set a goal of achieving universal access to health services by 2020 in the National Growth and Poverty Eradication Strategy (2004). The Law on Health Care (2005) stipulated that all citizens have the right to receive health care services regardless of their gender, age, ethnicity, race, religion or socioeconomic status and that services should be delivered in an equitable manner. The Law on Protection and Development of Women 2004, outlined strategies for ensuring that women’s rights are protected. These principles were enshrined in the Sixth and Seventh National Health Sector Development Plans (2006-2010 and 2011-2015) which set out approaches to strengthening the health system with an emphasis on improving infrastructure, health systems and quality of care. A series of subsector plans and strategies accompanied the overall plan and provide a detailed outline of how improvements were to be made. The Strategy and Planning Framework for the Integrated Package of MNCH Services (2009-2015) describes the minimum package of interventions that must be provided at each level of the system (province, district, and health centres) and focuses on high impact interventions delivered along the continuum of care for women and children.

**Establishing technical standards**

To accompany these frameworks, technical policies and guidelines were developed. These included:

- The National Birth Spacing Policy (1997), which recognized the importance of family planning as a means of child spacing in order to reduce maternal and child mortality; the Safe Motherhood, Deliveries and Neonatal Care Policy (1997), which focused on the provision of family planning information and services, antenatal and routine delivery care and management of obstetric and newborn complications; the National Population and Development Policy (NPDP) (1999, revised in 2006), which gave priority to extending reproductive health services (including family planning) to all areas of the country; and the National Reproductive Health Policy (2005).
- The Integrated Management of Childhood Illness (IMCI) Strategy was adopted in 2002; and a National Nutrition Policy in 2008. Malaria plans have been ongoing with the most recent being a National Strategy for Malaria Control and Elimination (2011-2015); as well as national policies and guidelines for immunizations and HIV.

**Developing mechanisms for improving coordination**

A Health Sector Working Group was formed to coordinate activities in health and a sector-wide approach (SWAp) was implemented. This helped align government ministries (including health, labour, social welfare and finance) and development partners to facilitate policy dialogue, technical discussions and strategic and operational coordination. A number of technical working groups support coordination of different technical areas. An MNCH Technical Working Group was established in 2007 and meets every two months. This approach has improved aid effectiveness by coordinating outside funding with government health priorities and plans.
Summary of health sector policy and programme inputs
which have contributed to improvements in maternal and child health, 1990-2012

Laws, standards and guidelines

**Universal coverage with package of high impact interventions**
- Law on health care (2005)

**RMNCH technical standards**
- National Birth Spacing Policy (1997)
- Safe Motherhood, Deliveries and Neonatal Care Policy (1997)
- Establishment of the National Commission for Mother and Child (1999)
- IMNCI strategy and guidelines (2002)
- Regulation on the promotion of MCH (2004)
- National Reproductive Health Policy (2005)
- Baby Friendly Hospital Initiative
- Technical standards for immunizations, malaria and HIV

**Mechanisms for improving coordination**
- Health sector working group
- Sector-wide approach
- MNCH technical working group
- Other technical working groups

**Strengthened health systems**

**Health care financing**
- Increased per capita expenditure on health and reduced out-of-pocket expenditure
- Introduction and scaling up of health insurance schemes – 18% of population covered
- Free delivery for women and free health care for under 5 children (Prime Ministerial decree 178/M 2010)

**Health workforce**
- Skilled Birth Attendance Development Plan (2008-2012)
- National Health Personnel Development Strategy (2009-2020)
- Regional in-service training centres – five core modules
- Decree on incentives for civil servants posted to rural areas (2011)

**Essential medicines**
- Essential drug list
- Drug kits for remote villages
- Decrees for integrated logistics systems, management and quality

**Tracking progress with data**
- Indicators and targets established in national strategies
- Mechanisms for routine monitoring
- HMIS strategic plan
- Regular population-based surveys and QOC assessments

**Delivery strategies**

**Integrated routine system through provinces, districts and health centres**
Run through the Centre for Maternal and Child Health with emphasis on reaching all communities using VHV, outreach, and links with NGOs and community groups

**Vertical programme approaches**
Immunization and malaria programmes have focused intensively on establishing supply chain, outreach and micro-planning

**Selective use of campaigns**
For measles, polio, neonatal tetanus vaccines, vitamin A

**Implementation partnerships**
Partnerships with development partners and NGOs have allowed sharing of human, material and financial resources to all districts of the country
5.2 Strengthened health systems

Health financing

Government policies have supported a number of improvements in health care financing. Total government expenditure on health per capita has doubled since 1995 to $78 (PPP int$) in 2011. General government expenditure on health as a proportion of general government expenditure has been around 6% for a number of years and there is a commitment to increase this to 9% from 2011/12 onwards. High out-of-pocket health expenses have been recognized as an important barrier to access to care and the government has made a policy decision to reduce this over time. Out-of-pocket expenses have declined from 60% in 2000 to 40% in 2012. A National Health Financing Strategy 2011–2015, building on past experience, outlines the main health financing strategies for the country.

Health insurance schemes have been implemented to support improved access to care and provide financial protection against catastrophic health care costs. Four health insurance schemes have been put in place for different population subgroups: State Authority for Social Security (for civil servants), the Social Security Office (for private sector employees), Community-based Health Insurance (for informal sector employees), and Health Equity Funds (for the poor). These schemes are estimated to have covered 18% of the population in 2011; the government has endorsed a decree to merge these social health protection schemes and improve the reach of equity funds for the poor. Further progress in providing universal access to health care was made in 2010 when the government introduced a policy to provide free health care services to all children under the age of 5 years and all pregnant women. Government funded implementation began in 2011 in 16 districts across four provinces; with development partners supporting roll-out in around 25% of country districts (37 in total). Positive results from early implementation have led to the development of a plan to further scale-up to 117 districts (80% of the total). A Ministerial decree formalizing free health care for pregnant women and children under 5 was formally adopted in January 2013.

A number of challenges to health care financing remain. Although total health expenditure has increased it is still low in terms of percentage of GDP (1.4% in 2011). Of total health expenditure, 49% is contributed by the government and 51% by private sources. To overcome government funding shortfalls, public health facilities currently use revolving drug funds, which allow health facilities to charge 25% of the purchase price, and which create a high out-of-pocket burden for consumers; and give inappropriate incentives for the overuse of more expensive medicines. Currently almost all preventive health services and programmes are funded by donors. Despite progress, therefore, health financing is relatively precarious because of its reliance on external sources. High out-of-pocket expenditures remain an important concern.
Health workforce
Inadequate numbers and skills of all categories of health personnel are noted in Lao PDR, with regular supervision limited and motivation often a problem. Distribution of staff is often inequitable, with many staff reluctant to be posted to remote and rural areas. As a result, services in many areas are underused and productivity is low. Shortages of skilled birth attendants have been identified as a particular problem. Many health workers in health centres are low-level auxiliary nurses, or auxiliary nurse-midwives with limited pre-service training. A National Skilled Birth Attendance Assessment conducted in 2008 showed that 80% of health workers had limited skills to assist women and newborns during pregnancy, labour and birth, regardless of their pre-service training. In response to these challenges, three key policies were developed: the Skilled Birth Attendance Development Plan (2008-2012), a commitment by the government to producing 1500 new midwives by 2015, by upgrading existing staff and training and recruiting new staff; the National Health Personnel Development Strategy (2009–2020); and the decree on incentives for civil servants posted to rural areas (2011). There is evidence that these policies have led to improved numbers of health personnel and improved deployment to more remote areas. The National Health Statistic Report in 2011 shows evidence of progress in health professional staff distribution of 2.4 doctors and 7.5 nurses per 10 000 population. Almost 500 midwives had been deployed by the end of 2012, all accredited through a national licensing exam. Several development partners have supported the Ministry of Health’s efforts to improve midwifery staffing by funding midwifery programmes in eight schools across the country; activities included upgrading schools, developing new teaching and learning materials, including materials in Lao language, and developing teacher capacity. The MOH reports that provinces have better health outcomes where greater numbers of higher level personnel are deployed to districts.

Essential medicines
An essential medicine list for RMNCH activities has been defined for all levels of the health system. A Food and Drug Department has been established to oversee and enforce standards; and a Medical Product Supply Centre is responsible for logistics management. Monthly reports on stock availability are reported to the centre for tracking. Ministerial Decree No.594/MOH integrates logistics into one system to harmonize the national drug supply. This along with a decree on drug management has helped establish a unified centralized system, which has improved the availability of quality drugs at all levels. Drug kits are distributed to all villages situated a two-hour walk or more from a dispensary; currently 5700 kits are distributed throughout the country. Refurbishment of provincial drug stores, financed by vertical programmes, has helped improve provincial drug storage for all programmes.

The current user fees system remains an important challenge since it leads to overuse of medicines, which are sold at a higher markup than the 25% allowed by government policy. Oversight of medicine pricing is difficult and not always done effectively. As a result, cost of medicines represents on average 36% of all out-of-pocket expenses by households. This is recognized by the government as an important issue that needs to be addressed by policy as a next step.
Tracking progress with data

The use of data to track progress is central to all planning activities. Targets have been established for key maternal and child health indicators. The 7th National Health Sector Development Plan (2011–2015) includes output and impact indicators. The Integrated MNCH Strategy and Planning Framework also includes outcome and impact indicators and targets for national, provincial and district levels. The National Commission for Mothers and Children is responsible for coordinating and monitoring implementation of the strategy. In addition the government has committed to MDG targets and those established in the Global Strategy for Women’s and Children’s Health. National population-based surveys remain the primary approach for collecting representative data on key demographic, impact and coverage measures. Lao Reproductive Health and Social Indicator Surveys have been conducted between 2000 and 2012. A Health Information System Strategic Plan has been developed, which includes strategies to implement population- and institution-based data collection systems including the vital registration system. In the interim, national standardized forms for facility-based death reporting are in place and a computer-based system is being piloted in selected central hospitals. A maternal death review has been scaled up to eight provinces; community reporting and feedback are also in place in selected provinces. The government has also begun to collect data disaggregated by sex.
Health sector spotlight

**REMOVING USER FEES TO IMPROVE DELIVERIES WITH SKILLED BIRTH ATTENDANTS**

In 1996, with the Lao health sector under strain and with limited scope to increase the public budget, the government legalized user fees for specified procedures after more than 30 years of government-funded health services. A year later, fees were extended to create a Revolving Drug Fund (RDF) system at health facilities. Subsequently there was widespread reliance upon user fees in government facilities throughout Lao, including for deliveries. On average, women were estimated to pay approximately US$ 20 for uncomplicated deliveries conducted at health centres, US$ 45 for deliveries at district hospitals, and US$ 90 for those at provincial hospitals. Costs for deliveries by caesarean section ranged from an average of US$ 70 in district hospitals to more than US$ 550 in provincial hospitals.

A study to examine the effects of removing user fees was conducted in 2009 in four high-priority poor districts in Savannakhet Province of central Lao. Two districts had all costs associated with facility deliveries paid, including transportation to higher-level facilities and support at these facilities if complications arose. Two districts acted as controls.

Following two years of implementation, an evaluation was conducted to assess the pilot impact. The study found a tripling of facility-based delivery rates in the intervention areas, compared with a 40% increase in the control areas. While findings from the control districts suggest that facility-based delivery rates may be on the rise across the country, the substantially higher increase in the pilot areas suggest that facility-based delivery fees are an important barrier to use, even in the presence of other access and cultural barriers. This study suggested that removing fees can play an important role in rapidly increasing the uptake of facility deliveries to reach the national targets and, ultimately, to improve maternal and child health outcomes. The pilot found that there were high costs associated with monitoring, evaluating and managing systems to make facility payments, especially in areas with limited district-level capacity to manage funds and deliver detailed and timely reports. It therefore recommended that scale-up would require procedures to oversee and manage financial systems.

Subsequently, study findings were part of the evidence used to support the government decision to provide free care for pregnant women and children under 5 years (Prime Ministerial Decree 178/M 2010). This approach is now being scaled up nationally.
5.3 Delivery strategies

A number of strategies were identified as central to improving the delivery of maternal and child health interventions since 1990 using available systems and establishing new methods of delivery. Delivery strategies include:

Integrated routine system through provinces, districts and health centres to reach all communities and households

The Integrated Maternal, Neonatal and Child Health Services Package is being implemented in a phased approach by the MOH in close collaboration with several development partners. The aim is to reach coverage of the entire country, district by district, through a uniform approach. The MNCH package includes an essential set of services and an additional optional set. Integrated Management of Neonatal and Childhood Illness (IMNCI) is the primary delivery strategy for providing preventive and curative interventions for childhood illness and was adopted in 2002. An outreach package of interventions has also been developed that responds to the needs of remote communities and increases coverage. The core package provides a framework for all levels of the health system: central, provincial, district, and household and community levels. This has helped ensure the development of systems to support maternal and child health activities along the continuum of care, from the preconception period through pregnancy, delivery, the postnatal period and childhood.

Collaborations with civil society organizations include the Lao Women’s Union, local and international NGOs, which have helped build community-based structures using community-based distributors of family planning methods, village health volunteers, and other available community resources. Links with district-based development partners have helped improve facility-based outreach activities and routine supervision.

Currently 93% of the population is estimated to be able to reach a health facility with a walk of 90 minutes or less.\(^3\) There remain, however, major differences in access to services by geographical, social, political, economic and other factors. User fees and high out-of-pocket payments have also led patients to delay care until illness is severe. High costs coupled with poor services lead to low utilization of services. A recent study commissioned by WHO\(^{28}\) found that financial barriers are still the most frequent reason for not seeking care among the poorest households.
Targeted vertical programmes

Malaria and immunization programmes have focused on building systems to support delivery of vaccines, insecticide treated bed nets and improved diagnosis and treatment of malaria. They have required dedicated staff and funding for activities. Both programmes have included development of distribution systems (bed nets, testing kits and medicines for malaria; and cold chain and vaccine procurement and distribution for immunizations); micro-planning which targets populations at higher risk; community-based distribution systems (facility-based outreach for immunizations; and village health workers to distribute bed nets and conduct case-finding, referral and vector control activities for malaria); dedicated systems of routine supervision; and use of data for tracking progress. The malaria programme has developed the malaria information system which collects data on the cases screened, testing positive and treated, and routinely conducts bed net surveys; the immunization programme tracks coverage with routine HIS data; and periodic population-based surveys are undertaken. Reductions have been demonstrated in the prevalence of malaria, use of insecticide treated bed nets by children under 5, and in the proportion of malaria cases treated effectively. Poliomyelitis was eliminated in 2000 and the country is close to eliminating measles and neonatal tetanus.

Vaccination coverage rates have shown steady improvements. A number of challenges remain, including better identifying and reaching high-risk populations; building subnational planning and management capacity; better integrating these vertical programmes with other routine programme activities; and reducing the reliance of these programmes on external funding. Although the government has assumed an increasing responsibility for financing programme activities, it is recognized that long-term sustainability will require that the government takes an increasing proportion of the financial burden.

Selective use of campaigns

Campaign strategies have been used periodically to reach large populations relatively quickly. This approach has delivered several vaccines (polio, measles, neonatal tetanus, and Japanese Encephalitis) and vitamin A. An annual breastfeeding week promotes the importance of exclusive breastfeeding at all levels with a variety of messages and activities which provide information and practical demonstrations. It is recognized that campaign strategies are a relatively expensive addition to routine activities but can be beneficial as a method for raising intervention coverage when systems are relatively weak.
Implementation partnerships

The Ministry of Health has formed partnerships to support MNCH programme implementation. The goal of these partnerships is to strengthen the capacity of the Ministry of Health at national and subnational levels to implement the Integrated Package of MNCH Services in selected districts, with a specific focus on the most vulnerable, especially in remote rural areas. Strategic partners include UN organizations, International Banks and Development Organizations. Partners work complementarily in different geographical locations and focus on areas of their specific expertise. They provide both financial and technical expertise to support routine staff and systems. This coordinated approach has ensured that resources are distributed throughout the country to all vulnerable groups and that there is less duplication and overlap of partner activities. Improved effectiveness of development assistance has resulted.

In addition, civil society in Lao PDR has been a valuable contributor to achieving the maternal and child health outcomes. The Lao Women’s Union is a broad-based support organization for women’s health at all levels and is particularly active in the area of community mobilization and education. Both local and international NGOs directly implement health services for rural and remote communities, in partnership with the provincial and district health offices. They provide training and support to build the capacity of local government partners, and support community mobilization. The Model Healthy Village development project was begun in 2006 with partner support. The aim was to strengthen community-based primary health care services. This approach emphasizes preventive health and water and sanitation activities. Criteria were established to determine whether villages are meeting simple standards. Around half of the villages in the country are currently accredited as model healthy villages.

NGOs have been particularly useful for reaching underserved and poor populations through the provision of mobile health clinics, and support for families or individuals with special needs. NGOs in Lao PDR have formed a NGO Health and Nutrition Working Group which is responsible for helping coordinate activities, share lessons learned and advocate for the populations they serve. International NGOs are supported by the Ministry of Foreign Affairs, and local NGOs by the Ministry of Home Affairs and the Ministry of Health. This support helps to coordinate activities and to ensure that NGOs’ activities are aligned with government priorities and technical standards.
6. Initiatives and Investments Outside the Health Sector

6.1 Education

What has been seen: Lao PDR has made steady progress towards universal primary education and is close to achieving the national target of 98% primary net enrolment ratio (NER) for boys and girls. All provinces show NERs of at least 80%, although several are below the national average of 95%. The survival rate to Grade 5 has improved from 48% in 1992 to 95% in 2012; and the transition rate from primary to secondary education shows a significant increase from 60% in the 1990s to 91% in 2012. At the same time, the proportion of all children of secondary school age who are enrolled in secondary education has increased from below 20% in the 1990s to 45% in 2012. The national literacy rate has improved over time and was estimated to be 73% in 2011 – with female literacy lagging behind male literacy by a few percentage points. In general, educational improvements have reached all segments of society but gaps are noted by a number of socioeconomic factors, with remote and rural communities being the most often excluded from education services. Continued and expanded efforts will be needed to sustain and further expand the reach of basic education to the entire population.

What has been done: Lao has put in place a number of laws, policies and programme actions to support improved education. Main strategies have included:

Laws to guarantee education as a fundamental right and to encourage attendance by all children:
Key laws include the 1996 law which made five years of primary education free and compulsory for all children between the ages of 6 and 14 years; and the Education Law (2000) which sets out the right for all Lao citizens to education without discrimination. In 2005, Lao ratified the ILO Minimum Age Convention (No. 138) which sets the minimum age for employment at 14 years by law.

Policies and plans to guide what is done and how:
Key policies include an Education Sector Development Framework and a national Plan for Action.

Improved financing and infrastructure: Public expenditure on education has increased by six times in the last 10 years. In the fiscal year 2011/12 total public expenditure was US$ 258 million of which 31% was from external partners. During the last 10 years, the proportion of the public budget allocated to education has increased from 10% to 14%, although its share of GDP has increased from only 2.4% to 3% (the average in East Asia and the Pacific was 4.4% in 2010). School infrastructure has been expanded for both primary and lower secondary schools. In 2012, it was estimated that 65% of all villages had a primary school in the village, 87% of all villages were within a one hour walk of a primary school and 80% of all villages had access to a lower secondary school.
Strategies to promote the education of children from poor families: Strategies have included: school feeding programmes in 30 districts aimed at encouraging poor students to attend; scholarships for poor students, including students from poor ethnic groups and lower secondary school students; and expanded literacy programmes and non-formal education, including programmes for children who are out of school. School block grants began in 2011 for all primary schools. The purpose is to provide a grant per child, designed to offset costs that are normally paid by parents. This has been supplemented by village block grants, administered by villages, which use the funds to provide support for children from poor families to attend school.

Focus on improving quality of teaching: Ongoing activities have focused on developing teacher training curricula and teacher training, to ensure that teachers are able to teach basic skills. Local assessments indicate that 11% of primary school teachers still do not have required qualifications and many teachers, particularly those in rural areas, are not able to teach certain subjects. Gaps in quality are identified as a key area needing attention.

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**POLICY AND PROGRAMME INPUTS SUPPORTING IMPROVEMENTS IN EDUCATION, 1990-2012**

**Improved financing and infrastructure**
- Increased government expenditure six times in the last 10 years
- Expansion of school infrastructure for both primary and lower secondary schools to remote areas and villages

**Laws to guarantee education as a fundamental right and to encourage attendance by all children**
- Free and compulsory public education (1996)
- Education law (2000)
- ILO Minimum Age Convention (No. 138)
- General education requirement extended to 12 years (5 + 4 + 3)

**Policies and plans to guide what is done and how**
- Education Sector Development Plan (2011-2015)
- National Growth and Poverty Eradication Strategy (2004) and Sixth and Seventh Sector Development Plan – both include an emphasis on improved education

**Strategies to promote the education of children from poor families**
- Improved school infrastructure in rural and remote villages
- School feeding programmes
- Scholarships for poor students
- Expanded literacy programmes included for non-formal education
- School block-grants for primary schools and villages to provide financial resources to assist children of poor families to meet routine costs

**Focus on improving quality of teaching**
- Strengthened teacher training curriculum – with a focus on adapting for local needs
- Improved teacher training in key subjects
6.2 Ensuring safe water and sanitation

What has been seen: The proportion of the population with access to improved sources of drinking water has more than doubled since 1990 to 70%. Both urban and rural populations have doubled access to clean water, although an urban-rural gap remains, and there are substantial differences in access by economic status and place of residence. Coverage with improved sanitation has increased threefold since the 1990s and in 2012 the national average access to improved sanitation was 60%, with urban sanitation coverage being 88%. Inequities for sanitation coverage are greater than for water, with rural populations having half the access to sanitation of urban populations, and 38% of the population still practicing open defecation. It is recognized that more attention is now needed on improving the quality of water sources in all areas and the capacity of sanitation facilities, tailored to the local setting.\textsuperscript{8, 13}

What has been done: Policies and programme activities that have been central to improving water and sanitation include:

Development of a strategic plan: The National Social Economic Development Plan includes a focus on improving water and sanitation infrastructure to all areas of the country. The National Plan of Action for Rural Water Supply, Sanitation and Hygiene guides activities for both government and stakeholders to improve equitable access to water and sanitation; and to maximize health and socioeconomic benefits. Twelve principles guide the plan, including improving the availability of essential infrastructure and improving practices through behaviour change, advocacy, and community mobilization. The plan also outlines approaches to improving financing for water and sanitation.

Recognizing the importance of equity: Focus has been on implementing sanitation initiatives in the poorest districts, most of which are rural. Government policy has ensured that poorer and marginalized groups are prioritized in both project design and implementation. Toolkits have been developed to improve targeting of these groups.\textsuperscript{25} It is recognized that use of improved water and sanitation requires engagement of communities not only to change long standing practices such as open defecation and encourage the use of improved facilities, but also to engage participation in the development and local financing of alternatives.

Partnerships to support investment: Development partners have contributed substantially to development of water and sanitation infrastructure. Approximately 11% of Overseas Development Assistance was allocated to this area in 2012 – and this has been essential to helping build systems. Never-the-less, to meet national urban and rural targets for water supply and sanitation the government estimates that approximately 40 million dollars per year will be required. Current levels of investment are substantially below this estimate.\textsuperscript{13}
6.3 Poverty Reduction

What has been seen: The national poverty rate in Lao PDR has declined 39% in the last 15 years, from 46% in 1993 to 28% in 2008. At least a million people have been lifted out of poverty since 1992; and these declines have been observed in nearly all population groups and regions of the country. Lao PDR has also shown a steady reduction in both the poverty gap and poverty severity since 1990. The poverty gap ratio among the poor decreased by 36% by 2008, from 11% to 7% of the poverty line. The poverty severity index also decreased during this period, suggesting that the poverty reductions have benefited the poorest. Poverty rates tend to be higher in rural and mountainous areas of the country.8, 13

What has been done: Poverty reduction underlies all development activities proposed by the government, cutting across many sectors including education, agriculture and the environment. Policies and programme activities that have been central to poverty reduction include:

Clear targets for poverty reduction: The National Social Economic Development Plan focuses on sustainable economic growth and poverty reduction, and the National Growth and Poverty Reduction Strategy includes targets for poverty reduction and reduced inequities between different population groups. These plans outline approaches to poverty reduction, and include criteria for defining high-risk groups and strategies for targeting those at highest risk.

Collection of data for tracking progress: Lao Economic and Consumption Surveys were conducted every five years between 1992 and 2009 by the Lao Statistics Bureau. These surveys provide the most useful data for tracking measures of poverty. In addition, data on high-risk populations are collected using district data on village location and availability of basic services.

Formation of an oversight body: The National Committee for Rural Development and Poverty Eradication (NCRDPE) monitors poverty and has responsibility for helping coordinate activities. It was established in 2006 under the Prime Minister's Office. Its role is to coordinate poverty reduction activities between line ministries and between the central and subnational levels, to improve the effectiveness of what is done, and track progress. The steering committee includes representatives from 20 ministries. The roles and responsibilities of the committee were formalized by Prime Ministerial Decree 20/PM in 2012.

Criteria for defining and targeting high risk populations: In the 2004 National Growth and Poverty Eradication Strategy, 47 priority districts and 25 second priority districts were defined, using a set of criteria for degree of need. Subsequently, targeted districts saw declines in poverty rates. In 2010, the strategy shifted focus from districts to the poorest villages and households – a more targeted approach. Criteria for selecting areas for targeted development include the poverty rate (based on income, access to education, health, and water and sanitation infrastructure); the remoteness of the area; and the geographic area (efforts are made to include all areas of the country).

Strategies for reaching remote and rural areas: These include provision of basic infrastructure and services, improving skills of communities and incentives for government staff posted to remote areas. The government is promoting strategies to improve food security and nutrition in highland areas by supporting farmer organizations and increasing the commercialization of the agricultural sector and support for the production of cash crops. The National Governance and Public Administration Reform Programme 2011-2015 is expected to improve public sector management and service delivery to better reach poor areas.
The government of Lao PDR has recognized that gender parity and rights for women are essential to improving health and development in the country because women’s education, health, nutrition and economic wellbeing are all closely associated with reduced maternal and child mortality. For this reason it has put in place policies and programmes designed to improve women’s rights and participation at all levels of society. Over the last 15 years, women’s gender parity has improved in education (primary and secondary) and female literacy. The share of women in waged employment in nonagricultural sectors has increased from around 20% in 1990 to 34% in 2010 – a key marker of improved ability of women to get higher paid work. In addition, Lao has achieved significant progress in improving women’s participation in the national parliament, and therefore in positions to influence national laws and policies.

Key policies and programme inputs that have helped improve gender parity and advance rights for women have included:

- A revised Constitution and other laws to guarantee rights for women: These include the Law on the Development and Protection of Women (2004), the 2005 amendment of the Penal Law criminalizing discrimination against women (Article 177), and a revised labour law in 2006 which requires equal access to employment for men and women. In addition, the government has committed to key international conventions and treaties that support rights for women, including ratifying the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1981), and the Convention on the Rights of the Child (1990). The government reports regularly.

- Development of institutions for advocacy, programme implementation and oversight: The Lao Women’s Union, established in 1955, works to protect and advance the rights of women throughout the country and plays an important role in advocacy and information dissemination at all levels. The Women’s Caucus, made up of female members of the National Assembly, was formed in 2003 to support women in government and help them develop and maintain skills. The National Commission on the Advancement of Women, established in 2003, works with the government to set policy and develop strategies for women, linked with ongoing programmes. Subcommissions have been formed at the national and provincial levels.

Together this policy framework has led to improvements in women’s participation across several sectors, and is seen as essential for sustaining, and expanding, gains in health.
Lao PDR is a single party socialist country and is governed through decrees. This contributes to a strong policy and strategy environment – because decrees must be implemented nationally. Lao has implemented initiatives to enable civic participation and improve accountability to the public. Between 1990 and 2003 the proportion of women members in the national legislature tripled; by 2011, one quarter of the lower/single house of parliament was made up of women. In 2011, Lao PDR established two targets for women’s participation in politics; that women constitute 30% of the National Assembly, and that 15% of decision-making positions be held by women. Lao PDR’s parliament had a woman speaker for the first time in 2012, and is on track to meet its MDG target for the proportion of seats held by women in parliament. Improved political participation by women is believed to be important to improve and sustain government commitment to women’s and children’s health. In addition, nationally there is a commitment to improving gender equality and improved rights for women – strategies that are also believed to improve demand and support for health more generally.
8. Governance and Leadership

Direction is set at the highest level by establishing clear development goals. The Lao PDR Government has a long-standing goal to graduate from Least Developed Country status by 2020. Health indicators, in particular child mortality indicators, are considered in the human assets weakness criterion, which Lao PDR must satisfy in order to graduate from Least Developed Country status. Reduction of maternal mortality has also been a top government priority. Lao PDR aims to achieve universal access to health care by 2020 and has a clear vision for health system reform to help meet this goal, outlined in the Seventh Five-year Health Sector Development Plan (2011–2015). In October 2010, the government and development partners signed an MDG Compact in support of the full achievement of the MDGs by 2015. The next Health Sector Development Plan (2016-2020) will need to further expand MCH gains, with an increased emphasis on quality of care.

A Sector Wide Coordination (SWC) mechanism for health is used to align and direct the contribution and activities of the development partners in achieving the Government of Lao and MOH health objectives. This mechanism involves high-level membership from government, health, labour, social welfare and finance ministries, and development partners and operates at three levels: the policy, operational, and the technical level. It is steered by a MOH Steering Committee that also coordinates activities between MOH programmes, including GAVI HSS and ongoing monitoring and evaluation activities. The Lao Women’s Union and the Lao Red Cross are involved in specific health activities, especially in prevention and promotion at the grassroots level.
9. Lessons Learned and Future Priorities

Improving access to key high-impact health interventions for all population groups underpins Lao PDR’s approach for accelerating progress towards MDG 4 and 5 targets. Although significant progress has been made, it is recognized that under 5 and maternal mortality remain among the highest in the East Asian Region, and therefore require sustained action. Ongoing attention is needed to ensure that managers and health staff at all levels prioritize maternal and child health and recognize that it is a basic human right.

In the longer term it is hoped that delivery of services will be further improved by the Three Builds Initiative which is the government’s approach to accelerating decentralization. The Three Builds began as a Prime Ministerial Instruction in 2000 and was subsequently replaced by a Prime Minister Ordinance in 2012. This approach establishes objectives and mechanisms for greater decentralization. It identifies the Province as the strategic unit, the District as the overall strengthening unit and Village as the development unit and has begun as pilots in 51 districts and 105 villages. The aim is to increase ownership, leadership and responsibility of local authorities in public and socioeconomic management and ensure effective delivery of services. In the longer term this approach shows promise for improving both access to and the quality of care delivered through the routine system.

Key technical challenges are nutrition and newborn health and quality of care, with an emphasis on quality of essential intrapartum and early newborn care. Stunting and undernutrition remain significant concerns in Lao PDR. Despite the efforts made to date, the percentage of children younger than 5 years of age that are underweight has remained around 30% for the past decade. Chronic malnutrition, or stunting, is a major issue and affects over 40% of children under 5. Nutrition requires urgent and continued attention by both government and the development community. Newborn deaths now represent 38% of under 5 child deaths and most newborn deaths occur in the very early post-delivery period. Reducing newborn deaths will require increased attention on improving the quality of intrapartum and early essential newborn care, by improving the skilled delivery care for all mothers and newborns as well as those at high risk. This includes prevention and management of prematurity and low birth weight, birth asphyxia and neonatal sepsis. An Action Plan for Improving Early Intra-Partum and Essential Newborn Care was developed and adopted in early 2014 and will now be implemented nationally.29

In order to address these gaps, areas of programme focus will include:

**Human resources for health:** Lao PDR needs to continue to invest in expanding the skill base, size and equitable distribution of its health workforce. Per 1000 population, Lao PDR has only 0.3 doctors, compared to a WHO Western Pacific Region (WPRO) regional average of 1.5. Lao has only one nurse/midwife per 1000 population, compared to the WHO/WPRO regional average of 1.9. The health workforce in Lao PDR is in critical need of expansion. Lao PDR committed to producing 1500 new midwives by 2015 through upgrading existing staff and training and recruiting new staff; however, action is needed to address the acute shortage of all categories of staff, especially in district hospitals and health centres.
**State health financing:** High out-of-pocket costs remain a key barrier to access in Lao PDR. Increased public health financing is required to achieve universal health care coverage. In Lao PDR, the continued timely implementation of government commitments to increasing health expenditure and the National Health Financing Strategy 2011–2015 are two key actions needed to reduce the financial burden of health care on households. Further expansion of the free health care law for women and children is required to improve access to care.

**Emergency obstetric and neonatal care:** Lao PDR faces a challenge in improving emergency obstetric care. Hospitals are mandated to provide such services, and to prioritize maternal, neonatal and paediatric services, but there are low levels of good-quality service provision. Providing basic and comprehensive emergency obstetric care and ensuring access, could avert a high proportion of newborn and maternal deaths. Improving quality will also require increased attention to improving referral care, particularly from remote and rural areas.

**Coverage of live births attended by a skilled health worker:** Although coverage has improved over the last decade, further efforts are required to improve skilled attendance at birth. These include continued training and deployment of midwives, improved facility infrastructure and supplies, and efforts to improve and sustain quality of routine delivery care.

**Community-based approaches to improving nutritional status and management of children with pneumonia and diarrhoea:** Continued high rates of stunting and underweight require both food security and other risk factors such as lack of sanitation to be targeted in high risk communities. Management of pneumonia and diarrhoea, including use of zinc for treatment of diarrhoea and dysentery, also need further attention.
10. Annex I

**Conceptual framework:**
Defining policy and programme success factors for women's and children's health

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**Political and economic context and overall governance**

**Health Sector Initiatives & Investments**
- Leadership/Governance
- Health Financing
- Health Workforce
- Health Infrastructure/Supplies
- HIS/Research
- Health Service Delivery

**Program Outputs**
- Increased supply/access
- Increased demand
- Improved quality
- Improved information/knowledge

**Increased Population Coverage**
Of key RMNCH interventions

**Improved Survival and Health**

**Other Initiatives & Investments**
Education (of women/mothers), Nutrition, Infrastructure, Water & Sanitation
II. References


12. Acronyms

ANC  Antenatal Care  
CEDAW  Convention for the Elimination of all forms of Discrimination Against Women  
DHO  District Health Office  
DTP  Diphtheria Tetanus Toxoid and Pertussis  
EmONC  Emergency Obstetric and Neonatal Care  
GAVI  Global Alliance for Vaccines and Immunization  
GDP  Gross Domestic Product  
HIS  Health Information System  
HIV/AIDS  Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome  
HMIS  Health Management Information System  
HSS  Health System Strengthening  
ILO  International Labour Organization  
IMCI  Integrated Management of Childhood Illness  
IMNCI  Integrated Management of Neonatal and Childhood Illness  
LMDG  Lao Millennium Development Goals  
LMICs  Low- and Middle-Income Countries  
LSIS  Lao Social Indicator Survey  
MCH  Maternal and Child Health  
MDG  Millennium Development Goal  
MMEIG  Maternal Mortality Estimation Inter-Agency Group  
MNCH  Maternal, Newborn and Child Health  
MOH  Ministry of Health  
NCRDPE  National Committee for Rural Development and Poverty Eradication  
NER  Net Enrolment Ratio  
NGO  Nongovernment Organisation  
NHSPD  National Health Sector Development Plan  
NNT  Neonatal Tetanus  
NPDP  National Population and Development Policy  
ORT  Oral Rehydration Therapy  
PDR  People’s Democratic Republic  
PHO  Provincial Health Office  
PMNCH  Partnership for Maternal, Newborn and Child Health  
PNC  Postnatal Care  
PPP  Purchasing Power Parity  
QCA  Qualitative Comparative Analysis  
QOC  Quality of Care  
RDF  Revolving Drug Fund  
RMNCH  Reproductive, Maternal, Newborn and Child Health  
SBA  Skilled Birth Attendant  
SWAp  Sector-wide Approach  
SWC  Sector Wide Coordination  
UN  United Nations  
UNAIDS  Joint United Nations Program on HIV/AIDS  
UNDP  United Nations Development Program  
VHV  Village Health Volunteer  
WHO  World Health Organization  
WPRO  Western Pacific Regional Office
13. Acknowledgements

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