

CENTRE FOR DISABILITY
RESEARCH AND POLICY

FACULTY OF
HEALTH SCIENCES



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Rehabilitation Sector Situation Analysis Report

Lao PDR April-May 2013

Professor Gwynnyth Llewellyn, Director
Centre for Disability Research and Policy

Faculty of Health Sciences
University of Sydney

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Faculty of Health Sciences
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Contact details

Professor Gwynnyth Llewellyn
Faculty of Health Sciences, University of Sydney
PO Box 170 Lidcombe NSW 1825 Australia

T +61 2 93519985

F +61 2 93519468

M +61 411489107

E gwynnyth.llewellyn@sydney.edu.au

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EXECUTIVE SUMMARY

Lao PDR is focused on Health Sector Reform - The *(Draft) Strategy for Health Sector Reform by 2020, dated 28th February 2013* - as it strives to meet the MDG's where it is significantly behind neighbouring countries in many areas including maternal mortality and stunting of children younger than 5 years. The country, as with many other low income countries in South East Asia, faces many challenges when providing disability and rehabilitation services. Some of these challenges come from the country's landlocked geography in the Indo China region with a relatively small population with few centres of significant density and many distant rural villages. Other challenges stem from socio-economic factors and the relatively recent emergence of national educational institutions capable of developing a well trained health workforce.

The Ministry of Health and the Director, Centre for Medical Rehabilitation, Vientiane are interested in and motivated towards establishing a coordinated national rehabilitation policy/strategy and accompanying action plan. The rehabilitation sector situation analysis undertaken for this report was a direct result of the Director, CMR Dr Khamphet Manviong seeking assistance from the Lao PDR WHO Country Office.

The situation analysis of the rehabilitation sector in Lao PDR was conducted by way of desk review and interviews and meetings over 6 days in-country. These meetings and interviews were held with government personnel responsible for rehabilitation and people with disabilities from the Ministry of Health and the Ministry of Labour and Social Welfare. Meetings and interviews were also held with key stakeholders in rehabilitation and disability including the Lao Disabled People's Association (LDPA), staff of the Centre for Medical Rehabilitation (CMR), WHO country office, Co-operative for Orthotics and Prosthetics Enterprise (COPE), Handicap International (HI), CBM, National Regulatory Authority for UXO (NRA), provincial public health department and hospital staff, village health workers and other village personnel. In addition, preliminary findings were presented and discussed at a Consultation Meeting on Disability and Rehabilitation with 65 invited participants chaired by Dr Khampheth Manviong, Director of CMR with Dr Gao Jun, WHO and Dr Phisith Phoutsavath, Deputy Director General of Health Care, Ministry of Health on May 6th 2013.

A rehabilitation sector situation analysis proforma incorporating the WHO building blocks for strengthening health systems was used to structure interviews and analysis of findings for this report. Detailed information is found in the full report under the headings of the six building blocks: leadership and governance, service delivery, health workforce, assistive devices and technology, financing and information systems. The full report is accompanied by Appendices of the relevant materials used in compiling this report.

Context

Rehabilitation is not a new concept in Lao PDR. Unexploded Ordnances are found across a well defined area of the country. Clearing landmines as well as providing services to survivors is a national effort with the support of INGOs, NGOs and donor agencies. There are also services provided to individuals with disabilities from road traffic and industrial accidents, genetic causes, and conditions associated with non-communicable diseases (NCDs).

The Centre for Medical Rehabilitation (CMR) formerly the National Rehabilitation Centre has provided in-patient physiotherapy, prosthetics and orthotics, and orthopaedic surgery with some out-patient services including an early intervention program for children with disabilities and developmental delay. More recently a limited range of rehabilitation services have been established in provincial rehabilitation units (PRUs) in 4 provinces. Community based rehabilitation, with support from donor agencies, has been implemented in various parts of the country over the last 15 or more years.

As in many countries, the rehabilitation sector is not high profile within the health portfolio (or the community). It currently lacks direction, high level leadership and governance structures, and lacks a systematic and coordinated approach between the tertiary, secondary and primary levels of health care. It is also heavily dependent on donor agencies, INGOs and NGOs for financial and personnel resources.

Several recent national developments offer opportunities to consolidate and work towards developing quality rehabilitation services in Lao PDR. Firstly, Lao PDR is investing in health sector reform. *The (Draft) Strategy for Health Sector Reform by 2020* has a particular emphasis on reducing maternal mortality (morbidity) and stunting in children under five. Both are highly relevant to disability – with maternal under-nutrition potentially leading to child impairment and under-nutrition in children causing lifelong impairments. Secondly, Lao PDR is implementing a community awareness raising campaigns in relation to non-communicable diseases (NCDs). The link between NCDs and resulting disability, for example, diabetes and peripheral neuropathy leading to amputation and hypertension and increased risk of stroke are well understood.

Thirdly, a greater awareness of disability (and the diversity of disability beyond landmine survivors) is emerging in line with Lao PDR signing the UN Convention on the Rights of Persons with Disabilities. This greater awareness includes national approaches such as the implementation of a decree on Inclusive Education (2010). Other developments include the drafting of the *Draft Decree on Protection of Rights and Interests and Development for Disabled People* (for implementation by end 2013). This is said to follow closely the UN Convention on the Rights of Persons with Disabilities, in which Article 26 is dedicated to habilitation and rehabilitation. The following recommendations are offered against this background of opportunity.

Recommendations

1. Infrastructure, leadership and governance in rehabilitation sector

1.1 Utilise the existing structure to develop higher quality and coordinated delivery of rehabilitation services at tertiary, secondary and primary levels

There is a nascent health infrastructure model from the centre to the village in at least one province, Champasak Province, into which rehabilitation services are already incorporated without the need to develop a separate model. This provides an excellent opportunity to systematically build and evaluate a well-functioning integrated system of rehabilitation services from community level to tertiary level. Once built and evaluated the lessons learnt in this one province would then inform the development of coordinated delivery of rehabilitation services in other provinces. This model is described briefly here with full details in Section 3.2 Service Delivery. A graphic illustration is included in Appendix 1a.

- Tertiary: a specialist stand alone rehabilitation unit (Centre for Medical Rehabilitation CMR) with a range of in-patient and out-patient rehabilitation services and a mainstream component with a rehabilitation department located within each teaching hospital in Vientiane.
- Secondary: a specialised Provincial Rehabilitation Unit co-located with the provincial hospital and providing primarily out-patient rehabilitation services with some services to in-patients on the hospital wards.
- Primary: CBR delivered via the village Health Volunteer as the ‘first line of defence’ to maximise community participation and ensure full engagement of people with disabilities and their families.

Over the next few years, additional benefit would be gained by expansion of the model at provincial level to district hospitals and health centres. This is described briefly here and graphically illustrated in Appendix 1b.

Lao PDR is implementing a plan requiring health graduates from Vientiane to serve in the provinces after graduation at both district hospital and health centre level.

- Health Centres (which serve several villages) staffed by nurses and in some cases doctors, could, with suitable training, offer a referral pathway, monitoring and support to village Health Volunteers.

- District Hospitals could provide services (e.g. physiotherapy) and serve as the point of direct referral to specialist rehabilitation services at the provincial hospital or, for more complex cases, to CMR in Vientiane.

This model aligns with *The (Draft) Strategy for Health Sector Reform by 2020*, in which ‘health interventions should be developed according to the Three Pillars: the province as a strategic unit, the district as a comprehensive, developed and strengthened unit, and the village as the development unit across the country (p.13).

1.2 Focus on leading rehabilitation initiatives, implement and evaluate

When there is commitment and motivation there is the temptation to change all parts of the system at once and to expand services before the outcome of the changes are known or understood. The approach taken here is to suggest building on a small number of existing initiatives in critical areas and implementing and evaluating these systematically across CMR and the PRU. It is critical to evaluate the proposed initiatives in one place – Champasak province is suggested - before applying the lessons learnt to expanding the model more broadly across the entire country.

1. Develop and implement documented care pathways

A fundamental component of a well functioning rehabilitation system is all staff adhering to agreed and documented care pathways. This provides accountability for evidence- informed care. It also leads to effective and efficient service delivery. A Cerebral Palsy Care Pathway has already been developed and agreed. This now needs to be systematically implemented and monitored in CMR and the PRU. Additional care pathways need to be developed and documented using the same process and then implemented and monitored.

Direction from CMR needs to be given to:

- Implement the agreed documented care pathways systematically in CMR and the PRU.
- Monitor the implementation over time to ensure adherence to the documentation and review lessons learnt.

2. Develop and systematically collect data relevant to the documented care pathways

A second fundamental component is collecting the same data and doing so systematically by all staff. This permits examining the effectiveness of the interventions. It also provides accountability for the benefits of rehabilitation care.

Direction from CMR needs to be given to:

- Develop an agreed concise and systematic data collection format to collect client data which is consistent across CMR and PRU.
- Monitor the implementation over time in CMR and the PRU to ensure adherence to the agreed format and review the lessons learnt.

3. Educate others about the benefits of rehabilitation

A third fundamental component is ensuring other health staff and potential clients and their families understand the purpose and benefits of rehabilitation. This ensures appropriate referrals by doctors and more accurate expectations of what rehabilitation services can achieve from clients and families.

Direction from CMR needs to be given to:

- Develop simple (preferably illustrated) written explanations of rehabilitation in relation to specific rehabilitation care pathways to be given to all potential clients and their families.
- Collect feedback on the usefulness of this information for clients and families and change if necessary to ensure optimal usefulness.
- Develop straightforward teaching materials on rehabilitation for doctors and other health professionals including Powerpoint and handouts and align these with national focus on improving maternal and child health and wellbeing, and preventing and ameliorating the effects of the NCDs.
- Train all staff at CMR and PRU in using these teaching materials to teach about rehabilitation to medical and nursing staff at the tertiary hospitals in Vientiane, medical and nursing students at University of Health Sciences, medical and nursing staff at the provincial hospital in Pakse and medical and nursing students in Champasak province.
- Collect feedback on the usefulness of the teaching and the teaching materials to each of the groups taught as per above and revise as necessary to ensure optimal usefulness.

2. Developing cross- sectoral collaboration and coordination

2.1 Build stronger relationships between the rehabilitation service sector and disability sector stakeholders

Although relatively recently formed, the broad coalition of disability stakeholders with its regular meetings is building momentum. The rehabilitation sector represented by CMR would benefit from engaging proactively with this network. This will permit at the very least:

- Prior knowledge and greater understanding of initiatives in the disability sector being planned by INGOs, NGOs, DPOs and other ministries.
- Learning from the experience of members of the forum in developing national strategies and national plans of action such as the draft National Disability Plan.
- Education of the members of the forum about rehabilitation and the role and responsibilities of CMR and the PRU and community based rehabilitation.
- Input from disabled people and their representative organisations, the DPOs, into the discussion about planning and delivery of rehabilitation services thus realising the general principle of the UN Convention on the Rights of Persons with Disabilities to which Lao PDR is a signatory of ‘nothing about us, without us’.
- Informing and gathering support from members of the forum for the implementation of the recommendations in this report.
- Opportunity to share concerns that affect both the rehabilitation and the disability sector and to work together as a combined group to advocate for change. One example would be that INGOs and donor agencies often provide assistive technology (AT) and equipment without consultation and without funding for maintenance and replacement. Advocating together could lead to much improved AT provision practices such as those employed by United Cerebral Palsy Wheelchairs for Humanity www.ucpwhf.org
- Building a strong alliance with a vested interest in working together to influence dedicated government funding to the rehabilitation sector and to achieving a higher quality, effective and efficient rehabilitation sector in Lao PDR

2.2 Build stronger relationships between rehabilitation service sector and University of Health Sciences

In many countries the rehabilitation sector has gained strength and influence as the training institutions for health professionals have developed and the development of professional associations has occurred.

As yet there is no professional association of rehabilitation personnel in Lao PDR. There is an opportunity with CMR and the PRU working collaboratively with the University of Health Sciences to initiate and support a professional association for rehabilitation professionals.

This would provide a coordinated cohort of rehabilitation professionals who would also work to strengthen the rehabilitation sector. For example, they could work together with colleagues from neighbouring countries and in the region to achieve internationally accredited curricula at the University of Health Sciences. They could seek donor funds to support continuing education opportunities to upgrade skills and knowledge. The networking opportunities provide by such an association could potentially assist in creating a more positive view of a career as rehabilitation

professional. There is the opportunity to learn from developments with regard to professional associations of rehabilitation professionals in neighbouring countries such as Thailand and Vietnam.

Conclusion

Building a sustainable and effective rehabilitation sector is not a task to be under-estimated. The recommendations above are aimed at practical, concrete activities with a history of success in other countries of developing the quality of rehabilitation services and in garnering support for rehabilitation in health ministry budget processes.

Working within the focus on maternal and child health and prevention and amelioration of the effects of the NCD's fits within current national health policy and action plan developments. All of the activities recommended will be familiar to those health ministry personnel who come from a clinical background (as many do). This is because these processes of utilizing to best advantage existing infrastructure, and providing leadership and developing guidance within the sector including developing, implementing and evaluating clinical pathways, developing systematic, comparable data systems, and educating others are all processes engaged in by other clinical specialties as these have developed over time.

In addition building stronger relationships with the disability sector and with the training institution, the University of Health Sciences, will assist in formulating a more persuasive proposal for rehabilitation sector funding and development as requested by the Ministry of Health. In the medium term a better coordinated and network rehabilitation and disability sector will be better placed to develop a comprehensive and considered national rehabilitation strategy and plan.

Implementation of the service recommendations could be actioned immediately as all build on existing initiatives led by CMR, COPE and others within the rehabilitation service sector. The recommendations provide a way to build on and expand these initiatives in an organized and systematic way. Implementation of the cross-sectoral collaboration and coordination recommendations could also be actioned immediately as foundation relationships already exist.

That said there would be benefit in bringing the main players together to learn specifically about building capacity in strengthening the rehabilitation service sector. This would entail gaining more detailed classroom knowledge and undertaking a series of field visits to observe and discuss functioning systems in action. The focus on the suggested short course – 3-4 weeks in duration – would be leadership and governance in rehabilitation, the organization and delivery of rehabilitation services, quality standards, implementation and evaluation, rehabilitation

workforce, financing of rehabilitation, and information systems and through. To that end, the final recommendation is to prepare a proposal for an Australia Award short course in which participants from the rehabilitation sector, Ministry of Health, NGOs and DPOs would undertake a class based and field visit course of approximately three- four weeks duration in 2014. The Centre for Disability Research and Policy, University of Sydney, in consultation with WPRO officers, is willing to develop such a proposal.

REPORT

1. Background

The situation of rehabilitation services in many low income countries is not well understood. At the same time, the number of people who would benefit from rehabilitation is expected to increase. The WHO/World Bank *World report on disability* (2011)¹ cited prevalence data indicating that approximately 1 billion people or 15% of the world's population has a disability, of which 110-190 million adults experienced very significant disability. This 1 in 7 number is expected to increase due to global population ageing and increased incidence of chronic diseases together with other environmental factors such as injuries from road traffic crashes, climate change, natural disasters and conflict.

Rehabilitation can improve functioning and lead to increased independence and participation in activities such as education, employment, and community life. Indirect benefits of rehabilitation include reduced care responsibilities for other family members and reduced pressure on health systems. However, there are large gaps in access to rehabilitation services in many low and middle income countries, and the quality of rehabilitation services that are provided is often inadequate². In addition, rehabilitation is often not prioritized within the different levels of health planning.

Lao PDR, as with many other low income countries in South East Asia, faces many challenges when providing disability and rehabilitation services. Some of these challenges come from the country's landlocked geography in the Indo China region; Lao PDR's recent history including a long period of disruption due to warfare and the legacy of unexploded ordnance devices; the nature of the country's geography with transport options being particularly limited during the monsoon season; a relatively small population in a country of reasonable size with few centres of significant population density; and, distant rural villages including a substantial population of minority groups. Other challenges stem from socio-economic factors and the relatively recent emergence of national educational institutions capable of developing a health workforce. Such a workforce needs to be educated to meet the growing demand for a more highly developed national health system which would include rehabilitation service provision throughout the country.

The current challenge is the initiation of a sound data based approach to the development of rehabilitation services in Lao PDR. Prior to undertaking that task, it is critical to develop an in-

¹ *World Report on Disability*. World Bank and World Health Organisation, Geneva, 2011.

², *Background to Call for Research Proposals*. WHO Guidelines on Health-Related Rehabilitation Development Group, January 2013

depth understanding of the current state of rehabilitation services in Lao PDR. This report details the conduct of a Rehabilitation Sector Situation Analysis undertaken in late April-early May 2013 for this purpose.

The report offers an analysis of the rehabilitation sector in Lao PDR through desk review and implementing a rehabilitation sector situation analysis pro-forma in interviews and meetings over 6 days in-country with key government personnel responsible for rehabilitation and people with disabilities. This included the Ministry of Health and Ministry of Labour and Social Welfare, Lao Disabled People's Association (LDPA), staff of the Centre for Medical Rehabilitation (CMR), WHO country office, Co-operative for Orthotics and Prosthetics Enterprise (COPE), Handicap International (HI), CBM, National Regulatory Authority for UXO (NRA), provincial public health department and hospital staff, village health workers and other village personnel.

A Consultation Meeting on Disability and Rehabilitation with 65 invited participants chaired by Dr Khampheth Manviong, Director of CMR with Dr Gao Jun, WHO and Dr Phisith Phoutsavath, Deputy Director General of Health Care, Ministry of Health was held on May 6th. Appendix 1 illustrates the current and potential future structure for rehabilitation. Appendix 2 contains the names and titles of all key informants. Appendix 3 contains the Vientiane Times report of the Consultation Meeting. Appendix 4 contains a list of list of DPO's in Lao PDR. Appendix 5 contains the list of documents accessed for this report. Appendix 6 contains a photograph of public health awareness campaign on NCD's.

2. Desk Review

Lao PDR was founded in 1975. The President, Prime Minister, and National Assembly are the primary governing mechanisms under guidance from Lao Peoples' Revolutionary Party (LPRP). The population estimate in 2011 was 6.4 million based on population census of 2005³. Lao PDR comprises 52% Lao who live in lowlands and 47 different ethnic groups who primarily live in the highlands.⁴ 32% of the Lao population lives in urban areas with the rest scattered in mountainous, hard-to-reach parts of the country, with little access to basic infrastructure and services. The Lao People's Democratic Republic has been undergoing momentous social and economic

³ *Statistic Population*. Webpage Lao Statistics Bureau (2013). Retrieved from http://www.nsc.gov.la/index.php?option=com_content&view=article&id=37:population&catid=6&Itemid=38

⁴ *Western Pacific Country Health Information Profiles: 2011 Revision*. World Health Organization. (2011). Accessed at: <http://hiip.wpro.who.int/hiip/chips>

transformation since the introduction of market-based economic reforms in 1986. Its economy has been growing steadily over the last 10 years, with average annual GDP growth at around 8%⁵.

Lao PDR is organised into 17 provinces and the capital is Vientiane. The poverty rate is understood in 1992-1993 as 47% which is understood to have reduced to approximately 27% by 2007-2008⁴. According to documented sources, poverty is mainly found in the highlands and in areas that are inaccessible by road or river – only accessible by walking for 1-2 days. The Lao PDR government has instituted a resettlement policy for remote villages bringing these villages closer to roads and public services. There is some concern from INGOs that this has made these populations more vulnerable as they are unable to rely on their traditional systems/techniques for food production and that this may have resulted in decreased health and nutritional status. A further concern is with corruption and transparency. In 2009 Lao PDR ranked 158th out of 180 countries on the Corruption Perception Index (Transparency International)⁴. Lao PDR ranked 138th amongst 187 countries on the human development index (HDI) scale in 2011⁶.

2.1 Legislation, decrees, policy documents and reports

2.1.1 Health

The 7th Five-Year National Socio-Economic Plan (2011-2015) approved by the Lao PDR Ninth Party Congress set out the target of achieving the Millennium Development Goals by 2015, and graduating from the list of the least developed countries by 2020. The 7th Five-Year Health Sector Development Plan (2011-2015) aimed to provide a clear roadmap to achieve Health MDGs. A review of progress and comparison with other countries in the region showed that the country was not on target in two MDG's for which the health sector is primarily responsible. That is, MDG1 improving nutrition and particularly in children under 5 and MDG5. The maternal mortality rate in Lao PDR is significantly higher than neighbouring countries (over 8- 9 times higher than China, Sri Lanka, Thailand and Vietnam)⁷.

In 2011 the Prime Minister instructed that the health sector in Lao PDR has to improve access to, and use of quality health services through health sector reform in order to acquire a rapid improvement in health and healthcare for Lao's population. Since early 2012, the Ministry of

⁵ *WHO Country Cooperation Strategy for the Lao People's Democratic Republic, 2012-2015*. WHO Western Pacific Regional Office, Manila, 2011-11-14

⁶ *Human Development Report*. New York, UNDP, 2011.

⁷ National Health Sector Reform Strategy, 2013-2025, 17 December 2012. Internal document Ministry of Health for comment only

Health, under the leadership of the Prime Minister and with support from WHO and other development partners, has undertaken a series of consultations on how the Lao PDR health sector needs to be reformed to achieve the MDGs by 2015 and Universal Health Coverage by 2025. From this a health sector reform strategy has been developed.

*The (Draft) Strategy for Health Sector Reform by 2020, dated 28th February 2013*⁸ (referred to hereon as *Health Sector Reform by 2020*) was based on the following:

- The Resolution of the Ninth Lao People’s Revolutionary Party Congress;
- The Seventh Government Social-economic Development Plan 2011-2015;
- The Health Sector Vision in 2020 and the 7th Five-year Health Sector Development Plan (2011-2015);
- Strategy and planning framework for the integrated package of maternal neo-national and child health services (2009-2015); and,
- The Statement of the Prime Minister on “Health Reform Principle” on 31 July 2012 at the Ministry of Health.

The *Health Sector Reform by 2020* document sets out a Master Plan with five priority areas: human resource development, health financing, organization, management and working style, health services and information, monitoring and evaluation. There are general and specific objectives with specific targets to be achieved by 2015 and by 2020. A decree for a National Commission to implement the *Health Sector Reform by 2020* has been drafted but not yet actioned. The Reform is planned in three phases:

- Phase 1: Achieving health-related MDGs (2013-2015)
- Phase 2: Improve access to basic health care and financial protection (2016-2020)
- Phase 3: Achievement of Universal Health Coverage (2021-2025)

The *Health Sector Reform by 2020* is a broad policy document; it does not refer to health conditions (outside the specific targets of MDG1 and MDG5), accidents, illness or injuries, population demographics such as increasing longevity or specific areas of population need such as increasing incidence of non-communicable diseases (NCD’s). There is no reference to disability and/ or rehabilitation.

2.12 Disability

⁸ (Draft) *Strategy Health Sector Reform by 2020*, 28 February 2013. Ministry of Health, Lao People’s Democratic Republic.

The following information on national legislation on disability and co-ordination mechanisms comes from the presentation by the ALA Fellows from Lao PDR and their subsequent case study⁹.

According to the Lao PDR Census of 2005, at that time there were 70,260 persons with disabilities which is around 1.3% of the population⁹. The types of disability were: arm or leg handicapped 39%; deaf or dumb 27%; visually impaired 17%; multiple disabilities 7%; other disabilities 10%. UNESCAP estimates that the population of people with disabilities is approximately 10% which is closer to the figure of 15% in the *World Report on Disability (2011)*¹. This would equate to approximately 640,000 people with disabilities in Lao PDR on 2005 population census figures.

Overall there are a number of legislative instruments that refer to/ include people with disabilities either generally as Lao citizens or specifically mentioned. These are:

- Lao constitution (amended 2003).
- Law on protection and promotion and Development of Children and Women. Law on Education. Law on Labour. Law on Health Care. Law on Construction and Transportation.
- National Policy on Inclusive Education 2010;
- The National Strategy and Action Plan on Inclusive Education 2011-2015;
- Decree No.061/pm on Organization and Implementation of the National Committee for Disabled People which gave rise to NCDP;
- Draft Decree on protection of rights and interests and development for Disabled People (to be approved by the government within 2013).

The Decree 061/PM, on Organization and Implementation of the National Committee for Disabled People, Chapter II Duties and Rights, Article 3 Rights states:

1. To coordinate with the ministries, ministry equivalents and social organizations at the national level to study and propose to the government legislation, a strategy plan, implementation framework, work plans, projects, and policies for people with disabilities; and to coordinate with these organizations for the supervision and implementation of these matters after the approval of the Decree.

The Draft Decree on Protection of Rights and Interests and Development for Disabled People was initially drafted in 2008. It is due to be completed and submitted for approval to the Ministry of Justice by end 2013. Lao PDR ratified the Convention on the Rights of Persons with Disabilities on 25 September 2009. Lao PDR country report on CRPD is due to UN Monitoring Committee by end 2013. The Draft Decree follows the Articles of the UN Convention on the Rights of Persons with

⁹ Presentation by Mr. Sisavath Khomphonh, Deputy Director General, Department of Pension, Invalid and Disabilities, , Ministry of Labour and Social Welfare, with Mr Nouanta Latsavongxay, Project Manager, Laos Disabled People's Association, and Mr Sisamer Inthavongsa, Manager DPO Project, Handicap International to ALAF Increasing capacity in disability rights based policy, University of Sydney, February –March 2013.

Disabilities (CRPD)¹⁰, and is designed to meet the obligations of Lao PDR to review and amend national legislation in line with CRPD.

The Strategic Plan of the Ministry of Labor and Social Welfare mentions in goal 1 that:

The state shall improve and create legislations, especially the Decree, strategic plan and regulation on labor and social welfare.

Regulations promulgated by the Ministry of Labor and Social Welfare and the Lao National Committee for Disabled Persons (NCDP) protect persons with disabilities against discrimination, however the regulations lack the force of law. In 2011, the Ministry of Labor and Social Welfare established regulations regarding physical accessibility and some ramps were built in Vientiane. Legislation adopted in 2009 requires that the construction of buildings, roads, and public places provide facilities for persons with disabilities. The law does not mandate accessibility to buildings erected before its enactment.

The Prime Ministers Decree No.115/2009 on Associations. Due to this decree, civil society and associations are now registered as legal entities. This can now include associations of people with disabilities such as the Lao Disabled People's Association (LDPA)¹¹. The LDPA, the national umbrella organization for disability groups that was established in 2001, was officially recognized as a civil society organization by the Ministry of Home Affairs in September 2011.

Organisation and structure for disability¹²

Under the leadership of Ministry of Labour and Social Welfare and NCDP, a Disability Focal Point (DFP) has been established within line-ministries including MoLSW, MoH, MoE, MoICT, MoPWT, MoJ, MoNS and MoF. There are also disability focal points within mass organizations including chamber of commerce, women's union and youth union. Under the National Committee for Disabled People (NCDP), the National Coordination Office of NCDP serves as secretariat of the committee of focal points on disability.

Under the NCDP, provincial and district committees for disabled people have been established in each of provinces. The National Coordination Office of NCDP, in collaboration with the Disabled People's Organizations, particularly the Lao Disabled People's Association (LDPA) and INGOs, have implemented and are currently implementing a number of disability projects in the areas of education and vocational training, employment, social-economic inclusion, sports and recreation, awareness raising on disability rights and accessibility, livelihood improvement. Past and current

¹⁰ UN Convention on the Rights of Persons with Disabilities, Article 4, General Obligations

¹¹ For a list of DPOs in Lao PDR see Appendix 4.

¹² Information in this section comes from footnote 10 op.cit.

donors and partners include: POWER Intl, ADDP, AusAID, HI, AAR Japan, CWARS, CARE Intl, UNICEF, Basic NEEDS, Caritas Australia, UNDP, JICA, APCD Thailand, Eden International, Hope Haven, Kingdom of the Netherlands, SHIA, World Vision, and International Committee of Red Cross Special Fund for the Disabled (ICRC SFD).

The Disability Network has established a regular DPO meeting which is held to exchange, update and support one another. There is also a Disability Forum which is held annually with participation of government officials from line-ministries, NGOs, INGOs and DPOs. The LDPA has a strong relationship with NCDP and ministries in supporting policy development, for example, the Draft Disability Decree and Ministerial Disability Action Plans.

The Ministry of Labor and Social Welfare has developed, with the support of JICA, a Master Plan on Social Welfare in which disability is addressed (from the year 2004)¹³. The NCDP will continue seeking support to develop the National Disability Action Plan within 2013.

2.2 Reports of Non-Government Organisations and International Non-Government Organisations

Lao Health Master Planning Study

A document which has been influential in key informants' thinking in Lao PDR about rehabilitation is the Lao Health Master Planning Study¹⁴ carried out by JICA in 2004. Chapter 23 of this document presents a Framework for Rehabilitation. This document identified five major issues in relation to rehabilitation at that time in Lao PDR. These issues pertain today. The issues in 2004 were:

- Insufficient statistics on disability
- Weak organisation of the rehabilitation program
- No regulation of rehabilitation services provided by the private sector
- Lack of rehabilitation services provided by professional staff in hospitals
- Unavailability of rehabilitation services in remote areas

The chapter also identified key directions and possible measures. The key directions were:

- (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;

¹³ This document has not been sighted.

¹⁴ Laos Health. Master Planning Study, 2004. Chapter 23 Framework for Rehabilitation, 23-1 to 23-6

- (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.

These five key directions remain relevant in 2013. Further comment is provided in the executive summary and recommendations section of this report.

Landmine and Cluster Munitions' Monitor

The Landmine and Cluster Munitions' Monitor (LCMM) regularly updates information on countries beleaguered by landmines. The most recent update on Lao PDR is 16th December 2012¹⁵. The statistics on injuries reported are as follows: 2011: 77 injured, 2010: 93 injured, with 56 injured as the reported number for 2012. Several years previously the number injured each year was considered to be around 300. There appears therefore to be a considerable decrease in the number of landmine survivors each year. Alternative reasons proposed for this success are: education about the risk particularly for school children, more clearance, and reducing the trade in metal by government intervention to control the price of scrap metal. However, the LCMM cautions that the "data was not considered to be accurate; even after six years of work on the NRA casualty data collection system, there was little or no improvement in the quality of the data available" (p.1)¹⁵.

That said there is more data available on landmine victims and survivors than on people with disabilities from other causes in Lao PDR. Lao PDR has estimated that there are some 12,500–15,000 mine/ERW survivors still alive, including approximately 2,500 survivors of unexploded submunitions. With regard to landmine work, more focus was on clearance and those killed until around 2010 when more attention began to be paid to victim assistance. There remains no reliable data about survivors' needs or the needs of their families. A national survey was commenced in 2009, but the victims' needs component was not completed. In 2012 some activities have occurred to try to gather data at district and provincial level on victims' needs.

The government coordinating body/ focal point is the NRA Victim Assistance Unit. The coordinating mechanism is NRA Technical Working Group on Victim Assistance (TWGVA) together with District and Provincial Focal points. There is no National Victim Assistance Plan in use although a plan was said to be being drafted in 2012. National standards for victim assistance developed in 2007 remained in draft form pending the completion of the national victim assistance strategy. According to LCMM "Reinforcement of linkages between victim assistance and the broader disability sector was still needed in 2011" (p.3)¹⁵.

¹⁵ Landmine and Cluster Munitions Monitor Lao PDR updated 17th December 2012 http://www.the-monitor.org/custom/index.php/region_profiles/print_theme/1935, accessed 5th May 2013

Evaluation reports of NGOs and INGOs

There are a number of NGOs and INGOs operating in Lao PDR. For example in the field of UXO Victim Assistance there are 4 NGOs and 5 INGOs as well as the government and the local organisation COPE which is funded by external donors but focuses its work on supporting CMR. Each of these organisations offers a variety of projects which change over time. Typically there is an evaluation report at the end of the first project period. Examples include the External Evaluation of Paediatric Rehabilitation (COPE, 2012) and External Evaluation of the CBR Project in Savannakhet of Handicap International in Collaboration with the National Rehabilitation Centre in Lao PDR (Handicap International, 2008). No attempt has been made to source a comprehensive listing of NGO and INGO reports. Material has been sourced where practical and available from informants and is listed in Appendix 5.

3. Rehabilitation Sector Situation Analysis

Method, pro-forma, interviews with key informants

A rehabilitation sector situation analysis pro-forma was developed for this project. The pro-forma was developed with assistance from Ms Alexandra Gargett, Research Associate, Faculty of Health Sciences and Ms Pauline Kleinitz, Technical Advisor in Disability, WPRO. The pro-forma is based on the WHO Health Systems Strengthening Framework and Key Components of a Well Functioning Health System¹⁶. The pro-forma consists of an introductory page followed by the following six sections: leadership and governance; service delivery; rehabilitation workforce; assistive devices and technology; financing; and information systems. A two page Health Workforce Data Collection sheet was attached to the pro-forma. This sheet is based on the International Standard Classification of Occupations adapted for the rehabilitation/disability sector by Llewellyn, Gargett and Short for the *Pacific Health Rehabilitation Workforce Project, May-September, 2012*. The Rehabilitation Sector Situation Analysis pro-forma is available on request.

Survey mapping was the first stage of implementation of the Rehabilitation Sector Situation Analysis. An invitation email with the pro-forma attached was sent to key informants. They were invited to review this, and consider the questions prior to the interview to be conducted in-country approximately one week later. The email explained that the pro-forma contained overarching questions which the project was designed to answer. Detailed questions were included to act as a stimulus to key informants' thinking prior to interview.

¹⁶ Key Components of a Well Functioning Health System, WHO, May 2010 which builds on earlier publications including *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*, WHO, Geneva, 2010

Key informant interviews were conducted over a seven day period in country from 29th April to 7th May inclusive. The list of key informants and their titles is included in Appendix 2. Every effort was made to interview the personnel nominated in the project proposal. However due to time constraints, logistical difficulties and time pressures for a number of key informants, this was not possible. Alternative informants were interviewed where possible, for example, the Head of Physical Therapy at Mahosot Hospital was not available; her deputy was interviewed in her place. Interviews ranged from around 30 minutes to several hours depending on number of people and available time. Other informants were suggested while in-country and interviewed where time permitted.

The pro-forma proved a useful tool to stimulate discussion and to collect data on the rehabilitation sector and on disability in Lao PDR. It allowed for 'testing' out that data in subsequent interviews where appropriate; limiting questioning and discussion to areas of known expertise; and a valuable aide-memoire to ensure all building blocks of effective rehabilitation systems were covered in the course of data collection. The Health Workforce Data Collection Sheet proved useful as a basis for discussion. Due to lack of documented evidence about rehabilitation personnel it could not be completed in detail. Therefore information on workforce relied on knowledge from key informant sources and this is included in Section 3.3.

Additional value would be provided in the form of an on-line data collection tool preferably on a tablet device. This would allow data to be recorded directly in the interview, identified by informant, and hyper-linked through to the relevant sections of the pro-forma. This would allow easier and quicker reporting linked to particular key informant knowledge.

The data produced from the key informant interviews has been aggregated, analysed and summarised below under each of the six building blocks to form an analysis of the rehabilitation sector in Lao PDR.

3.1 Leadership and Governance

National governance mechanisms

As described earlier there are a number of decrees and coordinating mechanisms relevant to disability and Landmine and Victim Assistance. There is also the *Draft Decree on Protection of Rights and Interests and Development for Disabled People* which is scheduled to be completed and promulgated by end 2013.

Several informants spoke of the proposal to develop a national rehabilitation plan (with the term used broadly to cover strategy and/or implementation/work plan). The lack of a national rehabilitation plan was frustrating to many who see that such a plan is needed to focus attention

on rehabilitation at MoH, educate others, and to attract resources from MOH to support and further develop the rehabilitation sector.

In the Ministry of Health, the department of Health Care (until around 12 months ago known as Curative Care) is now responsible for rehabilitation. There appeared to be no guidelines or guidance to the rehabilitation sector from this department. In addition, there are very limited vertical mechanisms within the government rehabilitation sector.

The Centre for Medical Rehabilitation (CMR) based in Vientiane is the central location of rehabilitation services with Provincial Rehabilitation Units (PRUs) in 4 provinces only. CMR informants noted that their influence at the provincial level (PRUs) is limited to technical assistance, and inviting provincial level staff to CMR workshops. The staff in the PRUs are government employees; each province however is responsible for their health budget, so resources available for rehabilitation (as with other health care sectors) depend on the state of the provincial economy and priorities.

There does not appear to be any cross-ministerial collaboration on rehabilitation or a focal point for liaison with other ministries, with the exception of MoSLW. Representatives from CMR attend the Disability Forum along with some technical staff. There are also representatives of NCDP, LDPA, other DPOs, NVA and NGOs and INGOs. In total about 40 representatives across the disability sector attend this meeting. There do not appear to be any mechanisms for people with disabilities/ DPOs to participate in planning, implementing, monitoring and evaluating in the rehabilitation sector.

Inclusion and exclusion criteria for rehabilitation

Key informants from CMR, Cooperative for Orthotic and Prosthetic Enterprises (COPE), Handicap International (HI) and CBM reported there is no formal inclusion or exclusion criteria for rehabilitation services according to impairment type. Some NGOs may focus on particular impairments, for example, Lao Association of the Blind or focus on particular districts or provinces. Other NGOs in partnership with an INGO may focus on particular aspects of life, for example, Lao Women's Union/Clear Path International (CPI) which has a micro-credit scheme to female heads of households in Xieng Khoung province. CMR and the 4 PRUs are theoretically open to any person requiring rehabilitation. Key informants noted however that people with mental illness, epilepsy or leprosy are not referred to rehabilitation whether this be centre based (CMR and PRUs) or CBR in the villages. There appears to be some positive discrimination toward victims of UXOs due to the focused and continued effort on landmine clearance, data collection, and reporting, and the availability of data via the 'bombing map' which shows areas of bombing concentration. There is no data available to determine whether a greater proportion of land mine victims receive rehabilitation service compared to those disabled from other causes.

Age is not an exclusion criterion for attending a rehabilitation services but cost, transportation and lack of priority for older people are barriers. Attending rehabilitation is frequently very difficult for women particularly in the villages as (i) they may not have ever travelled before, (ii) they are reluctant to go to a town or a city where the culture is likely to be quite different, (iii) they cannot leave their duties in the household and village, and (iv) their health care needs may not be viewed as a priority.

Cost of services is a barrier to rehabilitation. Government services are all user pays. Poor people can receive an exemption: it was reported that this exemption is quite hard to get and there is much paperwork to be done to apply for this exemption. Rehabilitation services paid for by COPE and INGOs are not user pays: these are free with an agreed rate determined (no matter which donor funds are used). There is some health insurance in Lao PDR, for example, for employees of international companies and also more recently a scheme for government employees. It was reported that the latter does not cover rehabilitation.

3.2 Service Delivery

The following information has been compiled from key informant interviews and relies on their knowledge which may be limited to their specific part of the rehabilitation sector. There does not appear to be any legislated, government, facility or professional standards for service delivery. CMR is currently trying to develop a closer relationship with the PRUs so there may be an opportunity to bring some leadership and governance approaches to the work of both CMR and the PRUs. Staff at CMR, the PRU visited and the CBR program all reported a distinct lack of awareness of the potential benefits of rehabilitation in the community.

Tertiary level rehabilitation

Tertiary level rehabilitation is provided at CMR in Vientiane and at the PRUs in four provinces at Luang Prabang, Pakse, Savannakhet and Xiang Khoung. At CMR, rehabilitation services include some orthopaedic surgery, physical therapy, prosthetics and orthotics, early intervention, wheelchair provision and some adapted equipment. The rehabilitation department has several sections including musculoskeletal, massage and electric therapies. At the PRUs a limited version of the above CMR services are reported to be available. Details of one PRU which was visited are provided below.

At CMR and the PRUs the staff are government employees, with the province providing the building and basic operational costs such as water, electricity etc. The equipment, materials, training for rehabilitation staff all come from COPE (donors). COPE pays for each patient: cost of the service, transport, food, accommodation. Donors have particular priorities for their funding,

for example AusAID – prosthetics training, USAID – orthotics, CBM – club foot, ICRC Special Fund for the Disabled (SFD) – amputations and the poor.

At the tertiary level, the best known rehabilitation service is physiotherapy. There been expatriate physiotherapists employed by INGOs and NGOs in Lao PDR for many years and there is now also a Diploma in Physiotherapy offered by the University of Health Sciences in Vientiane. Details about the rehabilitation workforce are provided in Section 3.3 below.

It was particularly difficult to establish the extent of physiotherapy provision in Vientiane and in the provinces. It was reported that in-patient physiotherapy is available at (at least) two major hospitals in Vientiane. It is understood that although Provincial Hospitals may have a unit designated physiotherapy this does not necessarily mean there is a qualified physiotherapist offering services in this unit.

Physiotherapy at the two major hospitals in Vientiane (data based on a visit to one and interviews with rehabilitation personnel at CMR and the University of Health Sciences) is mainly provided to adults post stroke, and to adults and children with cardio-respiratory conditions. Outpatient physiotherapy is focused specifically on teaching the family how to assist their disabled family member. For example, at Mahosot Hospital which is the most well known (and therefore respected and popular with patients) there are 9 PT's of which 3 are currently studying abroad. They are all graduates of the program at University of Health Sciences (UHS). On average PTs spend on hour with each out-patient; there are around 25-30 out-patients a day. They also provide in-patient services to ICU and on the wards – about 30 patients a day. New out-patients are typically seen every day and then every alternate day and this could be up to one year or longer depending on their condition. Out-patients (by report and by scanning diagnosis in records) are primarily neck pain, back pain, arthritis, sciatic pain). Patients are mainly adults, although there are some babies and children seen usually for pneumonia. There are no guidelines for clinical care guidelines; PTs make their own decisions about treatment, length of treatment, when to close the case etc. The tertiary hospitals also take PT students from UHS usually around 15 at a time for one month duration and then rotation. The services observed were all institutionally based: there did not appear to be any community out-reach, home based or mobile services.

Secondary level rehabilitation

Rehabilitation services are provided through the 4 PRUs. Data in this section is based on a visit to one PRU, at Pakse in Champasak province which is in the south of the country. The situation at the Pakse PRU may be somewhat different to the other PRUs as in Pakse there is well articulated support from the Provincial Public Health Department. Further investigation is needed to understand the rehabilitation service in the remaining 3 PRUs. There may also be some physiotherapy services at other provincial level hospitals however it was not possible to gain information on this.

At the Pakse PRU located in the grounds of the Provincial Hospital there is a range of physiotherapy, prosthetic and orthotic services, and some occupational therapy all on an out-patient basis with some services to hospital in-patients. The PRU has technical/ splinting rooms, a PT treatment room, and some occupational therapy equipment. It was not clear how much communication occurs between CMR (with a role to provide technical assistance) and the PRU although a strategic planning day with the 4 PRUs was being planned by CMR for early June.

The Pakse PRU takes referrals from the CBR program and one of the four districts served by the CBR program is in the town of Pakse – this was where the CBR program for the province started. The PRU also takes referrals from the Provincial Hospital. The main client base appeared to be stroke, orthopaedic conditions and injuries, and there was also a small early intervention program for children with disabilities.

Primary level rehabilitation

It was reported that previously there had been CBR programs provided by HI (in Savannakhet Province in collaboration with the PRU) and CBM (in Vientiane Province). It appears that there are self-help groups still running following the closure of these CBR programs. CBR has been available in other provinces previously, but in each case was dependent on INGO funding and, by report from the CMR CBR Coordinator, when external funding ceased, the CBR programs closed.

In Champasak province (visited), a government community-based rehabilitation (CBR) service is available at village level in four districts. CBM continues to provide an annual budget to support the work of the CMR CBR Coordinator and also four district level CBR monitors who support and monitor the village Health Volunteers.

CBR is carried out at village level by a village Health Volunteer. This person is chosen by the head of the village to carry out all health duties including immunization programs, maternal and child health programs etc. The person is often chosen because they can read and write. They undergo 2 weeks training on CBR carried out by CMR. The training is based on the initial WHO CBR Manual (1970's) known as the Yellow Book, an early edition (pre-1990) of Nancy Finnie (et al) work on *Handling the Young Child with Cerebral Palsy at Home* and David Werner's work on *Working with Disabled Village Children*. Manuals based on these resources are provided to trainees so they have instruction sheets to refer to.

The CBR program addresses physical rehabilitation needs. The other components of CBR according to the CBR Guidelines and Matrix are not covered. The main clients are older people with stroke following hypertension, and children with cerebral palsy. It appears that referrals to the Health Centre happen on a case to case basis rather than following any documented referral or clinical pathways procedure. Referrals to the provincial hospital depend on the family's ability to pay not

only for transport but also for associated costs of hospital care. The distance (around 2-3 hours by bus weather and road conditions permitting) limited the number of referrals.

The CBR program is conducted in cooperation with the Provincial Health Department. The Provincial Health Department staff: Provincial Supervisor, 2 Field Monitors, 4 District Coordinators (outside Pakse and one more in Pakse) are all government employees and have a primary job with their CBR responsibility being additional and for which they receive an incentive payment from CBM. As at May 2013 across the five districts receiving CBR there are 693 adults and 216 children (total 909) on the CBR books including closed cases. The total population of these five districts is 372,122. This equates to 0.24% of the population receiving CBR.

Donor funded services

Associated with CMR there are 7 projects as follows:

- Wheelchair Production
- CBR in Champasak Province- CBM
- Mother and child stimulation project in Savannakhet Province – HI
- First aid and emergency training in Xiang Khoung – AAR
- Health Centre Training – World Education Consortium
- Vocational Training School for Physically Disabled in Vientiane (small centres in Savannakhet and Luang Prabang) – Christian nuns

COPE (channeling funds from various donors to support CMR) pays for the significant majority of rehabilitation patients at CMR. One arm of COPE, called COPE CONNECT endeavours to screen at village level for children and adults who could benefit from rehabilitation and refer these potential clients to the rehabilitation service at the PRUs (in the four provinces where these exist) and to CMR in Vientiane for more complex cases where surgery and fitting with prostheses and orthotics is required.

This screening program - COPE CONNECT – has been limited to a small area in the south with a small area in the north being added over the last 12 months. The Coordinator of COPE CONNECT reported difficulties in motivating villagers to undergo rehabilitation treatment either at provincial level or in the capital at CMR. Although costs are paid by COPE there are many barriers: women for example cannot leave the family as there is no substitute for their contribution; villagers are very reluctant to travel beyond their village or neighbouring villages, and this is exacerbated if they are of a particular ethnic group (not Laotian); many villages are only accessible by foot either all year (or during the rainy season) which prevents people leaving; and cultural beliefs including animism which may provide an alternative ‘fatalistic’ attitude to injury, illness, impairment and disability.

Private rehabilitation services

There was one private rehabilitation clinic in Vientiane reported, conducted by the rehabilitation specialist and staffed with PT graduates. Psychiatrists working at CMR are also able to see patients privately. This suggests that more rehabilitation services exist than those directly under the MOH however the private services are user pays and therefore restricted to those with funds to pay. Gathering accurate data on these reported additional services was not possible to achieve.

Overall it appears that rehabilitation in Lao PDR is difficult to access due to cost of services (out of pocket payments on top of services subsidised by NGOs or fee waivers for indigent persons); travel costs and difficulty with transport due to poor roads and river crossings; food and accommodation costs; and, equipment costs. Health insurance for those who have this, for example, government employees, determines where people go for medical treatment when they are ill – as there are preferred provider arrangements in place. For Lao citizens employed by non-Lao companies, this is usually an international health insurance company and this pays for medical and hospital care in Thailand. For Lao citizens there is now a state health insurance enterprise (anyone could buy health insurance from this enterprise if they can afford this). This also utilises preferred provider arrangements as does the health insurance scheme for government employees. Family and friends are very prominent in all other aspects of Lao PDR life so it could be assumed these networks also strongly influence how and where patients seek health care.

Service standards for the delivery of rehabilitation services and monitoring and evaluation

Key informants reported that there are no legislated standards for rehabilitation or standards for rehabilitation issued by the Ministry of Health. Similarly there did not appear to be service standards or guidance for decision-making at the facilities level such as CMR or the tertiary hospital visited. Typically key informants talked instead about “doing what they were trained to do”, rather than relying on service standards or clinical guidelines.

The primary impairments included in rehabilitation programs are physical (e.g. stroke, amputation, spinal injury, back pain, neck pain, and cerebral palsy). This is not surprising given that the major service in rehabilitation at each level – CMR, tertiary hospitals and PRUs - is PT. It was reported that those with mental illness, epilepsy, and leprosy are not referred to/ considered by rehabilitation services. In the deaf and blind school at CMR there are children with multiple disabilities, however it was reported that children with intellectual disability were not included.

Referral pathways appear to be somewhat idiosyncratic with key informants noting that no-one seems to ‘understand what rehabilitation is or can do’. This means, according to informants, that there is little referral to rehabilitation. CMR has recently initiated working to educate doctors in the tertiary hospitals in Vientiane about rehabilitation to increase the number of patients referred. Informants agreed that patients only follow what the doctor says to do. So for example, doctors

might say “go to Thailand”, “come to my private clinic”, or “just go home” with no mention of rehabilitation.

There are some promising initiatives in developing referral pathways and treatment standards. COPE has endeavoured to develop referral pathways and standards for treatment in Paediatric Rehabilitation in collaboration recently with CMR, based on their experience in the Paediatric Rehabilitation Project funded by Power International from June 2009 to August 2012¹⁷. One – a Cerebral Palsy Care Pathway - is completed¹⁸. This is an excellent document with simple text, clear illustrations and structured pathways and will serve as a good model for planned additional care pathway documents in spinal cord injury and fracture management. Other initiatives also have developed from the Paediatric Rehabilitation Project. For example, P&O services are now being audited (all training in P&O is provided by COPE lead by P&Os trained in Cambodia under the guidance of P&O mentor; all materials, cost of service, accommodation and transport is paid by COPE). In at least three units- Vientiane, Pakse and Xieng Khoung - this auditing is being undertaken by ICRC/ICRC and in Luang Prabang and Savannakhet by COPE. This is a good beginning to developing service standards.

There was no evidence of professional standards for PT which is the only rehabilitation discipline in which there has been training for some time. There is currently no professional association/ group of physiotherapists which in other countries for example have been instrumental in developing practice guidelines and professional standards. As noted at facility level there is data kept on age of patient, gender, diagnosis and some data on frequency and type of treatment. This data, as far as could be observed, is not monitored or evaluated.

Monitoring and evaluating to improve outcomes does appear to happen at the behest of donor agencies, and on the recommendations of external evaluation reports, however this is infrequent. There are recent initiatives such as that planned by COPE to conduct a follow up survey of people screened through COPE CONNECT to understand the reason why those referred to PRUs or CMR have not taken up this option.

Factors that reduce access to rehabilitation

Key informants agree on the following factors that reduce access to rehabilitation:

- Lack of knowledge/ awareness in the community about rehabilitation and the benefits of rehabilitation.

¹⁷ Final Report External Evaluation Paediatric Rehabilitation Project, Palitha Jayaweera, Dr Sangha Xaysmouth, June 2012.

¹⁸ *Standards of Care for Cerebral Palsy: Protocols for Implementation of a Cerebral Palsy Care Pathway*. Developed by Clinical Cord Group (CCG), a joint working group between CMR and COPE, April 2013.

- Beliefs about disability – either Buddhist or animist – which in essence mean that disability is accepted as the person’s ‘lot in life/ fault’ – thus their health and rehabilitation needs are not recognised/ overlooked.
- Inability to access rehabilitation services as these only exist in the capital and at provincial level (in 4 provinces only). People from the villages are very reluctant to go to another district or the province level where the culture/ language and so on can be different to their own.
- Cost of leaving the village: no one to do farming, home duties, selling at the market etc; cost of travel and accommodation and food (even though this is paid by COPE once people agree to come to a centre).
- Expectations about ‘cure’, for example, with children with cerebral palsy, which cannot be met, and have a negative impact on families or other people in the village seeking assistance.
- Additionally, it was reported that concern about poor or poorer than expected outcomes from, for example, surgery at CMR, means patients are dissuaded from attending.

3.3 Rehabilitation Workforce

The current rehabilitation workforce

There was no data base or written documentation on the rehabilitation workforce available. The material reported here summarises information from several key informants.

- One rehabilitation medicine specialist with specialist qualifications from Thailand.
- There are rehabilitation clinics conducted by physiatrists, surgeons, orthopaedic specialists who come to CMR (number and qualifications could not be determined).
- Reportedly, more than 300 PT’s have been trained at the University of Health Sciences (formerly College of Health Sciences, under Ministry of Health) in the Associate Diploma (3 years), although reportedly a little less than half work as PT’s.
- At CMR there are 13 PTs as government employees; there are also a number, perhaps another 5 who are volunteers without government posts. Last year CMR only had 2 positions available for new PTs. Graduates volunteer at CMR from 8-4 pm in the hope of getting a position after several years; from 5-9pm daily they work in a massage clinic. Some do extra training in massage and become expert at this and do not return to PT (no positions available).
- There are 8-9 P&Os in CMR/COPE Prosthetics and Orthotics workshop plus two technicians for every P&O. Initially P&O staff were trained in Cambodia to IPSO standards, however only one remains at CMR. The CMR P&O staff, under the guidance of the P&O

mentor, have trained P&O's and P&O technicians who work in the 4 PRUs. The mentors use a train the trainer model.

- There are no OTs. Two members of staff at CMR spent 4 months training at Chiang Mai University in OT. On their return they made some equipment and trained some other staff so there is an OT section, and OT appears to be offered to out-patients, but it is uncertain exactly what is offered.
- It was not possible to ascertain how many trained PTs and P&Os there are in the PRUs or how many technicians. Currently there are no PTs at District Level with HI initiating a project in 2014 to place one PT in a district hospital for 2 years.

Training for rehabilitation professionals

The information in this section was provided by staff of the Faculty of Medical Technology, University of Health Sciences. There are no staff being trained in rehabilitation medicine.

In PT, there are two courses as follows:

- The first is a 3 year Associate Degree which is entered direct from secondary school (which only began 2 years ago, before this it was a diploma). There are only 2 years of students so far: about 83 in Year 1 and 83 in Year 2.
- The second is called Associate Degree (Bridging or Continuing) which is 18 months in duration and is for already graduated and experienced PTs. The development of this course was supported by JICA. The Faculty hope to get permission to offer a 4 year Bachelors degree, and there hope is that the students in this Associate Degree Bridging will get advanced standing in the planned bachelor's degree.

In P&O, an Associate Degree course began last year; the Faculty wanted to enrol 26 students but only 7 enrolled. The curriculum was written locally. As above technicians are being trained in the train the trainer model employed by COPE in CMR and the PRUs, but it is not clear how many or their level of training.

The staff from the Faculty of Medical Technology reported difficulties in the curriculum and the teaching. They are actively seeking help from outside Lao PDR including from Singapore General Hospital and the Faculty of Health Sciences. (The Faculty of Medicine at UHS has an MOU with the Faculty of Medicine at the University of Sydney).

Before 2009 the University of Health Sciences was a College of Health Sciences, under the control of the Ministry of Health. In UHS there are 7 Faculties. In the Faculty of Medical Technology there are four departments: PT, Laboratory, Medical Technology and P&O. Because it is now a university, UHS now also has to report to the Ministry of Education. Many challenges were observed. The facilities are very old and quite substandard. There are few pieces of equipment for learning practical skills. In the PT program there are three lecturers who lecture and teach practice; there are five teachers who only teach practice (two of these are currently studying

abroad). Staff from the Faculty of Medicine also provide some teaching, for example, about surgery. Staff from CMR also provide some teaching, for example, 40 hours on CBR in year 3 of the PT program. Otherwise the Faculty relies on staff from the hospital coming to teach; this is because the University does not have its own teaching hospital. However often hospital staff do not turn up to teach their classes. Hospital staff do not teach the students in the clinics; the staff from the University do this. It was reported there are no Lao PDR nationals who have been trained as PTs outside Laos: all PTs were trained in Lao PDR. Some may go to other countries later for further training.

There did not appear to be any government mechanisms for ensuring up-to-date practice for clinicians or for faculty staff at UHS. Individuals apply for scholarships for additional training, usually short courses, in other countries. Donors are reasonably active in providing scholarships; there are also some opportunities provided by INGOs for their rehabilitation (primarily PT) staff who are expatriates serving in Lao PDR for some time.

Mechanisms to increase rehabilitation workforce

The number of PT posts available each year appears to be determined by the budget allocated by MoH. Significant under-employment of PT graduates was reported such that those not able to get PT posts either work as volunteers hoping to get a position in the future; work in massage clinics or retrain for new profession/ job. The situation of trying to attract students to enrol in PT and P&O, it was reported, is not helped by the significant under-employment reported for PTs particularly in the PRUs which gives the course and becoming a PT a 'bad name'.

There are some MoH initiatives to improve distribution of health professionals to rural areas. Lack of interest by all health graduates to work in rural areas is an issue of concern reported in the *Health Sector Reform by 2020*⁸. There are incentives for rural students to study medicine at University of Health Sciences (only course in Lao PDR); however many are not well enough educated to do so. It is understood that there are now rural courses in medicine – at Luang Prabang and Champasak. These are lower level college degrees some of which is taught by faculty from Faculty of Medicine at UHS. This is considered to be a useful way to build the workforce in the rural areas. This could provide a useful mechanism for the Faculty of Medical Technology to educate these medical students about rehabilitation.

A second initiative is that all health graduates from 2014 will have to serve first in a rural area before formally receiving their certificate to practice and being allowed to return to Vientiane. Accounts of this strategy to increase health service delivery in rural areas vary. It appears to be that the new graduate will have to serve at the Health Centre level for some time (maybe a year or two) before serving at the District level and finally at the Provincial level before returning to Vientiane. It is hoped many will learn the culture at the local level, become part of the community

there, and marry so they will not then want to return to Vientiane. This condition will apply to doctors, nurses, PTs and presumably other health professionals such as medical technicians, laboratory technicians and so on, although the latter was not clear.

As noted in the The Paediatric Rehabilitation Project Evaluation Report¹⁷, there appears to be little incentive for health professionals either in the capital or in rural areas. They are government employees with wages that are reportedly not enough to live on. Many appear to have other jobs in addition to their government employee position as a health professional.

3.4 Assistive Devices and Technology

The primary types of assistive device available in Lao PDR are locally produced wheelchairs and tricycles (CMR Wheelchair Production Project) and prostheses and orthoses (COPE). Approximately 2500 wheelchairs and tricycles are produced each year on a standard model; infrequently with some adaptation/ customisation for an individual client's requirements.

The Military Hospital at Ban Kern in Vientiane province also provides wheelchairs to veterans. Reportedly, there is a plan by the Ministry of Labour and Social Welfare (MoLSW) to expand the rehabilitation services at this military hospital; to enhance the facilities with up-to-date equipment; to train medical, therapy and other staff in Vietnam; and to be open to all citizens in 2014. This facility will be run by MoLSW: the health staff will be government employees under MoH. This plan has been developed jointly between MoH and MoSLW.

It was unclear how children in the Deaf School get hearing aids; however, this is probably via donor funds given that the School is a project under CMR. The School, it was reported, will remain under CMR until the plan to transfer this to MOE in 2015 is actioned.

Donors regularly donate assistive devices and technology, however it was reported this often happens without prior consultation, and that the equipment donated may not be suitable for conditions in Lao PDR. As well, usually only purchase costs are covered and there is no budget for maintenance or spare parts. As observed at CMR, Mahosot Hospital and the Pakse PRU, equipment once broken remains in the corner of the room as there are no other funds to get it repaired.

The COPE OT and PT mentors have encouraged the design and production of supported seating, for example, for children with cerebral palsy. These are produced locally in a CMR workshop (or by local tradesman) and in the PRUs. In the villages, local handymen produce simple adapted

equipment, for example, bamboo parallel bars. The only adapted transport observed was the hand propelled, three wheeled wheel chairs and tricycles produced in the CMR workshop.

There do not appear to be any regulations and systems at government or central agency (MoH) level to govern assistive devices and technology. The only quality control systems reported were those introduced by COPE and the ICRC SFD to audit and introduce auditing measures into P&O provision at CMR and the PRUs. As all devices and equipment are funded by COPE, maintenance and replacement is dependent on donor funds being available for this purpose.

3.5 Financing

MoH figures on financing rehabilitation were not available. The following provides a picture, considered to be incomplete, from several sources:

- Dr Khampheth Manviong reports that only 30% of CMR budget comes from MoH and this only covers staff salaries with a very small allocation to some administrative costs. MoH also provides the buildings. The budget for CMR was reported to be 500 million kip in 2012.
- All rehabilitation costs: cost of service, travel, accommodation, food, equipment, P&O is all funded by COPE – COPE funds come from a variety of donors. For example, AusAID funds prostheses, USAID funds orthotics, CBM funds surgery for club foot, and ICRC SFD funds amputations from UXO, with priority given to the poorest clients.
- Through COPE and donor funds there is also support for PT, OT (sometimes) and P&O mentors. There are also some volunteers supported by external agencies, e.g. Australian Volunteers for International Development.

Several barriers to financing rehabilitation services were identified.

- There is no legislation mandating government spending on rehabilitation.
- There is no mention of allocation of funds to specific areas of health care (including rehabilitation) in the 7th Five-Year Health Sector Development Plan (2011-2015) or *Health Sector Reform by 2020*.
- In 2012 health expenditure accounted for only 4.2% of domestic government spending, or 1% of GDP. The estimated required budget for the health sector to achieve MDGs by 2015 is targeted at 9% of domestic government expenditure which is two times the current government expenditure on health⁸.
- By report the decision to allocate funds to specific areas of health care from within the overall budget is determined by MOH upon receipt of 'persuasive' proposals from the relevant sector, for example, rehabilitation as represented by CMR.

- There is concern at CMR and an acknowledged lack of experience and expertise in preparing proposals for rehabilitation services and funding.
- Key informants agreed there was little understanding of rehabilitation or recognition of rehabilitation contribution by MoH and more generally through the health care system which acted as a barrier to achieving increased funding.

Donor contribution to rehabilitation is sought via in-country strategic plans developed by INGOs and NGOs. Some donors are now quite long standing in Lao PDR in rehabilitation, for example, USAID, AusAID and others particularly those involved with Landmine Clearance and UXOs. INGOs such as HI, CBM, Power International, and ICRC SFD are also longstanding in providing funds for components of rehabilitation.

Currently it is not possible to understand the cost to government of providing rehabilitation services in Lao PDR. To be able to do so would require access to information about the funds provided by MoH to CMR. Added to this would need to be the cost of government employees throughout the system either directly carrying out rehabilitation, for example, in CMR and where this occurs in PRUs or playing a part in rehabilitation, for example, the provincial health department officials in Champasak province who are part of the CBR program.

To understand the total costs of rehabilitation services in Lao PDR would also require information from NGOs and INGOs. As a first step there would need to be an agreed definition of rehabilitation before the costs could be determined. Currently it is hard to envisage it would be possible to determine the costs of providing rehabilitation across CMR, the PRUs, CBR and that provided by outside agencies.

As noted earlier, all health care in Lao PDR is user pays including rehabilitation with very limited health insurance and fee waivers available. COPE provides the funds for all services, equipment, accommodation, food and transport associated with rehabilitation in the government services. In reality however potential clients are deterred from seeking services being unaware that COPE will pay for their costs and that there are exemptions from user pays for the poorest clients. In private clinics, the user pays. Information was not gathered directly on the situation at the Military Hospital but it was reported that there are no user fees as this is a service to military personnel.

3.6 Information Systems

Institutional mechanisms for collecting health/ rehabilitation data

Health data in Lao PDR is not disaggregated by disability. Rehabilitation data as noted previously are collected at each level of service delivery – CMR, PRU, CBR. All the information systems

observed were paper based and were reported to be developed at each facility or for a particular purpose (for example, CBR reporting to CBM and Provincial Health Department). It was unclear whether there was any alignment of this data with MoH requirements or coordination between facilities about the information collected. Given the lack of structures and processes between different levels of the health system and rehabilitation services noted earlier this seems unlikely.

Information used for rehabilitation policy and planning

All key informants talked about the need for data to assist in developing service delivery. The lack of data on the number of people with disabilities in Lao PDR and how many people require rehabilitation was keenly felt by key informants. It also appears to be a road block to action with more than one person commenting that they do not know what services to provide as the need for services is not yet known/ established.

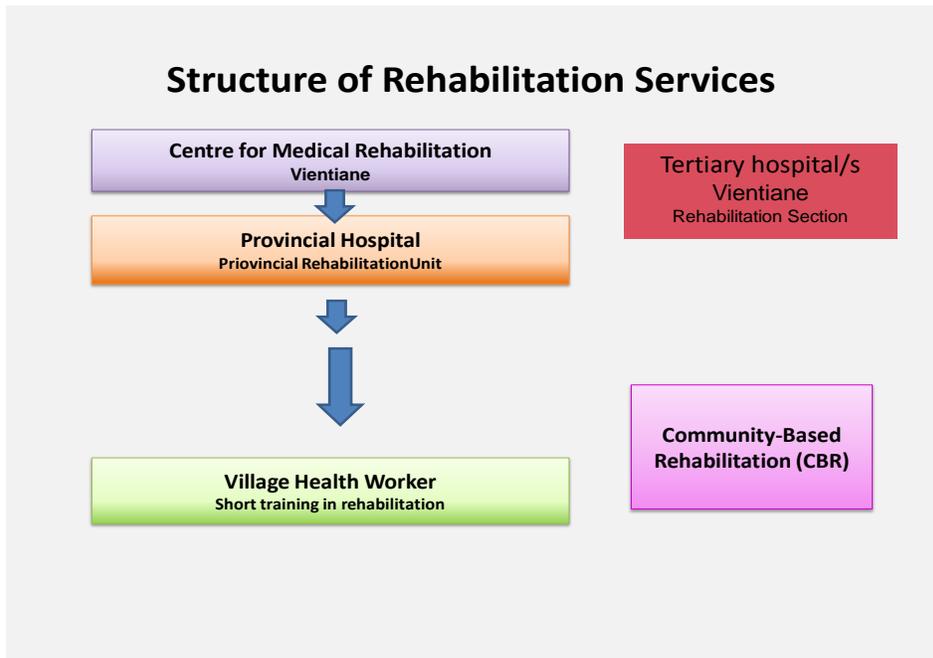
That said, the US bombing map of Lao PDR is used to make decisions about where services go on the quite reasonable assumption that there will be more people with disabilities in these areas. This overlooks however the changing factors now influencing service need. The number of victims of UXOs is dropping quite quickly as reported in Section 2.22. There is an increase in road traffic accidents caused by the increase in motor traffic. There is also the assumed increase in disability from other NCDs. There are also public awareness campaigns about these issues (see Appendix 7).

Individual INGOs and projects funded by donor agencies have engaged in data collection to assist planning and decisions about where to place specific projects. It appears that this information is not necessarily shared with others or used jointly for collaborative planning purposes. Various informants talked about upcoming data collection in relation to specific populations, for example victims of UXOs to understand their needs and the needs of their families (reported by Courtney Innes, National Regulatory Authority for UXOs).

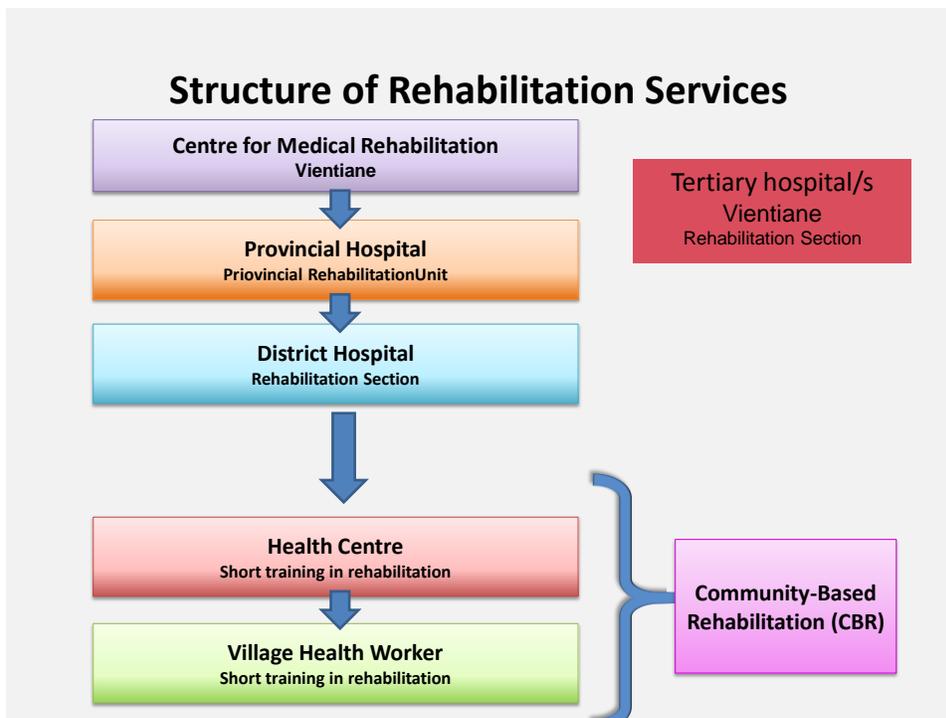
Typically government informants relied on data from the 2005 census while acknowledging that this is probably an under-estimation. The next census will occur in 2015; this seems to be a very good opportunity for a concerted effort to get better information about disabilities. Overall, there is agreement that there are not enough rehabilitation services. This is the given rationale behind the MoLSW initiative in expanding the services available at the Ban Kern Military Hospital to be available to all in the community.

There was no evidence of any standardized tools or instruments for example ICD10 or ICF used to collect health data at any level of the system. As noted above, each facility had a data collection and reporting system however these all appeared to be quite different and designed by that facility. Without routine and systematic collection of data there is no means by which to assess or evaluate changes in rehabilitation efficiency or effectiveness over time.

Appendix 1a Current structure for rehabilitation



Appendix 1b Potential future structure for rehabilitation



Appendix 2 Names and titles of key informants

Dr Bounack, Deputy Director, Health, Care Ministry of Health

Mr Sisavath Khommphonh, Deputy Director General, Department of Pension, Invalids and Disabilities, Ministry of Labour and Social Welfare

Mr Nouanta Latsavongxay, Project Manager, Laos Disabled People's Association

Mr Sisamer Inthavongsa, Manager DPO Project Handicap International

Ms Anne Rouve Khieve, Country Director, Handicap International

Ms Courtney Innes, UXO Victim Assistance Technical Adviser, National Regulatory Authority for UXO's.

Dr Khampheth Manviong, Director, Centre for Medical Rehabilitation

Laurence Degreef, PT, Handicap International

Dr Khamko Chomlath, CBR Project Coordinator, CMR

Mr Bounpheng Phetsouvanh, Deputy of Administration, CMR

Associate Professor Bouathep Phoumindr, Vice Dean, Faculty of Medical Technologies, University of Health Sciences

Ms Elizabeth Cross, Deputy Regional Director, Central East Asia, CBM

Ms Bounlanh Phayboun, Director, COPE

Mr Sengthong Soukhathammavong, Program Coordinator, COPE CONNECT

Mr Phonesavanh Keomanyson, Technical Officer NCD, NPO, WHO County Office, Lao PDR

Dr Phonxay, Head of Rehabilitation Sector, Champasak Provincial Health Department

Mr Phrankeo, CBR Field Monitor, Champasak Provincial Health Department

Ms Stephanie Sparks, COPE Program Manager

Deputy Head, PT Department, Mahosot Hospital

Geoff Fawkner, Disability Adviser, National Committee for Disabled People, Ministry of Labour and Social Welfare, Department of Pension, Invalid and Disabilities.

Medics convene to debate ways to assist disabled people

Xayxana Leukal

Laos and international health professionals have gathered to discuss improving the services and assistance to people in the country living with disabilities to ensure that they have an improved quality of life.

The discussion was held yesterday in Vientiane at the Consultation Meeting on Disability and Rehabilitation, aimed at encouraging the Lao government to continue developing effective policies and strategic action plans that will support people living with a disability in society.

On behalf of the World Health Organisation, Dr Gao Jun said that in many developing countries, including Laos, disabilities are often misunderstood and badly represented. Overcoming negative public perceptions of a person living with a disability is a significant challenge for everyone in society. "Increasing public knowledge and awareness of disability is an important step in overcoming the barriers to building a more inclusive society," he said. In addition, any actions proposed must always involve the people living with disabilities as it is their life and their rights

that we are talking about. As expressed by the disability movement, there should be 'nothing about us without us'.

Based on current research, it has been estimated that about 15.5 percent of the world's population who are 15 years and older live with some form of disability. Two to four percent of those also experience significant difficulties in performing basic daily activities. Globally, the rate of disability has been increasing due to an ageing population, increase in chronic health conditions and other factors such as increased road accidents, conflicts and disasters.

Dr Jun said that there is often limited data and understanding regarding persons living with disability. This is the case in Laos, where information about the situation of people living with disabilities is incomplete. The most recent national census, completed in 2005, recorded 45,000 people in the country living with some form of disability, but these figures are often underestimated due to statistical challenges. "If we were to use the 15 percent global estimate on the population, the figure may be closer to 900,000 people," he said.

WHO is working to

support the Lao government by providing both financial and technical assistance to improve the lives of people living with disabilities. "I hope that the meeting will come up with very concrete priorities to assist the Centre for Medical Rehabilitation and the Ministry of Health to identify a clear mission and vision for developing the national strategic action plan for the people concerned."

Director of the Centre for Medical Rehabilitation, Dr Khomphet Manivong, said that Laos has been impacted from war for many years of its history. After Laos was liberated in 1975, many of the country's people had disabilities and then suffered the risk of father-injury or death from Unexploded Ordnance (UXO). This has increased the number of disabled people in Laos, especially in the 47 poorest districts of the country.

"Today is a good event for Lao medical doctors to share experiences and information about improving the lives of people living with disabilities," he said.

Deputy Director General of Health Care Department of the Ministry of Health, Dr Phisith Phoutsavath, also attended the event.



(From left) Dr Gao Jun, Dr Khomphet Manivong and Dr Phisith Phoutsavath co-chair the Consultation Meeting on Disability and Rehabilitation.

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Appendix 4 DPO's in Lao PDR

Lao Disabled People's Association (LDPA) and three branch offices

Lao Disabled Women Development Center (LDWDC)

Association for the Deaf (AFD)

Association for the Autism (AFA)

Association for the Blind (AFB)

Intellectual Disability Unit (IDU)

Cerebral Palsy Children Center (Ban Saine Souk)

Aid Children with Disability Association (ACDA)

NCDP

Appendix 5 List of documents accessed (in order as in Report)

World Report on Disability. World Bank and World Health Organisation, Geneva, 2011.

Background to Call for Research Proposals. WHO Guidelines on Health-Related Rehabilitation Development Group, January 2013

Statistic Population. Webpage Lao Statistics Bureau (2013). Retrieved from http://www.nsc.gov.la/index.php?option=com_content&view=article&id=37:population&catid=6&Itemid=38

¹*Western Pacific Country Health Information Profiles: 2011 Revision*. World Health Organization. (2011). Accessed at: <http://hiip.wpro.who.int/hiip/chips>

WHO Country Cooperation Strategy for the Lao People's Democratic Republic, 2012-2015. WHO Western Pacific Regional Office, Manila, 2011-11-14

Human Development Report. New York, UNDP, 2011.

National Health Sector Reform Strategy, 2013-2025, 17 December 2012. Internal document Ministry of Health for comment only

(Draft) Strategy Health Sector Reform by 2020, 28 February 2013. Ministry of Health, Lao People's Democratic Republic.

Disability at a Glance 2012. Social Development Division, Economic and Social Commission for Asia and the Pacific, Bangkok, Thailand.

UN Convention on the Rights of Persons with Disabilities, Article 4, General Obligations <http://www.un.org/disabilities/convention/conventionfull.shtml> accessed 19th May 2013

Lao Health. Master Planning Study, 2004. Chapter 23 Framework for Rehabilitation, 23-1 to 23-6.

Landmine and Cluster Munitions Monitor Lao PDR updated 17th December 2012 http://www.the-monitor.org/custom/index.php/region_profiles/print_theme/1935, accessed 5th May 2013

Key Components of a Well Functioning Health System, WHO, May 2010 which builds on earlier publications including *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*, WHO, Geneva, 2010

WHO Country Cooperation Strategy for the Lao People's Democratic Republic, 2012-2015. WHO Western Pacific Regional Office, Manila, 2011-11-14

Final Report External Evaluation Paediatric Rehabilitation Project, Palitha Jayaweera, Dr Sangha Xaysmouth, June 2012.

Standards of Care for Cerebral Palsy: Protocols for Implementation of a Cerebral Palsy Care Pathway, Developed by: Clinical Core Group (CCG) a joint working group between the Center of Medical Rehabilitation (CMR) and COPE, April 2013.

Appendix 6 Public health campaign on NCDs

