COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH:

LAO PDR

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1. Introduction

The Lao People's Democratic Republic (Lao PDR) is a landlocked, mountainous and forested country and became a land linked country since 1997 as member of ASEAN, with estimated population of 6.6 million in 2012 (Lao Statistics Bureau, 2013), 59% of the population were children and young people below the age of 25 years. The majority of population lives in the rural areas (71%), including 8.9% who live in rural areas without road access. The annual population growth rate for Lao PDR is around 2.1% (Ministry of Health & Lao Statistics Bureau, 2012). The country is ethnically diverse, having 49 official ethnic groups with different 167 ethnic subgroups. There are four major ethno-linguistic branches are the Lao-Tai (68 per cent of the total), Mon-Khmer (22%), Hmong-Lu Mien (7%) and Sino-Tibetan (3% of the total population). The ethnic groups are marked by different cultures, and traditions (King et al., 2010). The health outcomes have been improving, as reflected in improving life expectancy at birth for both sexes from 53 to 66 years between 1990 and 2012 (51 to 64 years for men and 54 to 67 years for women (WHO, 2014).

Key Human Rights

The Constitution of Lao PDR was proclaimed in 1991 and amended in 2003 contains most key safeguards for human rights. The Lao Constitution also has provisions for gender equality and freedom of religion, for freedom of speech, press and assembly. The Lao Government ratified the CEDAW in 1981, the Convention on the Rights of the Child (CRC) in 1991 and the Convention on the Rights of Persons with Disabilities (CRPD) in 2009 (United Nations, 2011). Then, on 25 September 2009, Laos ratified the International Covenant on Civil and Political Rights, nine years after signing the treaty. Similarly the International Covenant on Economic, Social and Cultural Rights was ratified seven years (13th February 2007), after signing the treaty on 7th December 2000. Lao PDR did not sign and ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families yet as this convention is under consideration (United Nations Treaty Collection, 2014).

The government of the Lao PDR puts considerable efforts to encourage, promote and protect the legitimate rights and interests of Lao women in all fields: political, economic, social, cultural and family as provided for in the policy of the government, the Constitutionv and laws. In May 2002, the Government established the Lao National Commission for the Advancement of Women (Lao NCAW) in order to promote gender equality and to eliminate discrimination against women in Lao PDR. This commission's responsibility is to assist the Government in formulating national policy and strategic plans to promote women's advancement and gender equality in all spheres and at all levels of society (GRID, 2005). In 2004, the Law on Development and Protection of Women was promulgated to guarantee and promote the roles of women, to define the fundamental contents of, and measures for developing and protecting, the legitimate rights and interests of women (National Assembly of the Lao PDR, 2004). In 2007, the Law of Labour was issued to ensure the acceptance of Handicapped or Disabled Persons (Article 26) to work, the availability employment of women labor, the Child labor (Chapter 5, Article 38 to 41), and Equal right in receiving salary or wages (Article 45) (National Assembly of the Lao PDR, 2007).

Health financing indicators

Table 1 presents the government expenditure on health and out-of pocket expenditure on health. The total health expenditure (THE) as % of the GDP has increased from 3% in 2000 to 4% in 2005 and then it decreased to 3% in 2010 and 2012, however, the total Government Health Expenditure as % of GDP in Lao PDR is among the lowest in the region. This indicates that government spending on health lags behind the ideal government spending on health according to WHO of at least 5% of the GDP (WHO, 2013). The Lao government has committed to increase government spending to 9% of GDP which is increased 3 times in the fiscal year 2010-2012. There are large disparities in government spending of health budget between central, and provincial levels (World Bank, 2012).

The General government expenditure on health (GGHE) as % of THE has been increasing over the last years from 35 % in 2000 to 47% in 2010 and 51% in 2012 indicating that the Lao government spent about half of the total health expenditure (Table 1). The GGHE as % of General government expenditure had increased from 4% in 2005 to 5% in 2010 and 6% in 2012.

On the other hand, the out-of pocket expenditure as percentage of total health expenditure has decreased from 62% in 2005 to 42% in 2010 and 38% in 2012, out-of-pocket expenses by households are still the major source of health financing as the Out of pocket expenditure as % of Private Health Expenditure (PvtHE) is high as 75% in 2005 and 78% in 2012. Most costs are paid for by patients and their families, which have resulted in people not accessing health services as often as necessary. The out of pocket payment (OOP) has an implication on access and equity and the burden of population in health care. For financial coverage, according to the World Health Organization, it is very difficult to achieve Universal health coverage (UHC) if OOP as percentage of total health spending equal or greater 30% and the target for UHC could be set at 100% protection from both impoverishing and catastrophic health payments for the population as a whole (WHO, 2010). The government is concerned about "sustainable health financing" by increasing the government health budget, expansion of prepayment schemes, and developing the health equity fund to ensure that the poor vulnerable people could access to health services in order to achieve the UHC (Akkhavong et al., 2014).

Table 1: Lao Health Expenditure (%)

Indicators	1995	2000	2005	2010	2012
Total health expenditure (THE) % Gross Domestic Product (GDP)	4	3	4	3	3
External resources on health as % of THE	1	29	17	29	22
General government expenditure on health (GGHE) as % of THE	60	35	17	47	51
Private expenditure on health (PvtHE) as % of THE	40	65	83	53	49
GGHE as % of General government expenditure	8	6	4	5	6
Out of pocket expenditure as % of PvtHE	89	92	75	78	78
Out of pocket expenditure as % of THE	36	60	62	42	38

Source: National Health accounts data from the WHO Global Health Observatory. Available at the website: http://apps.who.int/nha/database/PreDataExplorer.aspx?d=1

2. Contraception

The ICPD Programme of Action stated - people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. The programme of action reiterated the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice (UNFPA, 2004, paragraph 7.2).

In this section we look at key indicators namely a) total fertility rate (TFR), which is an indicator of good or poor reproductive health as a high fertility rate (> 5 births) represents a high risk of reproductive ill health; b) Contraceptive Prevalence Rate (CPR), which is a proxy measure to access to reproductive health services assuming there is no coercion for acceptance of birth control through government policy as well distribution of contraception by methods to indicate access to range of contraceptive methods and male responsibility in use of contraception ; c) Unmet need for contraception, which is also a proxy indicator of access to reproductive health services (ARROW, 2003).

Fertility rate

There is evidence that the total fertility rate (TFR) has declined in the past two decades. For example, the TFR has declined from 5.0 births per woman around 1997-99 to 4.1 in 2003-05 and continued to decline to 3.2 in 2012. The TFR for Lao PDR for the three-year period preceding the survey (2009-2011) is 3.2 children per woman, with strong geographic variations (3.6 and 2.2 in rural and urban areas, respectively) (Table 2). The declining of TFR is due to educational level, delay age at first marriage and increasing contraceptive use during the past decades (National Statistics Centre, 2007; Ministry of Health & Lao Statistics Bureau, 2012).

Table 2: Trends in total fertility rate, Contraceptive Prevalence Rate and unmet need from 1995 to 2011

	Lao PDR		
	1994-1996	2003-2005	2011-2012
Total Fertility Rate (Number of children per women)	5	4.1	3.2
Contraceptive Prevalence Rate	32.2%		
Contraceptive prevalence modern method	29%	38.4%	49.8%
Unmet Need for Contraception	39.5%	35%	42%
		27%	19.9%

Source: State Planning Committee & National Statistics Centre. 2001. Lao Reproductive Health Survey 2000. Vientiane, Lao PDR; Committee for Planning and Investment & National Statistics Centre. (2007). Lao Reproductive Health Survey 2005. Vientiane State Planning; Ministry of Health & Lao Statistics Bureau. (2012). Lao Social Indicator Survey, 2012. Vientiane Statistics Division, Department of Planning and Finance, Ministry of Health, Lao Statistics Bureau, Ministry of Planning and Investment.

Table 3: Percentage of ever-married women currently using contraception, 2000, 2005, and 2012

Age (years)	Used any method	Any Modern	Modern Method				Traditional Methods	
			Pill (%)	IUD (%)	Male condom (%)	Injectable (%)	Withdrawal (%)	Periodic abstinence (%)
LSIS 2012 [a]	49.8	42.1	21.2	1.6	1.1	13.6	1.8	4.9
LRHS 2005 [b]	38.4	35.0	15.9	2.0	0.8	10.6	0.9	2.0
LRHS 2000 [c]	32.2	28.9	12.9	3.0	0.5	7.6	1.9	0.7

Source: a. Ministry of Health, & Lao Statistics Bureau. (2012). Lao Social Indicator Survey, 2012. Vientiane Statistics Division, Department of Planning and Finance, Ministry of Health, Lao Statistics Bureau, Ministry of Planning and Investment.
b. Committee for Planning and Investment & National Statistics Centre. (2007). Lao Reproductive Health Survey 2005. Vientiane State Planning.
c. State Planning Committee & National Statistics Centre. 2001. Lao Reproductive Health Survey 2000. Vientiane, Lao PDR

Table 4: Unmet need for contraception based on the LSIS, 2012

	Met need for contraception			Unmet need for contraception			Total demand for contraception			% demand for contraception satisfied
	Spacing	Limiting	Total	Spacing	Limiting	Total	Spacing	Limiting	Total	
LSIS 2012	15.0	34.7	49.8	8.2	11.8	19.9	23.2	46.5	69.7	71.4
LRHS 2005	6.2	30.4	36.6	11.0	16.3	27.3	17.1	46.7	63.9	57.3
LRHS 2000	10.5	29.0	39.5	6.2	26.0	32.2	16.7	55.0	71.7	44.9

Source: MoH, & Lao Statistics Bureau. (2012). Lao Social Indicator Survey, 2012. Vientiane Statistics Division, Department of Planning and Finance, Ministry of Health, Lao Statistics Bureau, Ministry of Planning and Investment.
- Committee for P lanning and Investment & National Statistics Centre. (2007). Lao Reproductive Health Survey 2005. Vientiane State Planning. State Planning Committee & National Statistics Centre. 2001. Lao Reproductive Health Survey 2000. Vientiane, Lao PDR.

Contraceptive prevalence rate (CPR)

There has been a consistent trend of increasing of CPR over the past 10 years from 32.2% (2000) to 38% (2005) and 49.8% (2012) (Table 2). In 2012, 49.8% of currently married women are using any method of contraception. The most popular method is the pill, used by 21.2% of married women in Lao PDR. The next most popular method is injectable (13.6%). Five per cent of married women are sterilized, and all other modern methods are used by fewer than 2% of married women. Five per cent of married women report using periodic abstinence. Use of a modern method tends to increase with increasing wealth quintile, but peaks among women in the fourth wealth quintile, not the highest (in which women report more use of periodic abstinence). Use of a modern method is similarly prevalent among urban and rural women. The major source of contraception is from the public sector (71%) which 35% of users obtained the contraceptive method from the public hospitals and 30% from the health centers, while 26% of users received from the private sector (Ministry of Health & Lao Statistics Bureau, 2012).

Male involvement in the using family planning is relatively rare as the percentage of using male sterilization in the country is zero with 0.1% in the Vientiane Capital and 0.1% in Sayabuly province; while the prevalence of female sterilization was 4.6%. The prevalence of condom use among male was 1.1%. Thus, men were less likely to take responsibility for fertility control (Ministry of Health & Lao Statistics Bureau, 2012).

Unmet Need for Contraception

The unmet need for contraception has declined from 39.5% in 2000 to 27% in 2005 and 20% in 2012. According to LSIS (2012), 12% of married women having an unmet need for limiting and 8 per cent having an unmet need for spacing. The high unmet need for limiting might be due to women not choosing to use family planning for different reasons such as side effects, health concerns, lack of knowledge, objections from a spouse and problems with accessibility and affordability to contraceptives (Committee for Planning and Investment & National Statistics Centre, 2007).

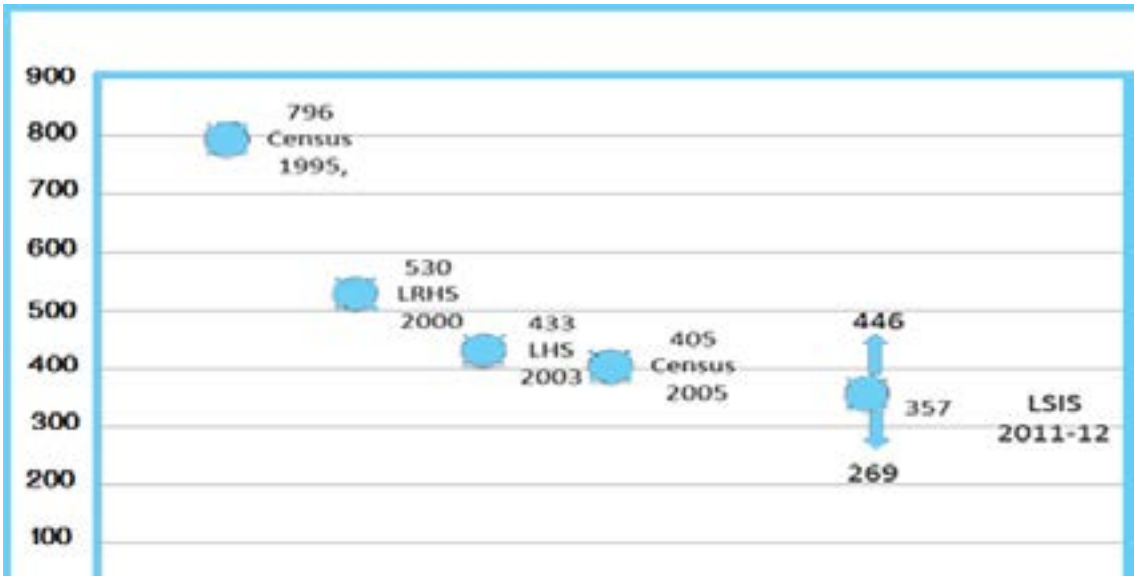
Unmet need is highest in the Southern region (24 %) and lower in the Central (21 per cent) and Northern (17 %) regions. In addition, there was a big difference of unmet need between urban and rural areas (19% versus 28%). Unmet need is highest among women with no education (26%) and decreases with increasing wealth, with the exception of the richest wealth quintile. Unmet need is highest among women in Hmong-Mien headed households (31%) and lowest in Lao-Tai headed households (18 %) (Ministry of Health & & Lao Statistics Bureau, 2012).

3. Maternal Health

The ICPD Programme of Action called for the promotion of women's health and safe motherhood by achieving a rapid and substantial reduction in maternal morbidity and mortality as well as reduce greatly the number of deaths and morbidity from unsafe abortion (UNFPA, 2004, paragraph 8.2).

In this section we look at key indicators pertaining to the promotion of women's health a) maternal mortality ratio (MMR), which is a reflection of how safe child delivery is for the woman; b) perinatal mortality rate (PMR), which is a good indicator of both status of maternal health and nutrition and quality of obstetric care; c)infant mortality rate (IMR) which is also a reflection of optimal maternal health, nutrition and care during delivery; d) proportion of births attended by skilled birth attendants , which helps understand the extent to which governments have invested in developing human resources necessary for ensuring safe delivery and prevention of maternal deaths; e) availability of basic emergency obstetric care and comprehensive emergency obstetric care to ensure safe delivery and prevention of maternal deaths; and f) antenatal care coverage (ANC) which is an indicator of women's access to health care services.

Figure 1: Trend of MMR during the last decades Death per 100,000 Live births



Maternal Mortality

Lao PDR has one of the highest maternal mortality in the South East Asia region. Figure 1 shows the trend of Maternal Mortality Ratio (MMR) from 1995 to 2012. At the time of the 2005 Lao Census and LSIS 2012 MMR was 405 and 357 per 100,000 live births respectively (National Statistical Centre, 2006; Ministry of Health & Lao Statistics Bureau, 2012). The MMR is high among mothers with low education, poverty as anecdotal evidence suggested that women from the Low Income Countries are more likely to die of related pregnancy causes higher than women from middle and high income countries (GoL & UNDP, 2013). Young or too old mothers are at higher risk of MMR compared to mothers at middle age or when the pregnancies are too close and too many. This could be due to gender role, gender inequality and gender empowerment. The current health indicators suggest that Lao PDR has a long way to go to meet the MMR target for the MDGs by 2015 and Lao National Targets. However, recently, the World Health Statistics Report indicates that trend of MMR is to achieve target by 2015 (1100 in 1990, 600 in 2000, and 220 in 2012) (WHO, 2014).

Perinatal Mortality Rate (PMR)

The perinatal period covers the period leading up to birth between 22 completed weeks of pregnancy and the first week of life; deaths occurring in this period are largely due to obstetric causes and poor maternal health and nutrition. Laos has a high perinatal mortality about 57 deaths per 1000 births (WHO, 2006). Stillbirths represent more than half of perinatal deaths. More than one third of stillbirths take place intrapartum, i.e. during delivery, and are largely avoidable. There is an urgent need to o improve the Emergency Maternal Obstetric Newborn Care (EMONC) services to mothers and newborns and to meet the minimum requirement of Basic Emergency Maternal Obstetric Newborn Care (BeMONC) and Comprehensive Emergency Maternal Obstetric Newborn Care (CEMONC). There is strong supporting evidence that Emergency Obstetric and Newborn Care should be an essential component of a program aimed at reducing maternal and neonatal mortality (Paxton et al., 2005). The National EmONC Assessment in 2012 showed that the coverage of EmOC services was 18 EmOC facilities with 04 Basic and 14 Comprehensive EmOC facilities for a population of 6,259,857 which falls short compared to the UN-recommended level of 5 EmOC facilities/ 500,000 which translates to 62 EmOC facilities with 50 Basic and at least 12 com-

prehensive EmOC facilities for the country. The under-coverage is compounded by a maldistribution of EmOC facilities; mainly in the Southern and Northern part (MoH, NIOPH & UHS, 2012).

Infant Mortality Rate (IMR)

The infant mortality rate, which is not only an indicator of mortality among infants, it also indicates the status of maternal health, nutrition and care during delivery. IMR has decreased from 104 to 70 per 1000 live births between 1995 and 2005. At this rate the 2015 MDG mortality targets seem within reach, though mortality rates are much higher in rural areas. The LSIS results also show that the overall picture of declining trends over the past two decades remains consistent. Taking this progress and the country-specific situation into account, the Ministry of Health has now set the new 2015 targets as 70 and 45 per thousand live births respectively for under-five mortality rate and infant mortality rate (Figure 2). The IMR is lower for mothers who live in urban areas (36 per 1,000 live births), live in the Central region (46 per 1,000) and have completed lower secondary (30 per 1,000) or upper secondary education (24 per 1,000). Most infant deaths are related to neonatal conditions and infectious diseases, in particular malaria, acute respiratory infections, diarrhoea and epidemics such as dengue fever, measles or meningitis (GoL & UNDP, 2013). Thus, the government has to ensure universal access to quality health care and particularly skilled birth attendants, combating malnutrition, and increasing and sustaining immunisation coverage.

Maternal death : Eclampsia

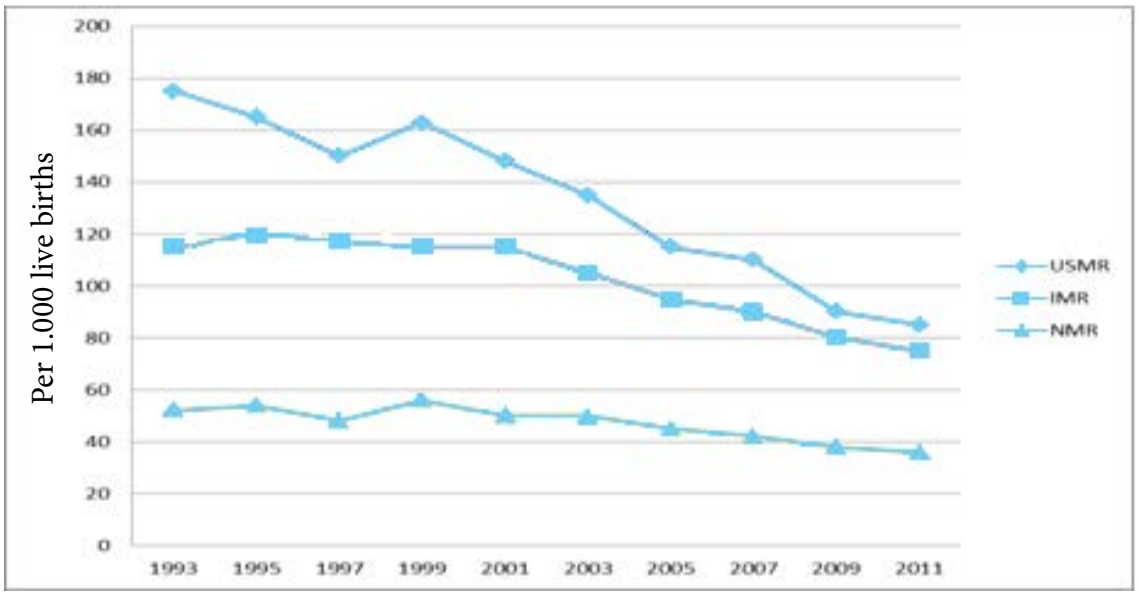
An uneducated Hmong woman aged 16 years old who believe in ghost. Her family worked on farming. They lived in village where was 3 Km far from health centre and 65 km far from district hospital. There was a raod access from village to health centre but the road aceess from village to district hospital is difficult especially in raining season. This was the first pregnancy, she did not visit helth facility for ANC. When pregnancy reacehd 8 months, an oedema occured over her body so she visited health centre for consultation.

Her pregnancy was term. This was the first time of pregnancy; she did not receive any antenatal care. When pregnancy reached 8 months, she started to have oedema. At first, oedema occurred on her feet, hand and face, then, it spread widely on over her body so she visited health centre. Health centre staff gave her some medicines but did not inform the name of medicines and advised that if the symptom did not improve, she should go to district hospital. Then, she came back home and took medicines that provided by health centre staff for about 2 weeks but the symptom was not improved, she still got oedema over her body. Her relatives brought a magic speller to treat her many times but the symptom still was not improved. Two weeks later, she started to have a labour pain. In the morning, she delivered a healthy baby girth with assistance of her mother-in-law.

After birth, she was so tired, had chest pain, difficult breathing and mild seizures from time to time. She wanted to go to hospital, but her parents and husband disagreed. They brought a magic speller to treat her again, but the symptom was not improved. The magic speller asked to choose between mother and baby. They needed to choose who they want him to rescue. If he helped to save mother's life the baby will die or if baby was rescued the mother will die. Parents, husband and relatives agreed to rescue mother, then they put the big stone on the baby's body, the baby then, cried out loud for 2 hours and finally died. The magic speller continued to spiritually treat the woman. Her symptom was not improved, and moreover she was badly tried, almost out of breath and had convulsion all the time. She asked her husband to bring her to hospital, but parents in law argued that she should continue with the treatment by magic speller. In the afternoon on the same day, the symptom became worse; she had blurred vision, convulsion all the time, difficult breathing. The chief of village observed that situation, and then he called to district hospital for sending transportation to pick her up. 15 minutes later, she died at home at the time district hospital staff arrived.

Source: Maternal Death Review

Figure 2: Trends in under 5 mortality rates (U5MR), infant mortality rate (IMR) and neonatal mortality rate (NMR) from LSIS, 2012



Proportion of Births attended by Skilled Birth Attendants (SBA)

The indicator on proportion of births attended by skilled birth health personnel is critical as it has a significant association with maternal mortality ratio. This indicator also helps to understand the extent to which governments have invested in developing the human resources necessary. The proportion of births attended by skilled birth attendants increased by less than 5% points between 1994 and 2005, however, assistance from a health professional at delivery increased steadily, from 20% (National Statistical Centre, 2008) to 42% in 2012 (Ministry of Health & Lao Statistics Bureau, 2012).

Only 7%of women who delivered at home were attended by a health professional. The proportion of urban women assisted by a health professional (80%) is more than double that of women in rural areas (31%). There was a disparity of delivery by skilled birth attendants (SBA) between ethnicity, mother's level of education and wellness. Hmong-Mien ethnicity received less SBA compared to Lao-Tai ethnicity (17.8% vs 58.5%); mothers with illiterate compared with mother with higher education (16.1% vs 92.8%); poor mothers compared with rich mother (10.8% vs 90.7%). The delivery assisted by SBA is higher in the urban areas than that mothers living in the rural areas (79.8% vs 30.7%) (Ministry of Health & Lao Statistics Bureau, 2012).

The delivery at the health facility based in Lao PDR is increased from 17% in 2005 to 38% in 2012 (National Statistical Centre, 2006; (Ministry of Health & Lao Statistics Bureau, 2012); however this rate is still behind the MDG target of 50%. The health facility delivery was mainly the public health facility (37%) (Figure 3). The life of mothers could be saved only if women deliver at the health facilities with access to basic and comprehensive emergency obstetric and newborn care.

Figure 3: Place of delivery based on the LSIS, 2012

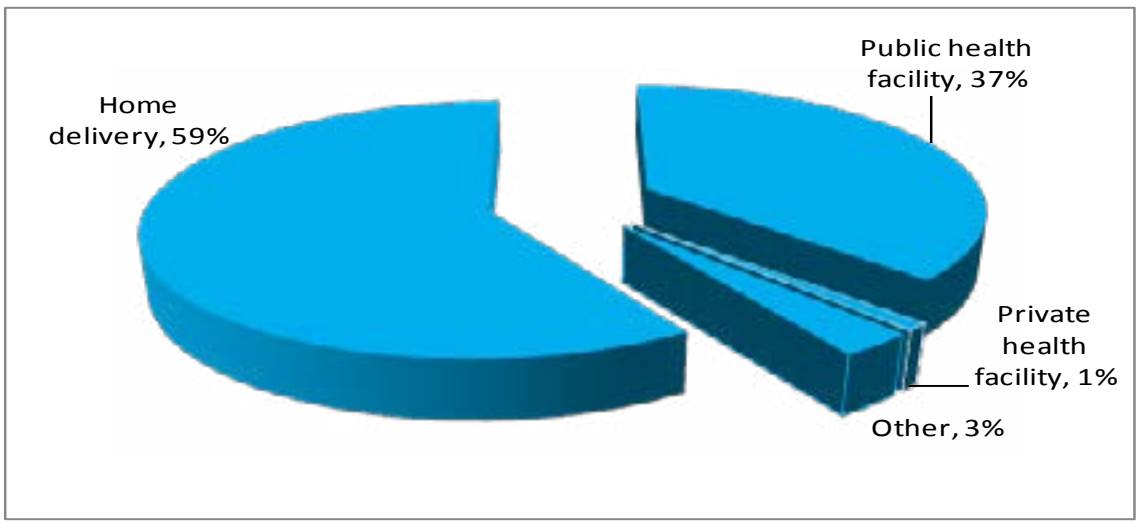


Table 5: Trends of maternal health services indicators from 1995 to 2012

Indicator	1994-1996	2003-2005	2012-latest
Maternal Mortality Ratio (per 100,000 live births)	796	433-405	357
Skilled attendance at birth	14%	23%	42%
ANC one visit	21%	29%	54%
ANC 4 Visits	Na	67%	36.9%
PNC	Na	Na	39.5%

Source: - MoH, & Lao Statistics Bureau. (2012). Lao Social Indicator Survey, 2012. Vientiane Statistics Division, Department of Planning and Finance, Ministry of Health, Lao Statistics Bureau, Ministry of Planning and Investment.
- Committee for Planning and Investment & National Statistics Centre. (2007). Lao Reproductive Health Survey 2005. Vientiane State Planning.

Availability of Basic Emergency Obstetric Care and Comprehensive Emergency Obstetric Care

Five EmONC indicators (some of them with variations) have been calculated for each province and for the country as a whole. For a total population of 6.2 million, 15 Comprehensive EmONC facilities have been identified in the whole country, close to the standard of 1 per 500,000 population. In reality 23 Basic EmOC facilities have been identified, most of them providing minus-one signal function, far below the standard of 5 per 500.000 population. Geographic distribution is roughly appropriate for CEmONC facilities but certainly not for BEmONC facilities, with a large deficit in remote areas. Only 20.3% of all expected deliveries took place in health facilities, while the met need for obstetric complications was 11.1%. Overall only 2% of all deliveries were by Cesarean section (MoH, UHS & NIOPH, 2012).

Antenatal care coverage (ANC)

During the past decade, ANC at least one visit is sharply increased from 24.2 (2000) to 28.5% (2005) and 54.2% in 2012 (National Statistical Centre, 2001; National Statistical Centre, 2006; MoH & Lao Statistics Bureau, 2012). The significant increase could lead to reduce the MMR as the ANC could give the opportunity for the health care providers to provide health education to mothers about the danger signs of pregnancy, high risk pregnancy and risk associated with pregnancy (Figure 4). About fifty-four per cent of women age 15-49 years who gave birth in the two years preceding the survey received ANC from a skilled provider3 – 46% from a medical doctor, 7% from a nurse or midwife, and 2% from an auxiliary midwife. Only 1% of women received care from a traditional birth attendant or community health worker. ANC was received by a higher percentage of women who live in urban areas (especially in Vientiane Capital where 9 in 10 women received ANC), those with at least upper secondary education, and the wealthiest women (Ministry of Health & Lao Statistics Bureau, 2012).

The main priority inventions to reduce maternal deaths include high ANC coverage, presence of skilled birth attendants at deliveries, and access to emergency obstetric and neonatal care. These interventions will only be effective if they reach out to women in rural and remote communities.

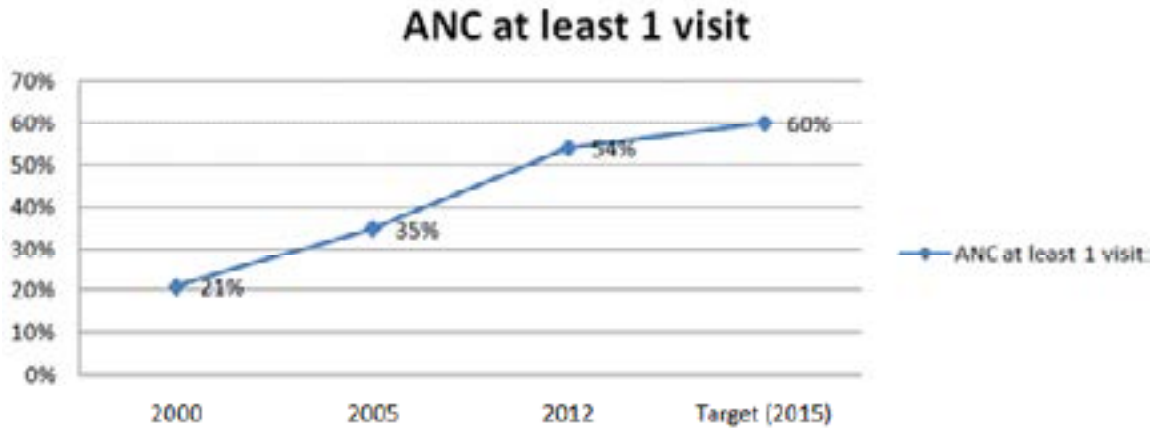
Coverage of post-partum/post natal care within 48 hours of delivery by a skilled health provider

Postpartum care is crucial because a significant proportion of maternal and new born deaths occur during delivery or in the post partum period. Safe motherhood programme have recommended that all women and newborns after delivery extending for 6 weeks should receive the postnatal health check up for both newborns and mothers (MOH, 2002). Thus, post-natal care (PNC) is important for both the mother and the child, not only to treat complications arising from the delivery, but also to provide the mother with important information on how to care for herself and her child.

Less than half (41%) of newborns received either a health check or PNC visit within two days of delivery. Four in 10 received a health check while in the health facility or at home, while 7 per cent received a PNC visit within two days following delivery (Ministry of Health & Lao Statistics Bureau, 2012).

Less than half of mothers (40%) received either a health check after delivery or a PNC visit within two days of delivery. Thirty-nine per cent received a health check after delivery while in the health facility or at home, while 3 per cent received a PNC visit within two days following delivery (Ministry of Health & Lao Statistics Bureau, 2012).

Figure 4: Trends in Antenatal care coverage (at least one visit by trained health professional) based on the LRHS 2000, 2005 and LSIS 2012



4. Adolescent and Young people SRH

The ICPD Programme of Action, called upon governments to substantially reduce all adolescent pregnancies, and address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortions and sexually transmitted diseases, including HIV//AIDS (UNFPA, 2004, paragraph 7.44).

In this section, we examine indicators of a) Adolescent Birth Rate; b) Status of availability of range of adolescent sexual and reproductive health services to assess the extent to which adolescent sexual and reproductive health and rights are being realized.

Adolescent birth rate

The adolescent birth rate in Laos is slightly declined from 115 in 1994 to 94 in 2012 during the past decades (National Statistical Centre, 2001; National Statistical Centre, 2006; Ministry of Health & Lao Statistics Bureau, 2012) (Figure 4). Laos is suffering from a high rate of teenage pregnancy, for every thousand adolescent girls aged 15 to 19 in Laos, there are at least 94 births annually (Ministry of Health & Lao Statistics Bureau, 2012). This rate was found higher among groups with lower levels of education, poorer living standard quintiles, and ethnic minority backgrounds, located in the Northern midland and mountainous regions, and the rural areas. A big difference in birth rates is found between urban and rural adolescents. The fertility rate among girls living in rural areas is nearly three times higher than among girls living in urban areas (114 and 44 births per 1,000 adolescents, respectively) (Ministry of Health & Lao Statistics Bureau, 2012). There are adverse effects of the adolescent birth rate such as high risk of pre-term delivery, low birth weight, stillbirth and neonatal mortality and MMR (Mahavarkar et al., 2008). Young motherhood affects mother and child in many way-it can bring down the education status and the socio-economic status of young girls, at the same time pregnancy among adolescents makes them vulnerable to maternal morbidity and mortality. Adolescent birth rate is an indicator of adolescent reproductive health and rights (ARROW, 2003).

Availability and range of adolescent sexual and reproductive health services

Sexual and reproductive health care services appear to be underdeveloped in Lao PDR. Basic maternal obstetric neonatal care (BEmONC) is mostly available in the district hospitals type A (MoH, NIOPH & UHS, 2011). Most of STIs/HIV/AIDS services are targeted towards the most at risk population while MCH services are more captured to the married couples (Lorete, 2012; Sychareun, 2004).

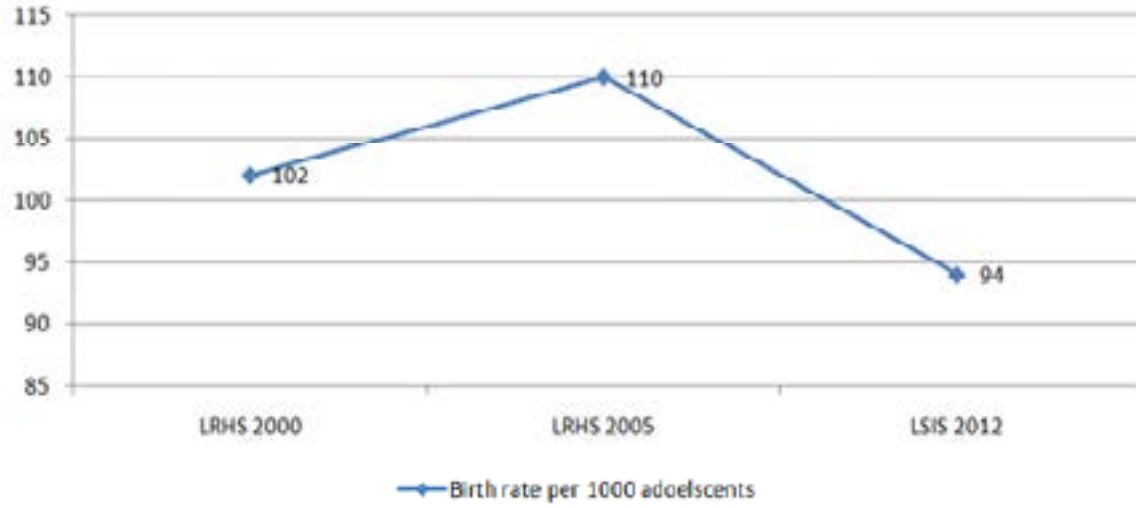
Abortion services in the public hospitals are available in order to save the life of the mother and to preserve the physical and mental health of women. Adolescent girls are more likely to seek for abortion at private clinic and many induced abortions are performed clandestinely, often under unhygienic and unsafe conditions thus can result in negative health consequences, e.g. hemorrhage, rupture uterus).

The provision of reproductive health services to young people is not adequate. Young people currently have no access to reproductive health services unless they are married and they feel embarrassed to openly discuss their sexual activities, therefore young girls are increasingly resorting to unsafe abortions, engaging in risky sexual behaviors and suffering from STIs. The use of services by adolescents is very often linked to how they perceive both the services available and the health-care providers' skills and abilities. Family planning services are available from both formal and informal sector providers. However, access to these services is quite different for married compared to unmarried youth. Unmarried adolescents have very little access to health education from health staff. Printed information on sexual and reproductive health is uncommon (Sychareun, 2004).

Sexuality education program was carried out in Lao PDR in 2001. This subject was superficial, and just integrated into different subjects such as the World around us for Grades 4 and 5 and secondary school subjects Civic Education, Geography, Natural sciences (in lower secondary), and Biology (in upper secondary) reaching 24% of primary schools and

80% of secondary schools (Ministry of Education & UNFPA, 2011).

Figure 5: Trend in Adolescent Birth Rate, Lao PDR 2000-2012



Sources: MoH, & Lao Statistics Bureau. (2012). Lao Social Indicator Survey, 2012. Vientiane Statistics Division, De - partment of Planning and Finance, Ministry of Health, Lao Statistics Bureau, Ministry of Planning and Investment.
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5. HIV/AIDS

The ICPD Programme of Action called upon governments to prevent, reduce the spread of and minimize the impact of HIV infection, and ensure sexual and reproductive health programmes address HIV infections and AIDS with adequate medical care without discrimination and ensuring confidentiality (UNFPA, 2004,paragraph 8.28).

In this section we examine indicators of a) HIV prevalence and burden; b) availability of services for HIV and AIDS. These indicators aim to provide pointers to the status of sexual health in the population as well as availability of services in the country (ARROW, 2013).

Prevalence and burden

Lao PDR's HIV epidemic is estimated prevalence of 0.2% among general population (UNAIDS, 2013). Unsafe sexual activity is the main mode of transmission in the Lao PDR (UNAIDS, 2012). In the National Strategic and Action Plan for HIV/AIDS/STI Control and Prevention (NSAP) for 2011-2015, the epidemic scenario is stated as "potential for a concentrated epidemic". The key populations at higher risk are identified as Sex workers (SWs), Men having sex with men (MSM), People who Use Drugs/ People who Inject Drugs (PUD/ PID); and clients of SWs. The prevalence of HIV/AIDS among young male people aged 15-24 years was 0.1% and female young people aged 15-24 years as 0.2%, 0.4% among FSWs in 2008 (Center for HIV/AIDS/STI Lao PDR, USAID, FHI, The Global Fund, et al.,2009) and 1% among FSWs in 2011 (MOH & CHAS, 2011)and 1.2% using Asian Epidemic Model (AEM) (CHAS & UNAIDS, 2011). The prevalence of HIV/AIDS was 5.6% for MSM in 2007 (Sheridana et al., 2007), 3.34% in 2012 in Vientiane Capital and 2.54% in Savannakhet province (CHAS & PSI, 2011). The HIV/AIDS prevalence among drug users was 1.5% (Center for HIV/AIDS/STI., 2010).

However, the estimation prevalence of HIV/AIDS among most-at risk population in Lao PDR is higher than the actual prevalence (Table 6) (UNAIDS, 2010).

The proportion of reported cumulative HIV cases due to mother-to-child transmission (MTCT) has increased from 2% in 2003 to nearly 5% in 2010 (CHAS, 2010; Department of Statistics, & UNICEF, 2008; National Committee for the Control of AIDS Lao PDR, 2005). In relation to this, HIV prevalence among ANC attendees in the three central hospitals of Lao PDR was 0.3% in 2008 (UNAIDS, 2012).

As of 2013, the cumulative number of people living with HIV 369,749 in the country, a total of 5,890 HIV and 3,595 AIDS notifications had been reported officially to the Centre for HIV/AIDS and STIs, of which 7.5% were children under 15 years old. The majority of the reported cases (23.5%) were adults between 25 and 29 years old; and the reported HIV+ cases aged 10-24 years was 18.1% (CHAS, 2013). Of the reported cases, 54% were male and 64% were female. Of the male cases, 42% were aged 25–29; and of the female cases, 3% were aged 25–29 (CHAS, 2013). Young people are higher at risk as most of new HIV cases occur among young people.

Table 6: Estimation of HIV prevalence amongst the general population & high-risk groups (%)

	2000	2005	2007	2009	2010	2012
General population aged 15-49 years, male	0.1	0.18%			0.25%	0.28%
Female sex workers aged 15-49 years	0.03%	1.83%			1.38%	1.20%
Men having sex with men aged 15-49 years	0.38%	1.26%			2.12%	2.44%
Young people aged 15-24 years, Male				0.10%	0.10%	
Young people aged 15-24 years, female				0.20%	0.20%	

Source: UNAIDS. 2010. General population: Spectrum projection. Young people: UNAIDS Report on The Global AIDS Epidemic, 2010, AIDS data hub. Female sex workers (FSWs) and men having sex with men (MSM): Asian Epidemic Model (AEM) projection.

Adoelscent Sexual Reproductive Health

A 19-year-old Laotian, Manysone Phetduangsy, will now tell the story of how poverty in her small agricultural village perpetuates the lack of education among girls and young women. Girls of the Akha ethnic tribe often only go to primary school and are expected to marry at an early age. Once married, they have no decision-making powers within the family, or over their own bodies. They have no access to sexual and reproductive health care services and information, since health care centres are far from the village. Traditional sexual customs that encourage early sexual maturity—such as "vaginal breakthrough" for girls aged 13 to 15, and forced marriage after unwanted pregnancies—further violate the rights of girls and young women.

Manysone's mom gave birth to her while she was still a teenager. She raised her as a single mother because her father abandoned them. With the help of the Faculty of Postgraduate Studies, University of Health Sciences in collaboration with the Vientiane Youth Centre for Health and Development, Manysone learned about sexual and reproductive health and rights education and became a peer educator. She provides comprehensive sexual education to her friends through activities such as games, discussions, and book readings. She gives basic counselling to young people who face SRHR issues. She also accompanies girls to health centres and helps them overcome their shyness in dealing with health care providers. As a daughter of a single mother who became pregnant in her teens, Manysone is passionate about helping her community deal with the SRHR issues.

Source: Travelling Journal for Sexual Reproductive Health and Rights

Availability of services for HIV and AIDS

Prevention and treatment are still unbalanced and the continuum of care is limited. There was only 3 health facilities (Savannakhet, Vientiane Capital, Champassak) out of 1594 health facilities were offering ARVs, expanding to 5 ARV sites (Savannakhet, Vientiane Capital (Mahosot and Sethathirath, Champassak, Luangprabang) and two satellite sites (Bokeo and Luangnamtha) in 2010 (WHO, 2009).

Treatment with ARV is free, although transport costs remain a barrier to access. Adherence and survival rates are reportedly good. According to the Global AIDS 2013 Report, 2,212 adults and 163 children were receiving ART in 2013 (UNAIDS, 2012). Furthermore, an estimated 4 100 adults in need of ART and 54% of them (based on 2010 guidelines) were reported to be received treatment by the end of 2012. As reported by the progress of MDGs, the proportion of adults and children receiving ART increased from 41% in 2005 to 55% in 2012 (UNAIDS, 2012).

The pilot PMTCT programme was started in 2006 in six provinces, the percentage of estimated HIV-positive pregnant women who received ART prophylaxis has remained low (around 14% - 15%). There are estimated about 180,000 pregnancies per year in the country (WHO) but although antenatal care (ANC) coverage rates are increasing across the country, those most at risk are not accessing ANC services. The percentage of HIV positive pregnant women receiving ARVs to reduce the risk of mother-to-child transmission (most effective regimens as recommended by WHO) is low from 7% to 15% in 2010 (WHO, UNAIDS, & UNICEF, 2011).

6. Availability of Sexual and Reproductive health Services at different levels of care

Sexual and Reproductive health (SRH) services are widely available in the public and private sectors and the government pays attention to and prioritises the Maternal Newborn and Child Health (MNCH) services. The public sector delivers most health services in Lao PDR through government owned and operated health centres and district, provincial and central hospitals. At the community level, the health center and outreach workers providing primary health care. The district and provincial hospitals provided secondary health care, while the central hospitals and specific centres provided tertiary care (WHO, 2012). The private sector includes drug-store, private clinics and few private hospitals. The formal health sector provided reproductive health services through MCH and Obstetric units located in the hospitals and through outreach community health workers. SRH services available include Family planning, ANC, Delivery and Postnatal care, emergency obstetric and neonatal care (basic or comprehensive). The health services in Lao PDR are focused on maternal, neonatal and child health issues (WHO, 2012).

The Referral and Counselling Network (RCN) was established in 2004 and aimed to improve the provision of quality sexual and reproductive health services to young people. It composes of 4 central hospital, 9 district hospitals, 2 rehabilitation centres , and three (3) counselling centres, including Vientiane Youth Center for Health and Development. There are 3 that are classified as drop-in centres which are the FHI Drop In Centre (FHI DIC) for Sex Workers, PSI Peuan Mai Centre for MSM and the Vientiane Youth Centre (UNFPA, 2008). According to the Table 7, 10 organizations are the government health facilities and 2 are INGOs (UNFPA, 2008).

Table 7: Type of Health facilities in the RCN

	Hosp	Rehab Centre	Cousel Centre	Drop-in Centre	Clinic	Protection Centre	Testing Centre
CHAS			x				**x**
Dermatology Centre					x		
Friendship Hospital	**x**						
FHI Drop In Centre for SWs				x	x		
LWU Counselling & Protection Centre for Women & Children		x	x			x	
Mahosot Hospital	x						
MC Hospitl	x						
PSI Peun Mai Centre				x			
Somsagna Drug Treatment & Vocational training Center		x					
Vientiane Health Dep (9 Hosp)	x						
Vientiane Youth Centre			x	x	x		

7. Recommendations

We call upon governments and UN agencies to improve the sexual and reproductive health of the Laotian people through the following actions:

Health Financing

• Out-of pocket expenditure is high which has an impact on the accessibility to health services among the poor and marginalized people, thus, the government should allocate more of the government spending allocated to health and increase the government expenditure on health as a % of GDP.
• Allocate national funds for the SRH, especially ASRH.
• Put in place sustainable and predictable financing for maternal, neonatal and child health services
• The government is concerned about "sustainable health financing" by increasing the government health budget, expansion of prepayment schemes, and developing the health equity fund to ensure that the poor have to access to health services in order to achieve the universal health coverage.

Contraception

• Reduce the unmet need by providing more comprehensive health education on contraceptive to all women, irrespective of their marital status and reach out to women in rural areas, women with less education and women in the poorest wealth quintiles.

• Involving their husbands in the decision making of use of contraceptives for limiting and spacing.

• Providing SRH services to all regardless of age, marital status and ethnicities.

Infant and Maternal Health (MDG 4 & 5)

• Effort should be made to reduce teen pregnancy by providing contraceptives to adolescents who are sexually active and comprehensive sexuality and health education, which includes education on the negative health consequences of early pregnancy.

• Increase accessibility to BEmONC and CEmONC to all women with special attention to vulnerable women, namely women with low education, ethnic and poor women and women living in the remote areas.

• Effort should be made to do advocacy, mobilization and health education activities to target women and men from communities living in the remote rural areas; these are often the same groups as those in the poorest quintiles and those with the lowest education.

• Improving quality of Maternal health services by Strengthening clinical and management capacity and developing better supply and logistics management systems.

Adolescent Sexual Reproductive Health

• Adolescents are entitled access to high-quality SRH education and information and services, especially ethnic minority groups, people living in rural areas and those with lower education levels. Mainstream the ASRH education curriculum, the school-based extracurricular programs into official school learning programs and CSE for out-of-school youth.

• Ensure access for adolescents and youth to quality youth-friendly SRH services by assuring availability and access to youth-friendly SRH and counseling services at the health facilities for both unmarried and married young people.

• Expand youth friendly services nationwide and training providers on providing youth friendly services by protecting the confidentiality and privacy of young people and ensuring affordability, accessibility and availability of SRH services.

• Expand the Referral and Counselling Network nationwide.

• Make effort to encourage adolescent girls to keep enroll and reaching the high schools, especially for vulnerable adolescents, men and women.

HIV/AIDS

• Formulated a national policy on non-discrimination which specifies protection for all people living with HIV especially vulnerable groups. Further addressing stigma and discrimination against people living with HIV.

• HIV Counselling and testing, and availability of ART be made more accessible through the primary health care system.

• Expand prevention services to more provinces and various settings, including the 100% condom use programme, voluntary counselling and testing (VCT), life skills-based HIV education and behavioural change interventions targeting mobile groups and most-at-risk population.

• Integrate SRH, including HIV/AIDS in the MCH and other SRH services.

• Strategically address the needs related to vertical transmission of HIV/AIDS from mothers to child during pregnancy and delivery.

• Providing HIV/AIDS health awareness to the young people and other most at risk population and Address the HIV-specific needs of women and girls.

• Integrate SRH into the school curriculum and provide comprehensive sexuality education.

• Provide universal access to HIV/AIDS counseling and testing for general population and most at risk populations and Scale up and secure the accessibility to ARV treatment to PLWHA.

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About FPS

The Faculty of Postgraduate Studies is one of the seven Faculties located in the University of Health Sciences, Vientiane Capital City, Laos and was established in 2001. The Faculty is responsible for higher education of different fields such as Residency Program, Master Program of Public Health, and Family Medicine and has a unique leadership position in postgraduate studies in the Field of Medicine and Public Health.

The objectives of the Faculty of Postgraduate Studies are to achieve the following human resource development goals.

1. Provide higher level of Postgraduate Studies, including Medical & Public Health Education within the country.

2. Conduct Researches both in Public Health & Medicine to promote health and participate in community Health services.

3. Train specialists in different fields of Medicine and Public Health personnel in response to current & emerging needs of the local people.
4. Provide technical services to the local people.

5. Integrate technologies and prac-tice, and interrelate research and educational activities.

6. Collaborate with different partners at the national and international levels.

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