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REPORT ON LAOS
EVALUATION OF SITES FOR DEIDS

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REPORT ON LAOS - EVALUATION OF SITES FOR DEIDS

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The major responsibility for the delivery of health services in the country of Laos has been assumed by USAID. Although there is a Ministry of Health in this country the availability of funds and trained personnel have traditionally been so limited that adequate development of health services delivery throughout the country has been virtually nonexistent prior to the major involvement by USAID. USAID health programs are developed and administered by a chief public health officer who is a physician. This office of public health is divided into two major subdivisions, one administrative and the other for supervision and development of projects. There are three administrative subdivisions: administrative support, medical supply and statistics and budget accounting. The project section is also divided into three: national health development, maternal and child health and narcotics rehabilitation. The National Health Development Program is described as being one whose first priority is primary medical care with back up hospitals capable of delivering services to refugees and resettlement areas in the short term sense, but in the long term dedicated to the development of an integrated stable health delivery system for the country. The National Health Development Program is under the direct supervision of

the Public Health Officer of USAID in collaboration with the Ministry of Health. The NHD Program currently has two subdivisions, one program run by Operation Brotherhood International (OBI) and the other a Village Health Program. OBI has had contractual relationships for approximately 14 years and its purpose was to provide hospital services to the people of Laos, to train health workers and to instruct villagers in hygiene and sanitation. The 6 hospitals during the first 3/4 of FY 74 carried an inpatient load of 18,034 admissions and an outpatient load of 146,804 visits. The national Maternal and Child Health (MCH) Program has some components operating in conjunction with the OBI hospitals and they in turn serviced 32,511 ambulatory visits, in the same time period. The Hygiene and Sanitation Program is described as consisting of education and instruction regarding privies, drainage, composte pits and dug wells. The Village Health Program is carried out through 193 dispensaries and 1 (one) hospital. In the first 3/4 of FY 74 these dispensaries handled 2,493,160 ambulatory visits and the village hospital during the same period has handled 7,377 admissions and 16,943 outpatient visits. In a nutshell these represent the major organized medical care programs of the country of Laos. The above figures for the hospitals and dispensaries add up to 25,411 inpatient admissions and 2,656,907 ambulatory care visits during the first 3/4 of FY 74.

The population of Laos is approximately 3 million people who are widely dispersed over a mountainous terrain. The population density is approximately 30/square mile (the U.S. population density is approximately 57.5/square mile). The cost of medical care (countrywide average) of this health program is \$10.70/day for inpatients and \$0.51/outpatient visit. The average inpatient stay is 6 days. This health program is run by 1433 people only 19 of whom are Americans. (See enclosed chart for further breakdown.)

The total USAID budget for FY 74 is \$6,718,600 which is added to the Laotian budget of 475,732,000 kip. Approximately 71% of the national health budget is spent on personnel costs and 3% on commodities. Another way of looking at the total health budget of the country is that 11% of the national budget comes from the Laotian government, 68% from the U.S. government, and 21% from other donors. Approximately 80% of the U.S. funds end up in services.

The vast majority of the dispensaries serving the Village Health Program are to be found in the region of the country known as Military Region II (MR II). This area lies to the north of Vientiane in the mountainous area between the Vientiane Plain to the south and the Plaine des Jarres to the north. A description of a portion of this area under consideration for the DEIDS program will follow later.

Dr. John E. Kennedy, USAID Public Health Officer, who works with the Ministry of Health in the direction of the health programs, spent approximately 10 days with me prior to arrival in the country during which time we had ample opportunity to discuss many aspects of health care in Laos. I then spent four days with him in Laos, the time being divided between Vientiane the province of Syaboury in MR I and a group of health installations in MR II. Dr. Kennedy, although previously not aware of the possibility of the development of a model health delivery program, such as DEIDS, nevertheless was quite keen to accept the idea, feeling that it fitted in quite well with his priorities and those of USAID. USAID is desirous of getting out of direct responsibility for the delivery of health services and has not felt that OBI is the program mechanism to accomplish this goal. Although having been involved in this country for 15 years, OBI has never been able to assume the responsibility for innovative program development of the type that would be necessary to fully accomplish the objectives mentioned above. During wartime,

OBI delivered emergency services under difficult circumstances but the needs for national health development now require a different kind of input. For this reason Dr. Kennedy felt that the transfer of an embryonic health system (in this case that under development in Syaboury Province) to the auspices of a university medical center would be appropriate.

On Sunday, October 13, Dr. Kennedy and I met with USAID Mission Director, Mr. Charles Mann, at which time we presented our joint thinking regarding the development of the DEIDS program in Syaboury Province. Mr. Mann agreed with the developmental potential but felt that we should consider the possibility of developing a project in MR II. He indicated that the hospital at Ban Xon was scheduled to be either rebuilt or moved and that there were a large number of health centers clustered thereabout which needed to be either phased out or improved, in terms of a system. In short, he felt that the challenge here was much greater and for political reasons internal to the country would be more significant. The area in question in MR II is the mountain stronghold of General Van Pay³, the Meo general of the key guerilla forces that were so instrumental during wartime. We agreed to visit both areas (Syaboury and MR II) and to compare their health needs.

VISIT TO SYABOURY

The town of Syaboury, capitol of Syaboury Province, lies on the banks of a tributary to the Mekong River about 15 kilometers to the west. The Mekong River is navigable both to the north and south of Syaboury and is the main source of transportation of large amounts of supplies. The population of the province is about 200,000, most of which lies in a valley approximately 90 X 45 km in size. The valley is very rich and is irrigated extensively as a result of a USAID project making it possible to extend agricultural pursuits

considerably. A large proportion of the population is of Montagnard origin (Meo and Yao) which are tending to settle in the valley engaging in agricultural pursuits.

In the town of Syaboury is a well developed permanent hospital structure of some 65 beds which also delivers a considerable amount of outpatient care. The services obtainable include complete lab, x-ray, dental care, pharmacy, and food and nutrition services. The administrative organization is well established under Laotian staffing and the hospital is well supplied with water and electrical power. The hospital design is interesting having been created to maximize efficiency of staff support. Four wings radiate off a central nursing and administrative center. Three are occupied by patients segregated according to whether they are in internal medicine, surgery, pediatric or contagious disease categories of treatment. The fourth is occupied by central supply, OR and OB suites and x-ray. The hospital is staffed principally with Laotians but key professional positions (MDs and nurses) are filled by members of Operation Brotherhood.

The equipment and facilities of the hospital unit in Syaboury were up to date, well kept and obviously well utilized. It would seem that use of this institution as the back up component of a model delivery system would not entail a major output of funds. In order to be more exact in this determination, however, a more complete inventory should be accomplished if a DEIDS program is seriously considered for this location.

Conversations with Dr. Kennedy led to the conclusion that the phasing out of the OBI staffing, probably over the period of one year, would be necessary, replacing them with other health professionals, backed up in key positions by individuals recruited from the contracting university medical center. The proper mix of Laotian professionals, third country nationals and back ups from

an American medical center would have to be determined at a future date, as a part of a program planning and development effort.

There was total agreement on the part of Dr. Kennedy and the medecin chef, Dr. Khamlay, that the major program commitment should be to primary care delivered by a series of ambulatory care facilities, strategically located through the Province, and that the role of the hospital should be secondary to a good primary care delivery as a back up institution. Dr. Khamlay's wife is a pediatrician and has been recently named as the director of the hospital. Unfortunately at the present time the two of them represent the only Laotian physicians in the Province and are heavily burdened by their official obligations. The hospital in Syaboury is staffed conjointly between the medecin chef and the OBI staff. It consists of 2 OBI physicians, 2 Laotian physicians (the medecin chef and his wife) and 26 practical nurses as well as administrative staff, most of whom are Lao. I was very much impressed by the quality of care and operational know-how of the Laotian staff and could envision their continued growth and development under the added influence of professionals from a U.S. university medical center

On the other side of the road, opposite the abovedescribed permanent hospital structure is the old hospital building which has not been recently used. At the time of our visit the medecin chef was requesting this building to develop the MCH Services Program to include well-baby clinics, prenatal care and immunization to back up services currently being given in the outlying facilities. This program currently is located in inadequate and limited facilities elsewhere in the town of Syaboury. Dr. Kennedy concurred in this plan.

A regional warehouse established by USAID exists nearby the hospital but in addition a large storage area for medical supplies, well organized and well kept, is maintained on the hospital grounds. Supplies are shipped

up the Mekong or sometimes flown in in small amounts. This supply system seems to be quite adequate to meet the needs of the hospital and outlying ambulatory health facilities.

It was felt that the utilization of the hospital could be greatly improved, especially in the area of outreach back up for the outlying 12 dispensary stations. Currently there is little direct connection between staff and programs in these outlying facilities and the central hospital in Syaboury. Certainly the gathering of a broader statistical base relative to health problems in the outlying areas is needed, giving information as to the nature and distribution of these problems. No program feedback of such information for program planning is in existence. About 8 years ago OBI and USAID began a long range integrated program with the medecin chef. Although progress has certainly been made it would seem that considerable improvement in terms of program planning is now in order, based on better information relative to health care problems in the area and further training and education of outreach personnel to function in the outlying centers at the interface between the population and its health care problems. Within the 30 days after our visit all services and programs were to be integrated under the medecin chef. The medecin chef was most impressive and described as being quite capable but his staff limitations are such that special input from a university medical center source could undoubtedly spell the difference between his ability to maintain the current status quo with difficulty as opposed to developing a top notch rural medical care program emphasizing primary care utilizing a sophisticated program based in the outlying facilities.

Running north and south through the center of the valley is a major highway which interconnects the various outlying dispensaries with the central hospital facility in Syaboury. We visited three of these dispensaries to the

south of Syaboury. In each instance they followed a structural design consisting of a corrugated roof and concrete slab floor both contributed by USAID with roughhewn wooden walls contributed by the local population. They contained either 2 or 3 rooms, one utilized primarily as an examination room and the other a consultation room, the distribution of medications occurring in the consultation room, as well. A drug cabinet was maintained in the consultation room and there are some 64 pharmaceutical items available out of a list of 96 items which can be requisitioned from the supply depot in the Province capitol, for maintenance of the dispensary facility. These items included certain symptomatic remedies, such as aspirin, but also more specific items such as a few antibiotics, antimalarial drugs and family planning items. The personnel manning the dispensary facilities are called medics although there are some family planning aides involved in some facilities. At least two medics are assigned to each dispensary. These medics are selected from the local population without particular reference to prior education. They are given six months training in the hospital environment in Syaboury under OBI. They may also receive training from the USAID project which lasts for 6 months, and then they are sent to an outlying dispensary where they work for 1-2 years, receiving apprenticeship training under a senior medic. Thereafter they may be brought in periodically for additional training of 1-3 months in the provincial hospital. Training consists of a small amount of medical science information, preventive medicine and public health theory and practice. Most of the training is in the recognition and diagnosis of disease categories based on symptomatic information. The diagnostic categories are standardized in relation to symptomatic complaints, making it possible for the medics to maintain a log in which patients are serially numbered and identified as to sex, either in adult or child categories

(children are defined as being under 12 years), complaint and treatment given. A monthly report is submitted, all patients being categorized in standard disease groupings and all of this information is compiled in the USAID office in Vientiane for the purpose of annual reporting. Examples of diagnostic categories are URI, vitamin deficiencies, malaria, skin diseases, etc. The MCH workers receive 9 months training under the auspices of OBI and are likewise recruited from the population surrounding the dispensary. These are young women and they are trained to give prenatal care, to do home deliveries, postnatal care and well baby care during infancy. They are also trained in family planning methods and in fact the entire program described herein is funded by USAID with population money. The MCH workers have kits which they use for home deliveries and which they keep in readiness in their homes. Family planning activities include the dissemination of information by word of mouth and with educational devices describing the various methods of contraception as well as the reason for the desirability of control of family size. IUDs are the only device which they do not use since they are not trained to insert them. In one of the outlying facilities we had the opportunity to talk extensively with two such MCH aides and I could not help but be impressed with the dedication and probable good works:

The outlying dispensary facilities are of three categories: 6 are supported and supervised by USAID, 4 by the medecin chef and the Ministry of Health and 2 are conjointly operated. One of each type was visited. The most productive and best quality operation was USAID run; the least impressive was the one supported by the Ministry of Health. In discussion with Dr. Kennedy it developed that the difference is relative to the input of back up and support which is available through USAID as opposed to the medecin chef who is dependent upon the Ministry of Health for his resources. These dispensaries were serving

on the average a population of 6-7,000 people each, all of whom are located either in a small village or in its immediate environs. The USAID supported facility at Nam Pouei was averaging 50 visits/day whereas the Ministry of Health facility at Nam Hia was said to average 20-25 visits/day, but the log indicated that the number may fall as low as 4-5 visits/day. The quality of the record keeping and the supply and utilization of medications and other items were less adequate in the Ministry of Health facility as opposed to the USAID facility.

One cannot help but be intrigued by the possibility for the intensification and expansion of health care delivery out of the dispensary facilities. The acceptance of these dispensaries by the populace is established and building upon the current level of training and capability of these facilities, if done well, could expand the care not only in terms of symptomatic disease processes but more importantly in terms of active prevention programs. The acceptability of family planning by the population would seem to be an indicator of the capability for the population to accept preventive measures. A well prepared team developed by a university medical center to work intensively with these dispensaries to expand their capability has a potential pay off which is truly exciting.

The dispensary facilities described (12) represent dispensaries only for the northern half of Syaboury province. The southern half of this province has politically been controlled by dissident Meo tribesmen identifying with the Pathet Lao cause. The medecin chef feels responsible for the entire province and does in fact relate to the southern half of the province, but it is unclear what facilities are available there. A relatively small number of patients come from the southern half of the province to receive inpatient and occasionally outpatient care at the hospital in Syaboury. The nature of

the political situation has limited USAID involvement in the southern part of the province. A distinct challenge would be to develop a neutral medical care approach perhaps under the auspices of a university medical center which could extend to all parts of the province. The coalition government makes this a possibility and the approval and involvement of the Secretary of State for Health who is a Pathet Lao would probably facilitate this.

In conclusion, Syaboury province presents us with a rudimentary health care delivery system consisting of a central rural hospital facility located in the provincial capitol which loosely relates to 12 dispensary facilities interconnected by a major highway. Considerable development has already occurred regarding the capacity to deliver care on the part of the hospital under the auspices of OBI. The resources exist within the hospital regarding staffing, facilities, equipment and supply systems to develop a top quality health care program with the added input of a university medical center. The much larger challenge, however, lies in the development of a top quality outreach program involving all of the outlying dispensaries not only by improving their ability to meet acute care needs of the surrounding population, but also by developing their capacity to mount aggressive programs of prevention. Primary emphasis in this regard would focus on MCH care needs, including family planning, immunization, improved pre- and post-partum care, as well as nutrition education and development programs, malaria identification and control, programs to better control gastroenteric disease, and others.

The current level of program, facility and staffing development is such that within a relatively short period of time, perhaps three years, an exemplary model of a rural medical care system could be well under way.

VISIT TO MILITARY REGION II

Military Region II (MR II) contains a heavy clustering of some 70 dispensaries and one (1) hospital. This represents the greatest concentration of medical care activity in the country, outside of Vientiane. This area located between the Vientiane Plain and the Plaine des Jarres, was the site of some of the most heavy and intense fighting in the war in Laos. The region was controlled militarily and now politically by a Meo general who is a national hero (General Van Paó). The main highway (#13) from Vientiane connects with several road tributaries which are the only access to this heavily mountainous area. At the most distal point of the road system high in the mountains is the Meo stronghold and at this location there had been built a new, permanent, stone and concrete hospital facility intended to serve that area. Unfortunately it was heavily damaged during the war necessitating the construction of an alternative hospital site at Ban Xon which is located approximately halfway between the mountain stronghold and highway 13. Three permanent type buildings and a number of temporary wooden structures constitute this hospital whose bed capacity is 225-250. It is usually described as a bush hospital. It is located in a heavily populated area which contains about 15,000 people. The hospital is highly utilized but its physical structure is deficient in terms of being able to be used for modern hospital care. The population of the entire area surrounding the road system connecting to highway 13 is about 150-200,000 people. It is roughly estimated that the quality of the land and current farming practices make it capable of supporting no more than 50,000 people. The valley system is much narrower than that in Syaboury Province and the quality of the soil is quite poor and because of peculiar acid conditions is almost unusable even for grazing purposes at higher elevations. There is no irrigation system as well developed as in Syaboury and no major agricultural effort has as yet been

undertaken for the entire valley system, although there are isolated, special irrigation projects. Slash and burn tactics used by the Meo tribesmen who represent the majority of the population have further depleted the land to a marked degree. The hospital is staffed by one OBI physician and two physicians supplied through the Ministry of Health, along with various types of nursing personnel, approaching 100 in number. The level of patient care in the hospital was obviously far below what had been seen at Syaboury hospital. No effort was made to segregate patients according to age or type of case. The tradition of family accompaniment presented a considerable problem in this hospital as opposed to Syaboury where special quarters had been constituted for living purposes for visiting families. An OR and delivery room area, intensive care and emergency facilities as well as supply activities are all located in the permanent building structures and are of acceptable quality. The patient care or ward areas, however, border on the primitive. Undoubtedly this hospital served emergency needs associated with warfare, but it is recognized by all that it must be either rebuilt or replaced.

At the head of the tributary valley is located Long Tien, the Meo stronghold, which is a village of approximately 10,000. It is an obvious military stronghold and heavily fortified. On the outskirts of the village is the hospital, originally built to serve that area, which has now been completely repaired but stands empty and unutilized. It has a bed capacity of about 100 and several outlying buildings for occupancy by staff and/or which house support activities. A small dispensary is the only operation currently active in that facility. It is the desire of General Van Paø and his constituency to have this hospital reinforced and expanded, along with the closure of the hospital facility as such at Ban Xon. At the present time, Dr. Kennedy indicates that he has about \$300,000 in construction money that can be used for this

hospital and associated health centers. Currently a \$5,000 contract has been let to architectural planners to develop a modification of this hospital capable of better differentiating categories of patients and service delivery. There are also available MESH units which could be used to meet the basic equipment needs of a new hospital facility. There is some doubt in Dr. Kennedy's mind as to whether more than 100 beds are really necessary to serve this population area. Because of the large districts involved in this valley system, Dr. Kennedy and I feel that several intermediary or secondary care units should be developed. With an updated central hospital, and several intermediary care facilities the number of dispensary units could be significantly decreased from the current level of 70 and at the same time improve the quality of care. The hospital at Ban Xon would lend itself to restructuring as a secondary care facility and along with the creation of 1 or 2 more such facilities there would be a cost entailed in construction and equipment. The disadvantage in relocating the hospital in Long Tien is that this site represents the most remote point in a transportation system extending from Vientiane rather than being centrally located to the population served (as is Ban Xon). Additional population and utilization studies need be done in order to decide the relative appropriateness of reestablishing the hospital of Long Tien versus the modernization and updating of the current bush hospital at Ban Xon. At best, however, internal political factors could be the deciding element. Although none of the dispensary units were visited in this area, several were seen from the air along the highway and I was reassured that they not only looked the same as those in Syaboury province but were similarly staffed and functioned basically the same. It should be mentioned that UNICEF and WHO have both indicated strong interest in this area, WHO by way of extension of their malaria control program and UNICEF in its expression of willingness to develop MCH

capabilities. Dr. Kennedy indicated that altogether there are \$2,102,654 going into health care delivery in Laos from sources other than USAID and the Laotian government. A listing of this outside aid input for FY 73 and ✓ FY 74 is annexed to this report.

In conclusion, the situation in MR II presents itself as a far greater challenge in that a large number of outreach dispensary facilities currently exist without a well-developed relationship to a central hospital. The appropriateness of some of these dispensaries is in question and the need for the development of intermediary care, limited bed occupancy facilities seems apparent. The establishment of a good quality, fully operational general hospital facility is also necessary but the decision as to its appropriate location requires additional input of both pragmatic and political nature. Finally, the interrelating of all three of these types of facilities needs to be established in a functional system. The health delivery system so developed by definition must be heavily involved in the social welfare problems of this entire valley system. This means that expertise other than strictly medical needs to be marshalled since agricultural, economic and housing problems are so intrinsically associated with the medical care system that its ultimate success may well depend upon such interrelationship.

CONCLUSION AND ANALYSIS

According to the statement of approach suggested by APHA my negotiations were almost entirely limited to representatives of the U.S. government in Laos. These were carried out at every level from the facilities visited all the way up to the U.S. Ambassador, Mr. Whitehouse. On the last evening in Laos I had the pleasure of dining at the Mission Director's house (Mr. Mann) which included Ambassador Whitehouse, Dr. Kennedy and Dr. Isaiah Jackson from AID, Washington. We again explored the appropriateness and manner of organization of a DEIDS project. There was a general consensus as to desirability of the project. The discussion covered the range of whether the project would be more appropriately done at Syaboury or MR II and there was general discussion as to the extension of U.S. aid to Laos in the future.

OBI sees its mission as primarily service rather than broad-based development or education. This approach was particularly useful during wartime but is not ideal for the development of first rate, up to date clinical, community medicine or public health programs. In addition, USAID support of OB requires more than simple funding of their delivery program, also entailing continued responsibility for program development and major policy decision. USAID commitment to a major involvement is waning and the basic nature of OBI is such that continued heavy USAID commitment would have to continue. It is not clear to me whether the decrease in commitment of USAID not only involves funding support as well as staff and involvement at policy levels. Certainly a comparison of budgetary commitment for FY 73 (\$5,577,200) with that for FY 74 (\$6,718,600) does not seem to indicate this, but a frank statement as to long term financial commitment was not at any time forthcoming. The decrease in the American staff component of the public health division in Laos down to the current level of 19 (our of 1433), with indications that this trend will continue, can be interpreted either as a commitment to turn things over to the Laotians and not necessarily as discontinuation of financial support or, on the other hand could be viewed as the first step in a major decrease in all types of U.S. support to the health system of Laos. Since the national budget of Laos does not seem to have any immediate prospects of assuming the burden of major withdrawal of U.S. support, this point is emphasized. Any commitment to develop a model delivery system component for possible replication nationwide, such as the DEIDS program, would seem to require some indications commitment of outside funds well into the future.

Past experience has indicated that the support of the recipients of services is of some importance. I am therefore concerned at this point in that I have only a spotty reading of the nature of support by the Laotian government. Other than the medecin chef in Syaboury province and the hospital director at MR II, both of whom wholeheartedly support the idea, I have no indication of what kind of response and support would be forthcoming on the part of Laotians. On the other hand, the opinions of the Ambassador, the Mission Director and Public Health Chief seem to be that the Health Ministry would support such a program and that this support would be strengthened by including an educational component to enhance the development of Laotian health professionals. I agree in the desirability of this concept and would propose that any health delivery project in Laos should involve the education of Laotian medical students who would be assigned to the delivery programs and that an additional education component at the university medical center in the U.S. should be built in. What would be anticipated here would be an academic program for not longer than one year in the U.S., designed to supplement the education of the Laotian medical student after completion of his full medical course in Laos. Such a program would not be designed for nor would it prepare the Laotian medical student to enter the U.S. medical system. It would, however, assure adequate scientific and clinical content to the Laotian medical students' fund of knowledge, according to U.S. medical education standards. The numbers of students that such a program would accomodate would have to be negotiated. In addition post graduate education in medical specialties could be made available to Laotian physicians including faculty in selected cases designated to meet the special needs of medical practices and education in Laos. There was the feeling in the U.S. Mission's staff that this would be particularly attractive to the Secretary of State for Health, Dr. Khamling Polsena, who is the number-two man in health but in effect is the more influential on the national scene. He is the Pathet Lao representative and it was anticipated that an important part of confirming his support for this program would be the arrangement of a visit to the U.S. allowing him to view first-hand the educational and clinical facilities of the proposed university medical center. Whatever additional Laotian support would be desirable yet remains to be developed and I would look forward to suggestions as to how this should be carried out beyond what is above outlined.

In reference to the two facilities presented for consideration as DEIDS sites, I would suggest that we should consider the development of a staged program which would begin by a period of not less than 6 months during which the necessary facts and background information would be gathered along with the completion of the planning of the operation as well as the development of all preliminary activities necessary for full institution of an operating program. The second step would be the establishment of a program in Syaboury province which would be designed to develop this into a mature health delivery system but at the same time would serve as a staging area for the development of a project in MR II. At some point during the first year of the operation in Syaboury, perhaps after the first 3-6 months of operation, the planning and development activities relative to MR II would be finalized and in the second year a staged sequential development program for MR II would begin. During the first year in active involvement in the delivery of services, experience could be gained through contacts with the Laotian medical students and faculty of the medical school allowing the planning and establishment of American university faculty and staff from the outset and, as appropriate, resident staff to carry out the process mentioned above, and, with the firm establishment of service delivery under these auspices, the inclusion of American resident physicians and students would also be desirable.

The planning and program establishment procedure described above is very preliminary in nature and I would propose that it be developed in association with APHA staff if the program proposed, is, in fact, accepted in principle.

REPORT ON LAOS (APHA/DEIDS)
French 10/74

USAID - PUBLIC HEALTH DIVISION PERSONNEL

Lao	1282
OBI	129
TCN	3
American	<u>19</u>
	1433

Lao Personnel

Practical Nurses	420
Medics	223
Auxillary	98
Administrators	104
Support Services	<u>299</u>
(Subtotal)	1144 - USAID

Lao Government Employees 235

Trainees	<u>140</u> - USAID stipend
(Total)	1519

"OTHER DONORS" TO LAOTIAN MINISTRY OF HEALTH

<u>A. Clinical Services</u>	<u>FY 1973</u>	<u>FY 1974</u>
Swiss RC - Luang Prabang	150,000	17,500
Japan PC - Thangon Dental LP	75,000	100,000
Asian Christ. - Vte, Bkn, SVRT	100,000	100,000
Dooley Foundation - Vte	60,000	75,000
MSC - IRC, WV, CMA, CRS		75,000

B. Institution Building

WHO	684,932	688,725
epidemiologic surveys, malaria control project (Vte plan), medical education advisors, vital statistics advisors, environmental health advisors, orthopedic rehabilitation advisors		
UNDP (5 yr malaria control project)	+ 132,500	155,120
Columbo (medical scholarship)		
France (medical education advisors)		
USSR (medical scholarships)		
UNICEF (MCH Family Planning)	90,000	104,000
IPPF (MCH Family Planning)	73,000	100,000
Asian Foundation (" " ")	14,000	19,800
Ford Foundation (" " ")	5,000	10,000

TOTAL

\$ 2,102,654.00