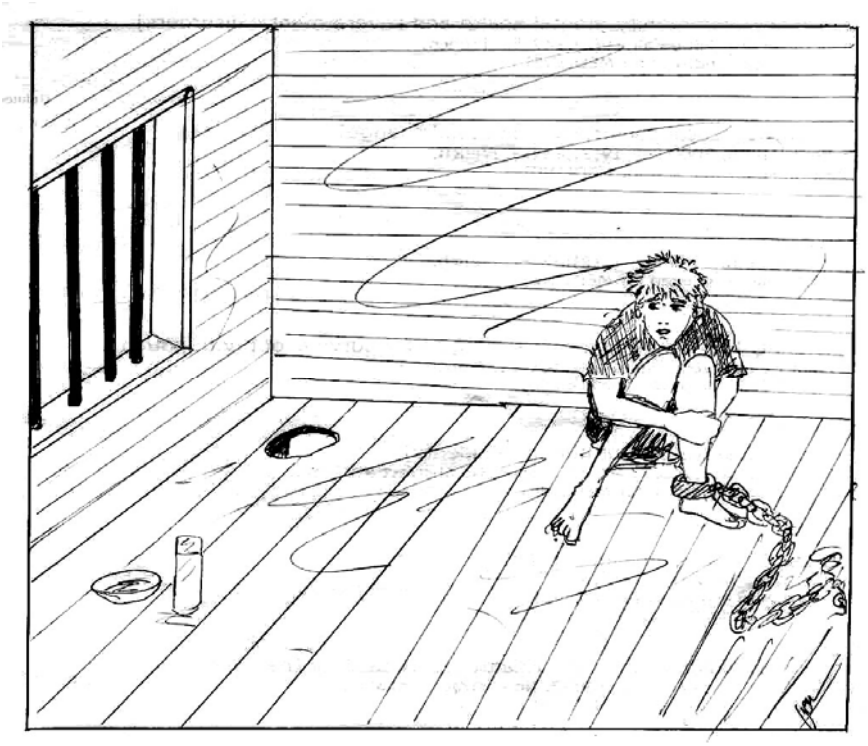
Mental Health Situation Analysis In Lao People's Democratic Republic



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Doux pays,

Il est un doux pays que le Mékong arrose
Où n'a point pénétré le snob, ni la névrose,
Où l'homme, insoucieux des vagues lendemains,
S'en va joyeux et fort par les libres chemins

Than, 1901

Sweet Country

There is a sweet country that the Mekong waters
Where neither snobbery nor neurosis penetrates,
Where Man, unworrying about vague futures
Goes happy and strong along free paths.

in A Raquez, Pages Laotiennes, F Schneider éditeur, Ha Noi 1902
Réédition Institut de Recherche sur la Culture, Vientiane, 2000, p12

Abbreviation List

AGL	Assurances Générales du Laos
ATS	Amphetamine Type Stimulant
CHBI	Community Based Health Insurance
ECT	Electro-convulsive Therapy
ICD	International Classification for Diseases
FMS	Faculty of Medical Sciences
IO	International Organisation
LDPA	Lao Disabled People Association
MLSW	Ministry of Labour and Social Welfare
MOE	Ministry Of Education
MOH	Ministry Of Health
MP	Medical Practionner
NGO	Non Governmental Organisation
NSC	National Statistics Centre
NUOL	National University Of Laos
PDR	People Democratic Republic
PSTD	Post Traumatic Stress Disorders
SSO	Social Security Organisation
STD	Sexually Transmitted Disease
TH	Traditional Healer
UNDP United	Nation Development Program
UXO	UneXploded Ordnance
WHO	World Health Organization

Executive Summary

Introduction

"Mental health is the foundation for the well-being and effective functioning of individuals. It is more than the absence of mental disorder. Mental health is the ability to think and learn, and the ability to understand and live with one's emotions and the reaction of others. It is a state of balance within a person and between a person and the environment. Physical, psychological, social, cultural, spiritual and other interrelated factors participate in producing this balance. The inseparable links between mental and physical health have been demonstrated" (WHO, WPR 2002, p7)

1. Context

Laos is a land-locked country of 237,000 square kilometres and a population of 5,377,000 (NSC – 2001 estimates). Seventy-five percent of the population live in rural areas and they are divided into 47-68 ethnic groups. Most of the non-Lao Buddhist ethnic groups live in the mountainous areas (2/3 of the country). Deforestation, dam construction, and the displacement of villages in order to regroup diverse ethnic groups are forcing many to adopt new ways of life while the availability of local natural resources is decreasing. Roads, markets, and access to modern communication such as TV support their opening to a new world for which they may not be well prepared.

Animism is part of the general belief system. Suk khuan : the call of souls is a ceremony widely performed at significant events such as birth, death, illness, and departures.

Monks are usually consulted in case of problems or to help interpret bad dreams, bad feelings or strange behaviours, they usually give prayers to appease or relieve.

Family-based values are widespread while some ethnic groups are also structured with clans. In urban areas mostly, familial structures are weakened and inter-generational links less tight, both of which may have a negative impact on child and youth development.

Mass organisations are deeply rooted and networked throughout the country. They tend to promote mutual understanding, solidarity, good morality, and nationalism. They reinforce the social control.

Economic and social changes are influencing the values, beliefs and way of life of Lao people, most rapidly in urban areas. With the increase of purchasing power, people may have started to become more materialistic and consumerist.

Peoples in Laos have often been described as gentle, easy going, having a happy life style and cultivating harmony. This portrait can support the idea that Lao culture is supporting a mentally healthy style of living.

2. Mental health services and facilities in Lao P.D.R

Mental health issues are completely new for the country and nothing has been set up yet apart from the psychiatry clinic.

Drugs are delivered through government health facilities, revolving drug funds in health facilities and villages, and through private pharmacies and drug sellers. Drugs are frequently delivered without adequate information or labelling. Most drugs are purchased on self-prescription and they are treated like a commodity. The irrational use of drugs is a major problem.

A National therapeutic drug policy with a list of the essential drugs was formulated in 1997. No psychiatric treatment drugs are available at the primary level.

- *The Mental Health Unit* opened in 1975 and has 15 beds for adults only located at Mahosot hospital; it is staffed with 2 psychiatrists, 1 neurologist, 4 general practitioners, and 8 nurses.
There are both inpatients and outpatients. Classical admission is designated for acute mental patients with an average length of stay of 2 to 4 weeks. Ambulatory patients come for minor psychiatric troubles or minor psychological problems. The psychiatric team sees patients once a week, accompanied by their family. The most frequent psychiatric diseases in 2001 are epilepsy (26%), followed by substance abuse (23.9%), schizophrenia (13.7%), and neurosis (11.2%).
The number of beds for the whole country is quite limited and in Vientiane only. In the psychiatric ward, most of the patients are mixed. There is a lack of experience in the field of psychiatry and mental health. Data collection on mental health is still limited. Follow up based on outreach work has not been implemented. Recreational activities, as well as professional training and rehabilitation for patients, are not available and should be developed with the National Rehabilitation Centre. Evaluation and research is needed to help set priorities and assess progress.
- *The psychiatric unit at the military hospital* was established in 1978 with 14 beds. The staff is composed of four general practitioners, five medical assistants and 13 nurses. The average length of admission is one week and after discharge the patient should come for weekly follow-up. 176 mental patients sought treatment at this unit from January-October 2002. The majority of cases are related to drug addiction. There were only ten psychotic patients. Seven cases were considered psychosomatic with symptoms such as insomnia, chronic fatigue, and neurasthenia. Some recreational activities are provided for those addicted to drugs such as drawing or sports. Home visits are also organised and conducted by a home visit team of a doctor and a nurse.

3. Main results of the situation analysis.

Methodology

In a directive manner, a questionnaire was developed. As a socio-cultural research it was mainly about meaning, i.e. what is done and said in terms of mental health and illness with a larger understanding of the whole context. Our analysis relies on 46 interviews with key informants and patients or their families and with 40 medical professionals (MP).

Main results

In general, mental health is referred to “chit chay” : the spirit and the heart, “neo kit”: the thought, “samong, sen pasath, labob pasath” : physiology, the brain, nervous fibres and the nervous system (medics provide more answers in terms of organic references).
Apart from insanity with obvious abnormal behaviours, mental suffering is not recognised as such or mentioned as a problem. Mental disease is perceived as: behavioural disorder, brain damage, and cognitive disorder (troubles of memory, speech, and hallucinations), affective-emotional disorder as well as physical appearance (e.g. untidiness and dirtiness).
Problems mentioned as met in the community or professional practice include: drug abuse including alcohol abuse, family violence, social problems such as conflicts, gambling, or delinquency, suicide, senility, sexual abuse and child abuse, abnormal behaviours (mostly referring to transsexuals).
The general feeling is that due to the opening of the country and a more economic-materialistic oriented life style, mental health problems are increasing while social

control and morality are decreasing. Expectations are getting higher while dreams seem to be inaccessible. One monk said, “people become are getting *ba yak dai*, (mad desire have) they suffer from craving madness”.

The understanding of mental disorders provides a dual classification, mad versus – non-mad, based on the symptoms. Further distinctions may be made based on the causes. The insane (ba) are described as presenting unusual thought and behaviours. They might be dangerous. Madness attributed to spirit (phi ba) is the major category of madness. Witchcraft and spells are still present in the minds of most people. Most acknowledged of the so-called mad is epilepsy. The non-mad category refers to several pathologies including depression, Down’s syndrome, and psychological/intellectual dysfunction (presenting impaired thought, memory, logic, and intelligence) including mental retardation. Causes are primarily attributed to organic problems such as nervous fibres/system and brain damage or genetic (kamaphan) and external spell or spirit attack-possession, people breaking a taboo, defective family care and education, food deficiency, and use of contraceptive medicine. The deficient mainly mental retardation category (bo them, unfilled) is common. Symptoms are low skills, poor memory, poor understanding, verbal difficulties, and slow mobility.

In several cases, patients or their family enunciated pluralistic aetiologies, looking for answers in both traditional and modern treatment contexts.

In rural areas, poorly trained medical assistants and nurses have little or no knowledge about psychiatric nosography and treatments. All the MP believe that modern medicine can be effective in treating mental disease while only just over half of the key informants believe so. Moral support is suggested as being effective. Traditional medicine got the same score from people for effectiveness as modern medicine.

Religious treatment at the temple is also felt to be effective for more than half of all the informants. Spiritual, magical treatment, while denied to be effective by ¾ of the MP, is mentioned by more than half of the other informants. Magical string and traditional souls calling ceremony performed by Lao from the plain is believed to be effective in reinforcing, if not curing, by a majority of all the informants. Non-medical care has been used by nearly half of the cases we met. One third only were referred to MP, mostly for epilepsy. One-fourth used traditional medicine. The necessity of long-term prescription for psychiatric drugs is often not understood by the patients or their families.

The majority of our informants expressed pity, compassion and tolerance towards mentally disturbed persons. Some did mention being afraid of violent behaviour. We found that the patients we met were well accepted and well treated in their family and neighbourhood, but they are not stimulated as families are not aware of potential improvments. Others were found chained but were washed, fed, and receiving some visits from their former friends. Maltreatment is mentioned as occurring during some rituals that are supposed to expel the bad spirits, e.g. biting the patient. Mental health is described as an economic and familial burden, difficult to bear in some impoverished families.

It seems that the overall level of discrimination and stigmatisation of both patients and families in the villages is low. This is positive and may allow the development of community based integration programs. Doctors are the first persons supposed to be able to help, followed by families (more than ¾ of answers), friends, neighbours, mass organisations and village leaders. ¾ of medical professions know about the role of a psychiatrist but ¾ of the other informants are unaware of such professionals.

More than half of the MP professionals call for the opening of a psychiatric consultation clinic in the hospitals. The hospital solution is mentioned by just over a ¼ of the non-medical informants but not by the concerned families. Specialised hospitals are also mentioned, as are specialised villages (based on the model used after 1975 for the handicapped veterans). Creative models for community care seem to be lacking. Professionals, families and mass organisations largely call for training.
It is understood that the Ministry of Labour and Welfare should also be involved in supporting patients and their family for job training and social reintegration providing a disability benefit.

Psychiatric drugs prescription and consumption
Phenobarbital is prescribed or used by less than half of medical informants. It is not available in remote areas and instead anxiolytics or anti-histaminics are delivered in some cases. Neuroleptics such as: haldol, and largactyl are known but usually not available out of Vientiane. Mostly psychiatrists prescribe them. Valium is very much used, as well as Tranxene. There is probably over prescription by Medical Practitioners and informal drug sellers due to its popularity in providing relief for stress.
A grave concern is that some neuroleptics are used in isolation without medication for neurological side effects.
Psychosis and schizophrenia
There is a need for better differential diagnosis in this area, such as psychotic-like symptoms that emerge from acute traumatic episodes. Most of the schizophrenics we met remain untreated by mental health professionals. Some families chained them at home. Others wander around, being fed by family or neighbours. Given the attachment to land and place, being chained at home and visited by community was seen as more pro-health than isolated and overmedicated with strangers in hospital unit far from home. Some people with schizophrenia can work and support themselves, they have rice fields, they catch fish, usually they have no marital life and children but their relatives are living next by.
Neurosis and anxiety disorders.
This problem has been under-reported as the use of Valium in cases of economic problems or family conflict is common, but this is usually not seen as a mental problem as such. Apart from megalomania (ba nyot) other forms of neurotic behaviour such as obsessive, perverse, or mania are not recognised as such. Few bipolar or maniaco-depressive patients have been seen at the clinic.
Suicide
Cases whose attempt was not lethal are probably under-reported. 25 cases, mostly related to young people with relational problems with their parents, spouse, or boy/girl friends have been reported.
Substance abuse including alcohol and tobacco
Substance abuse has been reported as a major mental problem apart from remote villages in Sekong where it is just starting. Alcoholism deserves more attention, its consumption being deeply rooted in social behaviour; it is difficult to find out the addicts. The use of Amphetamine-Type-Stimulant (ATS) has been increasing since the mid 1980s. Young men aged 15-18, students at secondary schools, from higher socio-economic classes and middle and lower class backgrounds are the most

concerned. Out of Vientiane, no treatment is provided, so cases are referred to the police following parents request, and sent to custody or police camps.

Mental retardation, intellectual disabilities and acquired brain syndrome.

All key-informants recognize mental retardation and can describe symptoms. Down's syndrome is not classified as a specific category but are seen as " unfilled". Intellectually disabled children are at risk for physical and sexual abuse.

Epilepsy

Most of the people interviewed know at least one case of epilepsy. The major concerns related to epilepsy are access to appropriate treatment and that MP should be cautious when using these diagnoses made on behaviour rather than individual case stories. Cysticercosis has to be considered.

Family violence as well as sexual abuses have been poorly reported.

Nutritional and Iodine deficiencies are a cause of mental disability: more investigations are needed in the most remote areas.

Child abuse and domestic violence are hardly reported. According to one report on street children (Delneuville, Unicef 2001), family problems and violence increase the risk of children being on the street.

Disabled children and adults: according to Inthirat (1999) 252,000 - 360,000 persons are affected by a permanent or temporary disability. According to a survey (HI and NCMR 1999) covering 400 000 people in Vientiane province a total of 27 % of the handicaps can be related to mental problems.

The psychodynamics of victims of mines and UXO is not adressed. Specialised services at the traumatology unit do not recognise any psychological troubles associated with accidents.

The high incidence of malaria and other infectious diseases might induce some psychiatric sequelae that deserve further investigation.

The Social Security Organisation (SSO) and the Community Based Health Insurance (CBHI) are providing some coverage for psychiatric illness.

4. Current human resource capacity in mental health in Lao PDR

There is a teaching board of psychiatry and mental health with 2 psychiatrists and 2 general practitioners who have received on-the-job training responsible to give lectures at the faculty of medicine. A short curriculum has been developed for medical students and nurses.

There is no postgraduate training in mental health organised in Lao P.D.R and no education program in mental health at the community level. The department of psychology at the National University of Laos has 9 professors. A general psychology textbook in Lao has been edited. The instruction that addresses the needs of teachers covers the fields of general, education and social psychology, and child-teenager development.

Analysis of other possibilities for human resources, such as non-medical workers or traditional professions

National Centre for Medical Rehabilitation / COPE / Handicap International

These structures depend on both the Ministry of Labour and Social Welfare (MLSW) and the Ministry of Health (MOH). The activities are oriented to the physically handicapped. The teamwork should also include a psychiatrist in order to provide psychotherapy to handicapped people.

Lao Disabled People Association (LDPA)
The association aims at promoting the rights of people with disabilities, empowering them to personal achievement, assisting them to develop their livelihoods and interests, and bringing about their full participation in society.

The National Ministry of Education. Many primary classes belonging to the inclusive education scheme are supposed to accept children presenting minor handicaps. A limited number of teachers received training about how to work with disabled children.

The role of monks and temple (wat)
Monks feel that they can deliver some messages to help people to face new challenges by reinforcing morality and solidarity. Meditation and relaxation can be useful in relieving stress and anxiety. We cannot consider as a general policy that the nearest temple be the place to receive some kind of treatment or support. Even if Buddhism developed a greater understanding of the human psyche, monks would need additional training to be able to cope with patients and to deliver care that goes further than teaching the five basic precepts and moral rules with stereotypic answers such as suffering being the result of excessive attachment and craving or karma.

The role of traditional healers
Religious rituals, spirit cults (possession or shamanism), conciliation ceremonies, offerings (kathong) and sacrifices are performed and traditional medicine is widely used. Setting integrated mental health care services with traditional healers could have positive results in interpersonal, intrapsychic and physiologic terms but their practices need to be more regulated and ethical guidelines developped.

Active participation of the family should be recommended because most families are able to provide more constant and persistent emotional and material support to their sick members, thus contributing to a better prognosis. Families nead also to be informed that positive stimulation could bring some improvements. One has to be careful about side effects such as embarrassment, resentment, criticism, excessive shame, and inappropriate intrusiveness.

Main findings and recommendations

- The Lao PDR is a multiethnic developing country, with a dispersed rural population, some in remote areas and some in small towns. Rapid environmental, economical, social and cultural changes are affecting people's lives. Poverty can be a cause and effect of mental health problem.. Increasing social gaps are inducing stress, family tensions and social violence, affecting mental health, particularly in urban areas. Moral values based on solidarity as well as Buddhist teaching and practices such as meditation are useful and should be promoted.
- In the mountains, the buildings of dams and deforestation, and the forced displacement of their villages, are affecting the traditioinal way of life and the traditional economy of some minority groups leading to increased worry about the future. Development projects should address these concerns, promoting cultural and languistic diversity along with modernisation.
- Apart from two psychiatric clinics in the capital with 2 trained psychiatrists and 1 neurologist, mental health issues have not been addressed. A short curriculum is taught to medical students at the Faculty of Medical Sciences and for the nurses but most medical professionals and common people do not have a general understanding of the meaning or significance of psychiatry, psychology, or mental health.
- Folk representations of mental illnesses are classified in 2 groups: mad and non-mad. Understanding of the causes of mental health is different according to the different socio-professional categories or class, but belief in spirits and magic is very strong. Sensitivity to these beliefs and the role of the healers is important because they do have a palpable influence on health care seeking behaviour of patients and families in the community.
- Health care seeking behaviours include various kinds of treatment, including traditional medicine and exorcism to chase the spirit. Western medicine is not excluded although there are problems as side effects are not well understood. In addition, the frequent need of long term if not life-long treatments is not well understood.
- This pilot study shows that apart from drug addiction, against which the government is commited to fight for some years already, epilepsy is also a serious and common problem due to the lack of appropriate treatment.
- Schizophrenics, if they become violent, may be chained at home for their entire life, as no treatment is usually available.
- Whatever the burden, the overall family and community response to mental health problems seems to be supportive and integrative. Any intervention should be careful to reinforce family intervention but also inform them that positive stimulation could bring some improvments.
- Chaining the mentally illoccured when families believed there was no other option.

- The use of Valium or other similar psychoactive drugs as self-medication is often reported but the degree of dependency is unknown; access to rational use of psychoactive medicine is essentially not avalaible in all Laos except Vientiane.

Priorities are:

- Raise awareness of policy matters; Mental health has to be promoted by development planers and advisory bodies as an integral part of national development and social mobilisation for health.
- Training and increasing the awareness and skills of medical professionals, community leaders, mass organisations, teachers, monks, traditional healers, social workers, and NGO's staff about mental health issues in their socio-cultural context. Mental health goes beyond drug abuse and should be adressed as such.
- Gathering more information and starting research about mental health issues.
- Implementing integrated, pluralistic, global care and services at 3 levels (villages, districts, and provinces) and considering innovative projects in the region as well as establishing interministerial links.
- Improving access to care and rational use of psychoactive medicines including patient follow-up and out reach work.
- Establishing rehabilitation and professional skills programs for people suffering from mental retardation and intellectual disabilities with the Ministry of Labour and Social Welfare.
- Reinforcing the inclusive schools program of the Ministry of Education.
- Promoting intersectoral cooperation within different ministries with a national committee.

Résultats principaux et recommandations.

Au niveau mondial, les problèmes de santé mentale ne sont pas bien diagnostiqués et traités alors que leur incidence est croissante et que leurs effets sur les individus, la qualité de leur vie et le développement socio-économique sont conséquents.

- La République démocratique et populaire Lao est un pays multiethnique en voie de développement; la population majoritairement rurale est dispersée dans des zones éloignées et de petites villes. La vie est affectée par des changements économiques, culturels, sociaux et environnementaux rapides. Dans les zones urbaines surtout, les distances sociales qui augmentent induisent du stress, des tensions familiales et de la violence sociale qui affectent la santé mentale. Des valeurs morales basées sur la solidarité ainsi que des enseignements ou des pratiques bouddhistes telle la méditation devraient être promues.
- Dans les montagnes, la construction de barrages et la déforestation ainsi que le déplacement forcé de villages accroissent les incertitudes par rapport à l'avenir. Les projets de développement devraient considérer ces soucis et promouvoir la diversité culturelle et linguistique tout en amenant une certaine modernisation.
- En dehors des deux consultations psychiatriques de la capitale (2 psychiatres et 1 neurologue), les problèmes mentaux ne sont pas encore traités. Un cours de base est donné en formation initiale à la Faculté des Sciences Médicales et à l 'école de formation de la santé mais la plupart des personnels de santé et des personnes en général n'ont pas idée de ce que sont la psychiatrie ou la psychologie et la santé mentale.
- Les représentations de la maladie mentale se divisent en deux groupes: les fous et les non fous. La compréhension des causes est différente selon les catégories socio-professionnelles mais la croyance dans les esprits et la magie reste prégnante. La sensibilisation des personnels de santé à ces croyances et au rôle des tradipraticiens est importante, car cela a une influence sur les parcours de recherche de soins, les représentations des maladies et l'intégration des malades dans leur famille ou dans la communauté.
- Les comportements de recherche de soins se réfèrent à différents types de traitements incluant la médecine traditionnelle et l'exorcisme, mais la médecine occidentale n'est pas exclue (quand les effets secondaires sont compris ainsi que la nécessité de traitements à long terme si ce n'est à vie).
- Cette étude montre qu'en dehors des toxicomanies (contre lesquelles le gouvernement lutte depuis plusieurs années), l'épilepsie est un problème sérieux et courant du à l'absence de traitement approprié. Elle affecte la vie de jeunes personnes et d'adultes compromettant leur avenir.
- Les schizophrènes sont parfois enchaînés à leur maison s'ils sont violents, pour toute leur vie en l'absence de traitements.
- Quelque soit le fardeau, les réponses de la famille et de la communauté aux problèmes de santé mentale sont plutôt positives, aucun cas de mauvais traitement n'a été reporté. Même quand le malade est enchaîné, cela semble la seule solution possible. Toute intervention devrait veiller à renforcer l'action de la famille mais aussi à l'informer sur les possibilités de faire évoluer les malades en les stimulant positivement.
- L'usage du Valium et d'autres médicaments similaire est courant, le plus souvent en auto-prescription mais le degré de dépendance est inconnu. L'accès à un usage rationnel des médicaments psycho-actifs est très restreint hors de la capitale.

Les priorités:

- Renforcer la sensibilisation en termes de politiques, la Santé Mentale doit être promue par les planificateurs de développement et les experts comme un élément du développement national et de la mobilisation sociale pour la santé.
- La formation et la sensibilisation des personnels de santé, des leaders communautaires, des organisations de masse, professeurs, bonzes, tradi-praticiens, travailleurs sociaux, personnels des ONG aux questions de santé mentale dans leur contexte social et culturel. La santé mentale dépasse les seuls problèmes d'abus de drogues et devraient être considérés comme tels.
- Réunir plus d'information et commencer des recherches sur les maladies mentales.
- Mettre en place des soins globaux pluriels et intégrés aux 3 niveaux (villages, districts, provinces) en considérant les projets innovants dans la région et développant les liens interministériels.
- L'accès aux médications, leur prescription et usage appropriés avec un suivi et une action en milieu ouvert.
- La mise en place de programme de formation et d'éducation pour les personnes souffrant de problèmes mentaux, retard mental ou intellectuel avec le Ministère du Travail et des Affaires Sociales.
- Renforcer le programme des écoles intégrées du Ministère de l'Education Nationale.
- Promouvoir la coopération intersectorielle entre les différents ministères avec un comité national de la santé mentale.

1. Introduction / Overview of mental health issue in developing countries

"Mental health is the foundation for the well-being and effective functioning of individuals. It is more than the absence of mental disorder. Mental health is the ability to think and learn, and the ability to understand and live with one's emotions and the reaction of others. It is a state of balance within a person and between a person and the environment. Physical, psychological, social, cultural, spiritual and other interrelated factors participate in producing this balance. The inseparable links between mental and physical health have been demonstrated" (WHO, WPR 2002, Regional strategy, p7)

There is a complex two way interplay between mental and physical disorders. The cost of mental illness is quite high. It can include the loss of employment and productivity and inducing a low quality of life. Somatic and psychologic effects can be severe and frequent if there is no follow-up and treatment. Violence is related to mental health, both in its causes and effects. In 1996, (WHA 49.25) the World Health Assembly declared violence as a leading public health problem.

Mental illness should be thought of as a personal illness within a family and cultural system. Referring to mental health one needs to consider individual persons and communities within three major dimensions:

- The biological, genetic and physiologic context.
- The psychological or psycho-development in its emotional cognitive and relational aspects.
- The social context: how the individual is settled in his culture and environment.

It is often considered that mental health is not a priority in a country where the health system is still under construction. In South East Asia, attention to mental health is relatively new, although there is little doubt that problems have always existed. The major concerns are: drug addiction, banditry, aging, and accidents with their attendant acquired mental damage. The burden caused by mental disorders is often perceived as being a relatively lower priority, mainly because of the large burden of communicable, maternal, perinatal and nutritional conditions. This is not necessarily true as pointed out in global burden of disease studies which place mental illness among the top five causes of disability adjusted life years lost.

For the Ministry Of Health of the Lao P.D.R, one of the aims of this situation analysis is to provide information to begin the process of establishing care and prevention units at the provincial level and to develop appropriate training curricula for medical professionals at the different levels.

(More information on Mental Health at the world level, see Annex 1)

2 Country context and mental health in Lao PDR

2.1 Socio-demography

Laos is a land-locked country of 237,000 square kilometres and a population of 5,377,000 (NSC – 2001 estimates). Seventy-five percent of the population live in rural areas and they are divided into 47-68 ethnic groups. The population is divided into three broad groups based on their origins, and the time and geographic location of their settlements. These are:

- Lowland Lao or Lao Loum, who make up 50% of the population, who are settled and leading the country since the 12th century, including several sub-groups, some of whom are non-Buddhist. Most Lao Loum are Buddhist, living in the plain. They are well represented in the administration and services, and represent about 35% of the total population, (Goudineau, p 23);
- Upland Lao or Lao Theung (35%) who are recognised as indigenous, belonging to the Austro-Asiatic language family; and
- Highland Lao or Lao Soung (15%), more recently settled in mostly the North, divided into two language families, Hmong-Yao and Tibeto-Burmese.

(Other data in Annex 2)

2.2 Socio economic context and influences

Laos is one of the poorest nations in South East Asia with a GNP per capita of US$ 350. The country relies heavily on foreign aid with half of government resources coming from external donors (UNDP, 1998). The unemployment rate is high although most Lao are subsistence farmers. According to a World Bank report (2000, p11-13*), "Inequality increased sharply in the recent years, the benefits of growth have not been flowing uniformly across the population and the proportional benefits received by the poor are less than those by the rich…Growth has not been good for the poor in Lao PDR. Economic growth led to a reduction in the standard of living of the bottom quintile of the population".* (More information in Annex 2)

Poverty is typified by the following:

- 22% of the population lives below a poverty line calculated as a basic income to provide minimum food intake, while some 46% lives below a poverty line that includes an allowance for non-food expenditure.
- Subsistence farmers represent 2/3 of those below the poverty line.
- The severity of poverty for the illiterate is double that of the literate.
- Female-headed households are identified as disproportionately poor.

The economy opened to market mechanisms at the end of the 1980's, allowing certain types of private business. Signs of wealth are now shown more prominently, such as costly vehicles, huge villas, and gold chains. This may be inducing some envy. Working in industry or in private foreign owned factories may also be inducing stress in a people once used to subsistence agriculture in a rice growing economy but now subject to the idea of productivity and intense production line work. The closure of

state owned factories or their privatisation are also inducing radical changes in some worker's lives, increasing their insecurity.

2.2 Education

Thirty-seven percent of the population over the age of six have never been to school, with females having fewer opportunities than males for education and urban people more opportunities than rural people. Only 0.5% of the total population have completed university level (about 22,875 graduates) and 0.1% postgraduate level (4,575 graduates).
Although Laos has not yet achieved universal primary education, it is competitive to be enrolled in the National University of Laos, the only university for the entire country. There are only 400 places available for a total of nearly 2,000 secondary school students each year. Some of the rest attend private professional colleges with training in computer, business and administration studies, or become unemployed.

2.3 Environmental influences

Mountains make up 2/3 of the country area and most of the non-Lao Buddhist ethnic groups live in this ecological environment. As much as 40% of the population live where they cannot be reached by roads. Deforestation, dam construction, and the displacement of villages in order to regroup diverse ethnic groups are forcing many to adopt new ways of life with its ensuing stress. The availability of local natural resources is changing and perhaps decreasing. Roads, markets, and access to modern communication such as TV support expose people to a new world for which they may not be well prepared. In the plains the risks of flood or drought affect their economical survival.

2.5 Cultural and religious influences: their incidence on mental health.

"Any efforts to provide mental health care or clinical services must begin with an understanding of local forms of distress and illness, systems of signs and meanings used to interpret illness and organize responses and local systems of care" (Desjarlais 1995).

The Lao PDR is recognised as a Buddhist country but for the most part it is the Lao Loum population that practices this religion. Monks are frequently consulted in case of problems or to help interpret bad dreams, bad feelings or strange behaviours. Monks usually give prayers to appease or relieve. Some monks are involved in magical practices and astrology or conjuring.

Animism is also part of the general belief system, either mixed with Buddhism or being completely separate. Numerous events are interpreted as a sign of the spirit presence, such as bad dreams, repeated accidents, and bad luck. Spirit houses in private gardens are common, although the practice was discouraged briefly after 1975. Spirits are to be fed with offerings, *lieng phi*, as they might be harmful if hungry. Many houses of different ethnic groups, including even the WHO compound, have an altar for either Buddha or spirits, and weekly or daily offerings of food, incense or flowers are made.

Attempts to minimize superstition or spirit belief systems have not been very successful. Sorcery and spirit healing practices are discouraged and pracitioners keep a low profile. Although it still occurs commonly, it is difficult to get information about such practicitioners.

Once forbidden after the revolution, *suk khuan (baci)*, the call of souls is a ceremony widely performed by the Lao Loum and increasingly by other ethnic groups. Ethnic Lao believe that each person inherits 32 souls which act as guardians over different parts of the body. For some reason, such as accident, shock, strong emotion or fever, these souls wander away or get lost and must be called back and charmed so that they can stay and provide protection. The animistic ritual of *suk khuan* is performed at significant events such as birth, death, illness, and departures. At the end of the ceremony, propitious white cotton thread is cut into short lengths and tied around the recipient's wrists, a gesture that symbolically connects the souls.

Christianity is very limited. Some migrants from the Indian subcontinent or South East Asia practice Islam with one mosque in Vientiane.

Family-based values and loyalty are widespread. Some ethnic groups are also structured with clans. Some changes in these patterns are occurring due to work migrations, such as young rural women coming to work in Vientiane and men going abroad, leaving their wife in charge of the household. Some children are left alone at home without much interaction with their parents. Divorces are thought to be increasing but no data is currently available. As in other countries, particularly in urban areas, familial structures are felt to be weakening and inter-generational links less tight, both of which may have a negative impact on child and youth development.

Since the 1975 revolution, Marxist rhetoric is propagated through the mass organisations (Lao Womens' Union, Lao Youth Union, National Front) that are deeply rooted and networked throughout the country. They tend to promote mutual understanding, solidarity, good morality, and nationalism. The national communist party is devoted to preparing a better future for the people. Its propaganda is deliberately positive and optimistic.

Economic and social changes are influencing the values, beliefs and way of life of Lao people, most rapidly in urban areas while life in remote mountainous areas changes more slowly. With the increase of purchasing power, people may have started to become more materialistic and consumerist.

Alcohol consumption is high for men as well as women. It is a widely shared social behaviour that is reinforced, as it is perceived as normal. The mass media (mostly Thai TV) have an influence on people's expectations. However, media access being widened could also be a useful tool for health education.

In spite of all of these changes and potentially negative influences, people in Laos have often been described as gentle, easy going, having a happy life style and cultivating harmony. This portrait can support the idea that Lao culture is supporting a mentally healthy style of living.

2.6 Health system and services in Lao PDR

(More information in Annex 3)

The Lao health care system is based on a network of 3 central hospitals, 18 provincial hospitals, 140 district hospitals, and about 500 health centres. There are about 12,000 villages with approximately 1,200 of them having a revolving drug fund managed by a village health volunteer or provider. Regular outreach services to villages are restricted mainly to immunizations, although other programmes such as malaria and family planning have limited outreach. Government health facilities are frequently underutilized, probably due to a combination of poor accessibility, lack of knowledge about the advantages of health services, and a lack of confidence in the health service. There are 2,000 private pharmacies and they are often the first contact of people with the health care system. About 2/3 of current health expenditure is directly from households, 1/3 used to pay fees at government health facilities and 2/3 used to purchase treatments from private sources, mainly pharmacies. The only mental health services are in Vientiane at Mahosot Hospital and Military Hospital 103.

3. Mental health services and facilities in Lao P.D.R

3.1 Administrative situation of mental health issues at the MOH

According to the MOH, mental health issues are completely new for the country. The shared concern among ministry officials is that mental health problems are going to increase due to the socio-economic situation that is generating stress and family and social violence. The national health plan doesn't mention non-communicable diseases and mental health as high priority programmes. There is no:

- Mental health policy.
- Mental health programme.
- Budget for mental health in the national health plan.
- Mental health reporting system. The actual hospital monthly report has one entry for asthenia. A proposed revised health information system will include epilepsy, psychiatric conditions, and road traffic injury, which will provide interesting data.
- Epidemiological study referring to mental health issues.
- Program for special populations affected by mental health illness or conditions.
- Professional network.
- Ministerial or Inter-ministerial committee for mental health issues.

3.2 General drug supply and availably of psychiatric drugs in Lao PDR

3.2.1 General drug supply

Drugs are delivered through government health facilities, revolving drug funds in health facilities and villages, and through private pharmacies and drug sellers. Drugs are frequently delivered without adequate information or labelling. Most drugs are

purchased on self-prescription and they are treated like a commodity and purchased, rather than as something requiring professional supervision. The irrational use of drugs is a major problem.

3.2.2 Availably of psychiatric drugs

A national drug policy with a list of the essential drugs was formulated in 1997. It includes psychoactive drugs such as amitriptyline, Valium (diazepam), imipramine, chlorpromazine, flupentixol, fluphenazine, and haloperidol that are available in the central hospital pharmacies as well as some private pharmacies. Mental health has not been part of the primary health care system and no treatment drugs are available at the primary level. However, Valium is very much used, as well as Tranxene, and there is probably over prescription by Medical Practitioners and informal drug sellers due to its popularity in providing relief for stress. (See Annex 4, more details).

3.3 Mental health care and professionals: the clinic at Mahosot hospital

3.3.1 Creation of mental health unit

In 1979, psychiatric consultations started at the Outpatients' Department of Mahosot Hospital in Vientiane with a Russian psychiatrist and his Laotian colleague. This evolved into the Mental Health Unit with 15 beds for adults only. The total number of mental health beds per 10 000 population is 0.03. As a comparison, Belgium has 18,000 beds for about 10 million people and Thailand 8,164 beds for 65 million people. The Mental Health Unit at Mahosot is staffed with 2 psychiatrists, 1 neurologist, 4 general practitioners, and 8 nurses.

3.3.2 The clinic at Mahosot hospital

There are both inpatients and outpatients at the mental health unit. The types of patients are:

- *Classical admission*

  Admission is designated for acute mental patients with an average length of stay of 2 to 4 weeks. Patients' families are allowed to stay in the mental health unit with the patients although the premises are not very suitable. Once the patients are stabilized and a treatment regimen established they are referred back to their community. They are expected to come to the mental health unit once a week for medication and psychotherapy. They are, of course, accompanied by one of their family members.

- *Ambulatory patients*

  This type of service is for minor psychiatric troubles or minor psychological problems. The psychiatric team sees patients in this category once a week, accompanied by their family.

There is no specialized centre in Laos for community treatment such as a hostel, therapeutic apartment, or host-care family system. Family participation is relied upon and utilized to handle the patients. There is no psychologist, no social worker

specialised in mental health issues, and no NGO involved specifically in mental health although some say it is a component of some projects. (Annex 5, more details).

3.3.3 Frequency of psychiatric disorders at Mahosot Hospital

- Table 1 (in annex 6) shows that the most frequent psychiatric diagnoses in 2001 are epilepsy (26%), followed by substance abuse (23.9%), schizophrenia (13.7%), and neurosis (11.2%).
- Table 2 (in annex 6) demonstrates the evolution of psychiatric diagnoses from 1996 to 2001. It is observed that the prevalence of psychiatric diseases presenting to the Mahosot Mental Health Unit varies from year to year.

In 2001, the total number of patients suffering from mental problems decreased to 519 but the difference between the rate of admission (45.5%) and the ambulatory patients rate (54.5%) is not highly significant. The largest numbers of admissions are affected by substance abuse (21%), followed by bipolar disorder (5.2%), epilepsy (4.8%), and neurosis (2.7%). The number of schizophrenic patients has decreased to 13 (2.5%) perhaps indicating underservice for this population.

It is noted that to date, Post Traumatic Stress Disorders or acute trauma has not been a category included in the diagnostic profile, nor have anxiety disorders been a diagnosis.

3.3.4 Difficulties / Obstacles

The obstacles and difficulties in providing good mental health care include the following:

- The number of beds for the whole country is quite limited. The Mental Health Unit is the only place providing mental health care.
- The patients are mixed no matter what the diagnosis, gender, or age.
- There is only tertiary care with no primary or secondary mental health care system.
- There is a lack of experience in the field of psychiatry and mental health, both psychiatric specialists and knowledge in non-specialists.
- Data collection on mental health is still limited. Data registration on mental illness is gathered only at the mental health unit of the Mahosot Hospital and the extent of hospitalization for mental illness among general hospital admissions is unknown.
- Follow up based on outreach work has not been implemented.
- Recreational activities, as well as professional training and rehabilitation for patients, are not available.
- Evaluation and research information is to help set priorities and assess progress is lacking.

3.3.5 The clinic at the military hospital No 103

The psychiatric unit was established in 1978 with 14 beds, 8 for psychosis and 6 for minor psychiatric illnesses to provide psychiatric care for soldiers. It was originally staffed with two general practitioners and three nurses. At present, this unit is still

composed of 14 beds but the number of staff has increased to four general practitioners, five medical assistants and 13 nurses. The average length of admission is one week. After discharge the patient should come for weekly follow-up. 176 mental patients sought treatment at this unit from January-October 2002. The majority of cases are related to drug addiction. There were only ten psychotic patients. Out of 8 depressive cases one case did commit suicide. Seven cases were considered psychosomatic with symptoms such as insomnia, chronic fatigue, and neurasthenia.

Drugs available at the unit are aminazine, largactil, fluanxol depot 20 mg, and tryptanol which are mostly ordered from a Vietnamese laboratory in Ho Chi Minh City due to their lower price. Medicines are sold at an affordable price in order to assure the recovery fund of the unit. If patients are unable to pay drugs, they can get them free of charge.

Some recreational activities are provided for those addicted to drugs, such as drawing or sports. Home visits are organised and conducted by a home visit team of a doctor and a nurse. This work is not sponsored by any organization.

3.4 Forensic psychiatry and public policy: legislation and regulations

Article 18 (page 96) in the penal code mentions that minors below 15 years of age and persons suffering from mental disorders are not responsible according to the law. The code of penal procedure (23/11/1989) gives more details on the process. In most of the cases, conciliation is obtained either by village leaders or the police before the offences reach the tribunal. If there is a suspicion of mental disorder the police will lead an investigation and refer the person to the hospital for diagnostic evaluation before sending a report to the tribunal where the judge will decide what to do. However, psychiatric evaluation is only available in Vientiane.

In Xieng Khuang some years ago, a man was advised by a fortune teller to kill two white chickens in order to win at the lottery, but instead on his way back home, he met two young girls with white clothes and killed them. He has been sentenced to death.

Civil damages are to be paid by the family who is considered as responsible. If there is a need to look after the mentally disturbed, the head of the village might be requested to arrange this. Mad people should not be in jail but some epileptics can be, as epilepsy is not considered as a mental health disease. Mental illness is not considered as a reason for divorce. In fact, spouses are supposed to support each other in case of illness.

There is very little information about forensic psychology and psychiatry in the curriculum at the faculty of law and none at the school of magistrates.

4. Methodology and main results of the situation analysis.

4.1 Methodology

Key informant interviews were conducted as part of the situation analysis. A questionnaire was developed which led investigations into key areas. As a socio-cultural research it was mainly about meaning, i.e. what is done and said in terms of mental health and illness with a larger understanding of the whole context.
The main issues are:

- Mental health understanding in general and an evaluation of the situation by the person being questioned.
- Beliefs about mental illness and its causes.
- Description of the health seeking behaviour and explanations for those patterns.
- The availability and character of care in the family and community.
- Intervention models, which might be culturally acceptable and technically feasible.
- Cases studies with in depth interviews of patients, where possible, as well as relatives and other informants, including an opportunity for those questioned to give advice and suggestions.

86 interviews were completed, 40 with medical professionals (district health director and village clinics doctors, nurses etc) and 46 with other key informants who included village leaders and teachers, monks or healers. Sick people and families were found by a snowball sampling method and selected according to the seriousness of the cases as described by the informants A more detailed description of the methods and findings is in Annex 7, 8, 9.

4.2 Main results

4.2.1 Community perception of mental health illness.

What is known/done about mental health? What is the perception of mental disease (lok chit or pannyat chit).

In general, mental health is referred to as (see table in Annex 10):

- "chit chay" : the spirit and the heart.
- "neo kit": the thought.
- "samong, sen pasath, labob pasath" : physiology, the brain, nervous fibres and the nervous system (medics provide more answers in terms of organic references).

Many people have no idea about the main mental health problems. Apart from insanity with obvious abnormal behaviours, mental suffering is not recognised as such, or mentioned as a problem.

Mental disease is perceived as one of the following:

- Behavioural disorder.

- Brain damage.
- Cognitive disorder: troubles of memory, speech, and hallucinations.
- Affective-emotional disorder.

Physical appearance is seen as a sign of mental disease, e.g. untidiness and dirtiness. Few informants have mentioned sleeping disorders as resulting from mental health problems.

4.2.2 Evaluation of the mental health situation in the community

Problems mentioned (see Annex 11) as occurring in the community or professional practice include:

- Drug abuse, including alcohol.
- Family violence.
- Social problems such as conflicts, gambling, or delinquency.
- Suicide.
- Senility.
- Sexual abuse and child abuse.
- Abnormal behaviours (mostly referring to transsexuals).

The general feeling is that due to the opening of the country and a more economic-materialistic oriented life style, mental health problems are increasing while social control and morality are decreasing. Examples of problems associated with mental illness include:

- Challenges for improving daily life, such as work or hard study and social activities such as gambling are seen to be putting pressures on people, particularly in urban areas, leading to tensions and conflicts in the communities and families.
- Parents don't take care of their children. Children ask for money from their parents to go to video games where they get bad habits.
- The poorest feel that they do not have access to a better life and services such as education and health care. Life is getting more difficult for them within the current context of rapid societial change.
- Individualism and competition are less accepted in a society that has traditionally promoted some egalitarianism and in a society less used to the concept of life as a struggle for survival.
- Expectations are getting higher while dreams seem to be inaccessible. As one monk said, “people become are getting *ba yak dai*, (mad desire have) they suffer from craving madness”.

The effects of precarious socio-economic conditions and poverty on mental health have already been widely described and acknowledged (Rosa 2000). Our results suggest that socio-economic changes as well as increased poverty for the poorest are inducing social and mental problems, as expressed by women in a recent report (Lao Womens’ Union, 2002).

4.2.2 Lao folk representation of mental illness

By incorporating illness categories that are meaningful to local people, a more equal allocation of power across indigenous and non-indigenous approaches to treatment can be realised. Our general findings (more detailed table in Annex 12) are showing that for non-professionals:

- The understanding of mental disorders will mostly provide a dual classification, mad versus non-mad, based on the symptoms. Further distinctions may be made based on the causes.
- Madness is recognized and labelled by most of the villagers with a high degree of reliability in the absence of psychiatric treatment.

This seems to be true for a range of psychiatric disorders. Folk diagnosis could be a reliable source for finding the ones who are suffering from psychosis. However, caution should be exercised. It is important to pay attention to the personal history in order to understand better the symptoms within their socio-cultural context.

The mad category

The insane (ba) are described as presenting unusual thought and behaviours. They might be dangerous. Other subgroups of mad refer to the aetiology attributed to the problems or to their behaviours. (See details in Annex 13)

Madness attributed to spirit (phi ba) is the major category of madness. Some doctors and officials mention that it depends on belief. Witchcraft and spells are still present in the minds of most people. If not convinced themselves, they refer to this as a strong belief of others, either due to non-belief in spirits or because they do not want to be suspected of believing in superstition. “Mon” is supernatural power derived from the Sanskrit word “mantra”. It can be learned. Monks are supposed to get magic (mone) as well.

Most acknowledged of the so-called mad is epilepsy with 70 informants mentioning it. Diagnostics should be used to confirm cases if possible. Epilepsy is well known in the traditional nosography in Lao (and in Khmer) as “ba mu”, pig madness. Epilepsy is understood as a genetic or hereditary disorder by medics and other informants, but spells and spirits are not excluded as causes as they are felt to be able to damage the nervous system.

The non-mad category

These diagnoses are more mixed. This category refers to several pathologies including depression, Down’s syndrome, and psychological/intellectual dysfunction including mental retardation. It also includes some abnormal behaviour in the Lao socio-cultural context. Causes are primarily attributed to organic problems such as nervous fibres/system and brain damage or genetic (kamaphan). Various causes are also mentioned such as:

- External spell or spirit attack-possession.
- People breaking a taboo.

- Defective family care and education.
- Food deficiency.
- Contraceptive medicine (affecting brain).

The deficient mainly mental retardation category (bo them, unfilled) is common. Symptoms are low skills, poor memory, poor understanding, verbal difficulties, and slow mobility. It can be related to mental retardation or intellectual deficiency. Lost heart “sie chay” is not pathological as such. It is widely used in common interactions but its severe form can be associated to depression “seum sao”. Other words are used for fun in everyday life, they are a kind of condemnation of socially disapproved behaviours without necessarily being considered as psychiatric disorders.

4.2.4 Main causes of mental disorders named by informants

The origins of mental health problems (see table in Annex 14) are mostly linked to:

- Social, family and economical factors (68+61/86).
- Biologic factors such as physiological and neurological impairments (30+51/86).
- Psychological factors (61/86 informants).
- Accidents (46/86 informants).
- Malnutrition was mentioned by one fourth of the informants and can be related both to its physiological effects and its economical origin.

It is surprising that magic has such a low rate (21/86) compared with the previous folk categorisation. The high proportion of medical personnel and the fact that the interviewers are either medical or foreigners might explain the relative paucity of magic as an aetiology of mental illness. This result is contradicted by the case studies and may demonstrate the phenomenon of telling investigators what it is felt they want to hear and reinforces the need to get data from multiple sources.

Interviewing patients or their families, we found that spiritual causes are perceived as being predominant, followed by genetic and biological causes (see table in Annex 15). Genetic causation has to be broadly understood as not only medical. It can refer to karma as well. *"In the Lao culture, some wrong doing in previous life, karma effects, might lead to madness"* declared Mr Rattanavong, director of the National Institute for Research on Culture.

A chain of events or connectedness in aetiologic diagnosis is frequent in our informants. In several cases, patients or their family enunciated pluralistic aetiologies, looking for answers in both traditional and modern treatment contexts. For example, it is believed that a spirit or a spell attacked the nervous system or the brain, so that the patient can look for medicine to repair the brain with a medical practitioner and also deal with malevolent spirits to appease or chase them or lift the spell with the appropriate traditional healer. People are not making these links between traditional healers and medical practitioners as such. They just combine or add the different diagnoses. The two professions do not actually meet. However, the door might be open to some joint intervention.

4.2.5 Health professionals' nosography, diagnosis and understanding of mental health problems.

Epilepsy is well described and recognised based on symptoms only. Case histories are usually not investigated. In rural areas, poorly trained medical assistant and nurses have little or no knowledge about psychiatric nosography and treatments. In urban areas, about a third of the hospital medics are able to describe the symptoms of schizophrenia and mental retardation. One fourth recognise depression, while only a few of them know about other major problems such as neurosis, bipolar disorders, paranoia, and Alzheimer's disease. Post partum has been described as a mental problem by over a third of the Medical Practitioners interviewed, although its exact nature is somewhat hazy.

4.2.6 Ways in which people seek help and how do they present to services

The common representation of problems, beliefs about their origins, and health care seeking behaviour are linked. The way the treatment is received, accepted, and understood depends on these representations as well as the representations of healing.

All the medical practitioners (MP) believe that modern medicine can be effective in treating mental disease while only just over half of the key informants believe so (68/86). Moral support is suggested as being effective (59/86), although this is not surprising considering the causes (social and family) identified for mental health problems. Traditional medicine got the same score for people as modern medicine (28/46) but only half of the MP thinks that it can be used (51/86).

Religious treatment at the temple is also felt to be effective for more than half of all the informants (55/86). Spiritual, magical treatment, while denied to be effective by ¾ of the MP, is mentioned by more than half of the other informants. The same discrepancy is shown toward diviners even if less obvious. Magical string and traditional souls calling ceremony performed by Lao from the plain is believed to be effective in reinforcing, if not curing, by a majority of all the informants (22/40+29/46). It is believed that while evil spirits can cause illness, presence of the good souls (khuan) preserves health and good fate.
Diviners, (Mo do) are supposed to be able to make bad luck (sie khock) disappear. 17/46 key informants and only 5/40 MP mention them.

We notice a difference between people and MP considering these answers showing that their understanding of treatments are quite different. These issues should be raised in the MP training curriculum on mental health.

Treatments sought by those patients in case studies (see Annex 16) are showing that:

- Non-medical care has been used by nearly half of the cases we met.
- One third were referred to MP, mostly for epilepsy.
- One-fourth used traditional medicine, which was considered potentially useful for mental health problems.
- The necessity of long-term prescription for psychiatric drugs is often not understood by the patients or their families. The belief is that one is sick or not sick. If he is not sick, he doesn't need to take drugs any more. If he

remains sick, it means that the agent that induces the disease is still present, so the medicine is not effective. This can lead to complex health care seeking behaviours. In several cases, the treatment has been stopped after some improvement and families don't understand why the patient got sick again and this will present a challenge to improvement in the care of many mental conditions.

Health care seeking behaviour has to be understood within this type of framework of interrelated explanations and practices.

Buddhist	Cosmic	Biomedicine	Humoural	Animism
Karma	Horoscope	Organs	4 elements - wind	Spirit possession/loss

4.2.7 Current prevailing societal attitudes towards mental health patients and mental illness in Laos

Mental health is perceived as: living in harmony with the society, doing things that are expected by the community, having stable mind, sharing happiness and fun.

Mental illness is perceived as: disturbing behaviour for the family and community and showing personality disorders. Disorders in the person that would be referred as mental health problems are mostly acknowledged when they develop a social incidence. As in Cambodia, (Van der Put and al, 1999, p 4) *"psychosocial problems are sometimes equated with mental health problems"*.

In the past, some villages gathered persons accused of being phi pop. Ban keun was a village for phi pop last century (Raquez, p134). According to the author who didn't visit the place, 500 persons lived there excluded by the society and isolated. A sane person ran the village, maintained it very clean and managed the community. Ban Nakasang mentioned by Hours (1973) in Champassak province, Sanasomboune district, is still a village where people possessed by spirits including epileptics resettle with traditional healers. The reaction against phi pop can be very violent, according to some of our informants leading to their eviction from the village and assassination. Sorcerer killing happened until recently in Cambodia and in Bali during political tensions, they have been also reported in southern Laos.

A Handicap International report (HI and NCMR 1999) shows that the disabled didn't usually perceive of themselves as being thought of badly. It is unclear whether this extends to the mentally ill. (See Annex 18)

The majority of our informants expressed pity towards mentally disturbed persons. Some did mention being afraid of violent behaviour. We found that the patients we met were well accepted and well treated in their family and neighbourhood. This may seem incongruous in that some patients were chained. However, chained patients are washed, fed, and received some visits from their former friends. “Mad people are not much discriminated, and they are chained only when their behaviour might be harmful for them or for others" according to Mr Rattanavong, director of the National Institute for Research on Culture. Basic needs are always provided by the families (food, shelter, and clothing) but the Medical Practitioner informants estimate that often there is no care as patients are just let free to wander around. It is true that many families who have already tried a wide range of treatments, although not always medical ones, they often have no hope and feel there is nothing else to do but to release the patient. Some maltreatment is also mentioned as occurring during rituals that are supposed to expel the bad spirits, e.g. biting the patient.

The impact of mental health problems varies depending on the situation (see table in Annex 18). Some key findings are:

- Mental health is described as an economic and familial burden, difficult to bear in some impoverished families who spent a lot already to treat unsuccessfully their member and lost some of their belongings, such as rice fields, buffalo, etc.
- Medical practitioners mention the psychosocial consequences where some patients become indifferent and can't share in their family life, which can worsen depressive symptoms.
- Several informants mentioned that problems associated with mental health and illness or disabilities are growing.
- Shame is rarely mentioned. It seems that responsibility for the disease is not directly attributed to the patient or his family.

It seems that the level of discrimination and stigmatisation of both patients and families in the villages is low. Most people express tolerance and compassion towards the mentally ill. This is positive and may allow the development of community based integration programs more easily than in some settings. More in depth research is needed to support this assertion, as some testimonies from other social or health workers are contradictory. (See Annex 18).

4.2.7 Who can help?

Our results (see annex 19) show that:

- Doctors are the first persons supposed to be able to help, followed by families (more than ¾ of answers), friends, neighbours, mass organisations and village leaders. This shows the importance of human relations in order to support patients and their families with counselling, promoting healthy life, and referring to doctors.
- ¼ of medical professions don't know about the role of a psychiatrist and ¾ of the other informants are unaware of such professionals.

4.2.9 What could be done within the National Health System?

- More than half of the Medical Professionals call for the opening of a psychiatric consultation clinic in the hospitals. The hospital solution is mentioned by just over a ¼ of the non-medical informants, but not by the concerned families.
- Specialised hospitals are also mentioned as are specialised villages for the most severely mentally disabled, based on the model used after 1975 for the handicapped veterans. The idea of regrouping “mad” is based not so much on the treatment perspectives that can be offered but more on the idea "to keep clean the streets". Creative models for community care seem to be lacking.
- Professionals, families and mass organisations largely call for training. Mental health issues are still very mysterious and people want to know about them.
- It is understood that the Ministry of Labour and Welfare should also be involved in supporting patients and their family for job training and social reintegration. There is a disability benefit for persons with mental disorders from the Ministry of Social Welfare but none of the persons visited received any support.

4.2.10 Psychiatric drugs prescription and consumption

The following information was gathered on the use of psychiatric drugs:

- Anxiolytics :
  Valium or diazepam is a well-known and famous, if not infamous, medicine in Laos. People don't hesitate in buying it on self-prescription if they don't sleep well. Doctors prescribe it, as well as the closely related Tranxene and Lexomil. We met several cases of improper prescriptions of Valium for epilepsy or schizophrenia.
- Anti-epileptics
  Phenobarbital is prescribed or used by less than half of medical informants (Depakene 1 case). To our concern it is not available in remote areas and instead anxiolytics or anti-histaminics are delivered in some cases.
- Antidepressive: tryptanol or amytriptyline is used among the GP.
- Neuroleptics: haldol, largactyl are known but usually not available out of Vientiane. Mostly psychiatrists prescribe them.

A grave concern is that some neuroleptics are used in isolation without medication for neurological side effects. Thus, some patients are at risk for TDK (tardive dyskinesia) and permanent damage, thus increasing the burden of care on the community.

4.3 Specific issues arising from the research

4.3.1 Major mental illnesses: schizophrenia and neurosis

Psychosis and schizophrenia

The following information was gained (more details concerning schizophrenia are given in Annex 20):

- The term ba (mad), apart from ba mu (epilepsy) generally refers to schizophrenia.
- We are not able to present any epidemiological figures but 13 cases of 'mad' have been reported by villages' leaders for a population of 10,507 inhabitants in 11 villages. Psychiatrists have not validated this diagnosis. The researchers have not checked the exact number, asking for example more than one informant in each village.
- There is a need for better differential diagnosis in this area, such as psychotic-like symptoms that emerge from acute traumatic episodes.
- Most of the schizophrenics we met remain untreated by mental health professionals. Some families contained them or chained them at home. Others let them wander around, being fed by family or neighbours. Some are safe and some unsafe. Given the attachment to land and place, being chained at home and visited by community was believed to be more pro-health than isolated and overmedicated with strangers in a hospital unit far from home. If community treatment alternatives could be offered, this practice of chaining could be stopped. Some of the cases diagnosed as schizophrenics without treatment can work and support themselves, they have rice fields, they catch fish, and usually they have no marital life and no children but their relatives are living near by.
- Spiritual explanations are usually provided while referring also to brain or the nervous system as being damaged.

Neurosis, anxiety disorders, and other conditions

The following are the major findings in regards to neurosis and anxiety disorders:

- Only 3 cases of major sleep disturbance have been mentioned during the research. This problem may have been under-reported as the use of Valium in cases of economic problems or family conflict is common, but this is usually not seen as a mental problem as such.
- In the Lao culture, expressing sadness is not common, so it is difficult to assess internal emotional states. People try to hide their negative feelings, perhaps leading to smiling depression or psychosomatic disorders. (More details in Annex 20)
- Some patients presenting a somatic form of depression have been referred to the psychiatric unit by their family doctor. Tryptanol has been prescribed successfully.
- Apart from megalomania (ba nyot) other forms of neurotic behaviour such as obsessive, perverse, or mania are not recognised as such.
- Few bipolar or manic-depressive patients have been seen at the Mahosot clinic.

4.3.2 Suicide

Suicide is a major cause of mortality in several countries of the WP region where it is estimated that at least one million people attempt to take their life every year. It is among the 10 leading causes of death for all ages in most of the countries and in some among the top three causes of death for people aged 15-34 (WHO, 1998 p 78). It is a sensitive issue in Laos and it is difficult to get reliable data about suicide. In

neighbouring Thailand, the rate reached 8.6 per 10000 in 1999 and has been rising on a yearly basis. (National Mental Health Report, 2001, p 46)

When asked if they know any case of suicide (ka to tai) several of our informants said no, but if we say, "did you hear or meet any people who tried to drink poison?" then some cases are mentioned. Cases whose attempt was not lethal are probably under-reported. In the Lao culture, the one who takes his own life will be buried out of the pagoda and his wandering souls (phi tai hong) might be harmful to his relatives and other people. This behaviour is condemned by society. However, our 96 informants have reported 25 cases, mostly related to young people with relational problems with their parents, spouse, or boy/girl friends. Only 3 cases of attempted suicide presented at the psychiatric clinic.

4.3.3 Substance abuse including alcohol and tobacco

Substance abuse has been reported as a major mental problem apart from remote villages in Sekong where it is just starting. Alcoholism deserves more attention. However, alcohol consumption is deeply rooted in social behaviour, so it is difficult to find out the addicts.

A previous study (Choulamany, 2000) has shown that the use of Amphetamine-Type-Stimulant (ATS) has been increasing since the mid 1980s (Kamiemiecki, page 4). The prevalence of use with school pupils is from 175 per 1000 in Vientiane to 11 in Luang Prabang (details in Annex 21). The male school population is more prone to Ya-Baa use than females. The most susceptible age group is between 15 to 19 years old. The mean age of first ATS use is 15.4 in Savannakhet, 15.6 in Vientiane, and 16.5 in Luang Prabang. In summary, it has been noted that ATS users seeking treatment at the Mental Health Unit tend to be younger than opioid users, exhibit a wide range of psychopathology associated with their methamphetamine use, and the most affected age range is between 15-19. Males are more affected than females, most of them are students of secondary school, and usually school performance deteriorated due to the lack of concentration, lack of attention, and mood disorder although none of them dropped out of school completely. They were mainly from higher socio-economic classes. ATS use has also been reported with manual workers and speedboat and truck drivers.

During this survey we found out the following concerning ATS abuse:

- Out of Vientiane, no treatment is provided, so cases are referred to the police following parents request, and sent to custody.
- Only 29 cases in Vientiane municipality have been reported. This number is probably underreported as only village leaders report it.
- Alcohol use and abuse is hardly reported, as it is not socially condemned.
- The danger of developing schizophrenia from use of ATS has not been explored yet.

We didn’t include tobacco in this study although it is a growing threat in terms of public health.

4.3.4 Mental retardation, intellectual disabilities and acquired brain syndrome.

"Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the development period which contribute to the overall level of intelligence i.e. cognitive, language, motor, and social abilities". (ICD-10, classification of mental and behavioural disorders, 2 p 226). Many words refer to mental retardation in Lao. All key-informants recognized mental retardation and could describe symptoms. Down's syndrome is not classified as a specific category but belongs to a general group called "bo them" which means incomplete. 27 cases have been reported in our samples. Usually they stay at home or with their family, few of them get married, and many just wander around. Intellectually disabled children are at risk for physical and sexual abuse. (More information as well as one case is reported in Annex 22).

4.3.5 Epilepsy

Epilepsy is the most common serious brain disorder worldwide with no age, racial, social class, national or geographical boundaries. (More information in Annex 23) Epilepsy is characterised by recurrent seizures. Epilepsy affects 1 in every 100 people and represents a heavy burden on patients and their families. Most of the people interviewed know at least one case of epilepsy.

The major concern related to epilepsy is access to appropriate treatment. For example, one case was treated with Valium and Phenergan to prevent the crisis. In Sekong, no case is treated and phenobarbital is not available at the Tateung district hospital. Phenobarbital raises serious concerns in terms of side effects and families and patients should be informed. It should be prescribed very carefully as overdose can be lethal and ideally there is close follow-up, but it is is known that widespread use of phenobarbital would decrease the morbidity and mortality from epilepsy.

Medical Practitioners should be cautious when using these diagnoses made on behaviour rather than case histories. They should not desist from detailed history taking and clinical investigations where appropriate. Not every seizure should be diagnosed as epilepsy as cysticercosis or other causes of seizures have to be considered.

4.3.6 Women and mental health

In terms of mental health problems in our small sample, 25 female cases have been reported against 70 male. It leads us to suspect some under-reporting of the womens' mental health issues. Contrarily, more women than men reach the psychiatric consultation at Mahosot hospital for unexplained reasons. In Laos, women are responsible for all house related activities including children's education. Having a lower education level than men on average, many women still try to find some income generating activities. A lot of burden lies on their shoulders. They are the ones in charge of care giving for most of the mental health patients.

Other gender related issues include:

- The case of old Katu men (over 60) wanting to start marital life with young females or children (case study is presented in Annex 24).
- Family violence as well as sexual abuse has been poorly reported.
- Post partum seems not to be a major problem (see discussion in Annex 24).

4.3.6 Child and mental health

- Nutritional deficiencies
  Malnutrition is understood as a cause of mental disability but we don't have any strong information in Laos to support this assertion. Forty percent of children in Laos are stunted, indicating chronic malnutrition.

- Iodine deficiency.
  The sequelae of the lack of iodine can be severe as it leads to cretinism. In 1993, 95% of children suffered from lack of iodine and it was severe for 65% of them. However, universal salt iodisation now reaches 75% of the households, according to the National Health survey in Lao PDR (2001). According to Unicef and others, more investigations are needed, particularly in the more remote areas; to ensure that universal iodinisation of salt is achieved.

- Child abuse and domestic violence.
  Cases are hardly reported. According to one report on street children (Delneuville, Unicef 2001), 44% of all the street children interviewed said that mostly their fathers had physically abused them. 22% say a family member is addicted to drugs. Family problems and violence are reported. They increase the risk of children being on the street as such family violence is a major cause for children to leave their house. One doctor from the bacterial analysis laboratory (Mahosot hospital) mentioned that it is not so rare that children are referred for an STD, leading to suspicions of family abuse. A recent report on street children's mental health (Delneuville, Unicef, 2001) provides interesting information concerning street children who show a high level of stress. (See Annex 25). We need more information on child rearing practices, the impact of poverty, and the importance of school pressure on children. We have no information on the mental health of children in orphanages.

4.3.8 Disabled children and adults

According to Inthirat (1999), in Lao P.D.R, 7 to 8% of the population is affected by a permanent or temporary disability. According to a survey (HI and NCMR 1999) in 4 districts in Vientiane prefecture and 3 districts in Vientiane province, covering 400 000 people in 370 villages; the rate of handicap is 0.8%. That is less than the average in other less developed regions. The following information is available from the surveys:

- The fourth cause of disability in this study was intellectual, representing 10% of the cases,
- Psychological problems were sixth, 7%,
- Multiple handicaps represent 6%, and
- Epilepsy, 4%.

(See the contributors to handicaps in Annex 26)

4.3.9 Elderly: old age dementia and senility

Old age dementia is present in all populations but it can be experienced differently according to the socio-cultural and economic context. Kleinman shows that it is significantly constrained by shared psychobiological processes so that their form bears some resemblance in different societies. Most of the families report forgetting things, incontinence, talking about the future and the past, spatial and temporal disorientation (wandering around) but not yelling, or aggressive behaviour. Their relatives usually provide all the elders' needs. As related by Olson (p 94) for the Hmong, "They become nearly invisible, don't seek for treatment and remain at home". Four cases have been reported in our survery. We met one that is presented in an Annex 27.

4.3.10 Post Traumatic Stress Disorders

No case reported, (see Annex 28 discussion about trauma)

4.3.11 UXO and land mine victims

The July 2002 Report of UXO cases (OPS-UXO Lao, 01/01-31/07-2002), for the six first months of the year, relates 37 accidents resulting in 82 victims, including 35 children 58 injury and 24 deaths. The toll, since the end of the war, could be several thousands victims.
The psychodynamics of victims of mines and UXO is not recognised nor treated yet (see Annex 28).

4.3.12 Accident victims and trauma

Road accidents are increasing. Due to the lack of use of helmets their effects are worse. Traumatic injuries can be debilitating. They are mentioned by half of the informants as a potential cause for mental illness. Specialised services at the traumatology unit do not recognise any psychological troubles associated with accidents, although Lao tradition provides already psychodynamic rituals, such as the call of souls that might have left the body during the accident. Three mental health cases have been mentioned as resulting from accident injury.

4.3.13 Other issues

Infectious disease and mental health.

In some cases, undiagnosed high fever (malaria, encephalitis, meningitis) during youth has been mentioned as one of the causes for mental disorders such as seizures and psychosis. The high incidence of malaria in some areas might induce some psychiatric sequelae that deserve further investigation. The Thai army stopped using mefloquine as it was suspected to generate burn out or violent crises. The effects of

long-term use of anti-malaria treatment on mental health should be considered although the adverse effects of malaria itself almost certainly outweight any risk from anti-malarials.

Somatization and mental health

The presentation of physical symptoms without organic pathology is extremely common in all areas of medicine. It has been frequently described in South East Asian refugee patients (see Annex 29). Relations between psychosomatic disorders and mental health are widely reported in the scientific literature. It is an area not investigated in this situation analysis.

Amok or Sudden Mass Assault (burn out)

This occurs rarely. One case is reported from the Ministry of Justice. (See Annex 29)

Coping with the past: incidence of war and revolution

Mental health problems have been reported in the villages built after the revolution for the handicapped war veterans. Due to time constraints, we have not been able to visit these places.

HIV /AIDS

The impact of HIV/AIDS on the mental health of patients and family members is recognised. We didn't meet any case yet apart from the recent suicide of a young service woman after learning she was HIV positive.

Mental health in jail and police camps

No information has been directly collected, during this study. Some people suffering from mental health problems might be sent to jail if their behaviour is too disturbing. No detainees presenting mental health problems in jail have been referred to the psychiatric clinic, apart from one case of a foreigner. An informant reported severe mental health problems affecting drug addict teenagers sent to police camps.

Homosexuality- transgender issues

Some informants mentioned homosexual and transvestites (katoey) as abnormal behaviour cases. It doesn't seem to be a major concern and the ones who can't adapt to the Lao society move to Thailand where they expect to find a better future.

4.4 The National Ministry of Education and mental health issues.

Many primary classes belong to the inclusive education scheme (89% in Vientiane including most of kindergardens and primary schools but only 13% in Huapanh, the

national average 47%). These classes are supposed to accept children presenting minor handicaps and being able to learn without disturbing the other pupils. Some teachers received training about how to work with disabled children but a lot of them still need to be trained as these classes might accept all kinds of handicaps (see Annex 30 description of one school). The Ministry of Education is involved in the fight against drug abuse with a nation wide campaign.

Mental health problems have been reported on the university campus at Dong Dok, mostly related to students coming from the provinces. Learning problems might lead to suicide attempts when the students failed the exams. Other students are depressed and miss their family and village. Others are overwhelmed by economic problems.

4.5 Health Insurance and mental health.

The Social Security Organisation (SSO) and the Community Based Health Insurance (CBHI) are providing some coverage for psychiatric illness. AGL, a private insurer, provides insurance only in cases of traffic accident as mental health, including epilepsy, is excluded from their health insurance package.
(See details in Annex 31)

5 Current human resource capacity in mental health in Lao PDR both specialists and non specialists

5.1 Mental health training at the Faculty of Medical Sciences and the faculty of psychology, National University of Laos

5.1.1 The Faculty of Medical Sciences (FMS)

General presentation of the FMS (see Annex 32)

Undergraduate, postgraduate training and in-service education on mental health

There is a teaching board of psychiatry and mental health with 2 psychiatrists and 2 general practitioners who have received on-the-job training who are responsible to give lectures to the:

- Sixth year general medical students at the Faculty of Medical Sciences.
- Fifth year dentistry students at the Faculty of Medical Sciences.
- Third year nursing students at the College of Health Technology.

The chair of psychiatry belongs to Dr. Sisouk who is the director of the psychiatric unit at Mahosot hospital. Dr. Sisouk trained in Hungary. Dr Chantharavady Choulamany is the assistant professor with a DES Universite Libre de Bruxelles as a credential. Dr. Vikham teaches Neurology. A short curriculum has been developed (see annex 32) within the faculty of medicine for the teaching of psychiatry but there is no teaching of medical psychology.

A small resource centre exists at the first floor of the library building. It contains some scientific journals (*Clinical Psychology, Addictive Behaviour, British Journal of Psychiatry, Child Development, Social Psychiatry and Psychiatric Epidemiology, Journal of Behavioural Medicine, American Journal of Drugs and Alcohol Abuse*), about 50 books, a few videotapes and a computer. CD-ROMS and extra videos are

needed as well as a more comprehensive fund of books in English, French, or Thai. There is little regional academic cooperation. One regional conference project on drug addicts' treatments and rehabilitation will be organised with Vietnamese, Cambodian and French professionals with the support of Agence Universitaire de la Francophonie.

Problems in the education and training encountered are:

- Lack of books in psychiatry or mental health in Lao version.
- Lack of a manual concerning mental health issues for any Medical Practitioner.
- Lack of trained teaching staff.
- Lack of an appropriate room and teaching equipment.
- According to the vice dean of the FMS, it is urgent to develop a curriculum focusing on mental health in the community and primary care for general practitioners.

5.1.2 College of Health Technology

The programme is more or less similar to the one taught at the FMS, the difference between nurses and doctors should be aknowledged while developing the curriculum. (See Annex 33).

5.1.3 Postgraduate training in mental health

There is no postgraduate training in mental health organised in Lao P.D.R. A cooperation program has been developed for a few years with Professor Isidore Pelc (Université Libre de Bruxelles) with an annual regional 2 weeks seminar in French. Four doctors recently obtained a certificate of Medical Psychology.

5.1.4 Education program in mental health in the community

There is no education program in mental health at the community level.

5.1.5 The Psychology department at the faculty of education sciences in the National University of Laos (NUOL), Dong Dok Campus

The department of Psychology was opened in 1995 within the Faculty of Education Sciences with 9 professors in charge of teaching psychology. The department has no student studying psychology only, but psychology is included in several curricula. It is a compulsory subject in the teacher-training program. A psychology textbook in Lao has been recently edited. It is 188 pages long and gives a very general idea about psychology in 12 chapters. The instruction addresses the needs of teachers and covers the fields of general psychology, education and child-teenager development as well as social psychology.

Some research has been started, namely:

- Mental situation of leprosy affected persons,
- Behavioural stress with secondary school students, and
- Teacher's practical needs when they start to teach.

(More details in Annex 34)

5.1.5 Psychology teaching at Comcenter

One module of general psychology is taught by three professors at a private college in Vientiane (Comcenter). A general psychology manual in Lao with the main concepts in English is distributed to the students. Names of the professors are: Mr Som Sa Nouk, Mr Sa Yone, and Mr Horme.

5.1.6 Description of current health worker training and experience concerning mental health

The experience and knowledge concerning mental health is very limited even if some usual local practices can provide some relief. Regular training of primary care professionals is not carried out in the field of mental health

5.2 Analysis of other possibilities for human resources, such as non-medical workers or traditional professions

5.2.1 National Centre for Medical Rehabilitation / COPE / Handicap International

These structures depend on both the Ministry of Labour and Social Welfare (MLSW) and the Ministry of Health (MOH). The activities are oriented to the physically handicapped. The medical staffs pay no attention to the mental health of the handicapped seen at the national rehabilitation centre, as they are not aware of these issues. No counselling is provided regarding the first contact with the prostheses. It has been stressed that the team should also include a psychiatrist in order to provide psychotherapy to handicapped people and an occupational therapist to organize occupational activities for the ones who completed the treatment.

Project with Handicap International

This project based in Vientiane province supports community based rehabilitation for handicap people in cooperation with the National Rehabilitation Centre and COPE. All the people suffering from handicaps (physical, sensorial, mental, and intellectual) are provided some kind of rehabilitation, but due to the lack of human resources and skills, psychological handicaps receive little attention. However, several have been escorted for psychiatric consultation at Mahosot Hospital to have a diagnosis and receive treatment. Thanks to the community rehabilitation team working in Pon Hong district, we have been able to visit several cases in one day and the psychiatrists did provide some advice for future treatment both to the team and families. Further cooperation should be encouraged as well as integration of medical students interested in psychiatry for internship within this project.

5.2.2 Associations

Lao Disabled People Association (LDPA)

The association was approved in 2001 by the MLSW and received support from the British NGO Hope who sent an expatriate part time advisor. It employs mostly persons with physical handicaps. Present in 4 provinces (Vientiane, Luang Prabang, Xieng Khuang, Champassak and Sekong), the association aims at promoting the rights of people with disabilities, empowering them to personal achievement, assisting

them to develop their livelihoods and interests, and bringing about their full participation in society (LDPA, pV). The blind association recently joined the LDPA. The membership conditions don't allow the mentally disabled to join the association as they require:

- He/she is a disabled of good conduct.
- He/she is a disabled person of good character, accepted by society.
- He/she is not an insane person.

We have been informed that these conditions should be reconsidered at the next statute formulation within 3 years.

The problem is that there is no specialist of mental disorders and therefore it seems difficult for the person in charge of the association to accept mental cases apart from Down's syndrome and mental retardation. The staffs do not feel skilled enough to answer the needs of the mentally ill. These also has to do with the conception of people suffering with mental disorders who often are not supposed to have a voice, and are often felt not to be able to formulate ideas.

Lao Handicapped Women and Children Association (LHWCA)

This small charity organisation was founded in 1997 with approval from the MLSW. Since 1998, the volunteers distributed over 58 million kip in cash, rice, dry food and clothes for the handicapped people who asked for support. They also run a small loan service at a rate of 5% monthly. Being present only in Vientiane, they hope to develop new activities with international support and the ladies in charge are open to work with mental disabilities.

National Committee for Handicapped Persons

Not met

5.2.3 The role of monks and temple *(wat)*

Monks feel concerned by the increasing problems met by the contemporary Lao society. They feel that they can deliver some messages to help people to face new challenges by reinforcing morality and solidarity. Monks refer to the morality developed in Buddha teaching (dharma). Its aim is to help to deliver from suffering and relieve from mental illness practicing the 5 rules and meditation (samathi) as well as concentration (sathi panna). Meditation and relaxation can be useful in relieving stress and anxiety and their use could be developed further.

Karma (results of action committed) is one explanation for the causes of the misfortune that one is facing. It is not what people are ready to accept as it makes them responsible. Folk Buddhism is also related to magical practices as Buddha words are supposed to carry some power. One popular technique in Theravada countriesis that of monks pouring water over a sufferer while chanting Pali incantations which is felt to be effective with a lot of psychosomatic disorders and stress relieving while reinforcing the ego. Exorcism and chasing spirits, even if performed by some monks, is not part of their duty according to their rules of life and it is difficult to gain information about this.

Temples should remain primarily the place where people come to pray and meditate. To transform them into psychiatric asylums would not be a good idea and is unlikely to be successful. If persons suffering from mental illness take refuge in a temple, it should be seen as an individual process. We cannot consider as a general policy that the nearest temple be the place to receive treatment or support. It is unlikely that every monk would be skilled in addressing or advising people with mental illness, although certainly some are. Even if Buddhism developed a greater understanding of the human psyche, monks would need additional training to be able to cope with patients and to deliver care that goes further than teaching the five basic precepts and moral rules with stereotypic answers such as suffering being the result of excessive attachment and craving or karma.
(More details in Annex 36)

5.2.3 The role of traditional healers

Many traditional healers (TH) have been accused of propagating superstition and try to hide and therefore are not easily recognised. It has been difficult during this study to initiate any formal interviews with them. The symbolism and rhetoric of healing are fundamental to understanding the traditions and any healing process associated with traditional healers, and these issues have not been well investigated.

Religious rituals, spirit cults (possession or shamanism), conciliation ceremonies, offerings *(kathong)* and sacrifices are performed and traditional medicine is widely used. Most of rural villages in Laos have at least one traditional healer and our survey shows that patients are used to consulting a large range of traditional healers (see Annex 37).

In other countries, efforts to develop relations with traditional healers so that they provide for psychiatric care led to famous experiences in Dakar, Senegal (Dr Colomb, Senegal) and in Indonesia. Dr Hiegel's successful experience with Cambodian refugees and Cambodian traditional healers (kru Khmer) became famous in the Thailand border camps. In Cambodia, the Transcultural Psychiatry Organisation does work with traditional healers in community based mental health rehabilitation programs.

Possible strengths of traditional healers include the following:

- The cultural characteristics of some traditional therapies are found to include some of the same active ingredients that account for the success of psychotherapy (Bertrand 1997). Positive results in interpersonal, intrapsychic and physiologic terms have been demonstrated.
- THs usually treat patients in their families with adequate support. They provide culturally understandable answers and healing techniques.

Somatic disorders present a problem, as it is difficult to separate mental illness from physical disease. This distinction is not so clear for most of the people of Laos. Even in urban areas, resistant somatic disorders are often referred to traditional healers if modern medicine has not been able to treat them. Typical conditions using THs are headache, stomachache, and pain in the joints. Some might be successfully treated

once referred to spiritual entities with which relief of the patient has been negotiated or once bad evils are expelled from the body.

There are definite limits on the potential of traditionatl healers to treat mental illness. We are most skeptical as regards the ability of traditional healers to treat acute disorders such as psychosis. Some traditional healers are wise enough to declare that they can't heal the patient, as the spirit is too strong for them or the brain is irremediably damaged, but many families have spent large sums on traditional treatments to treat mental illness to no avail. There is also a potential for abuse by traditional healers. The use of psychoactive drugs has been document in Cambodia by Bertrand (1997,1998, 1999), who has reported several abuses including using Western medicine, such as largactyl, in traditional care. Investigations should be made in Laos, as there are similar suspicions that some traditional pharmacists do in fact mix allopathic drugs with their plants. Also, violence and physical or mental abuse, mostly in exorcism rituals, in order to chase the evil spirits, have been reported during our survey.

As with other health professionals, profit making might motivate THs and they might propose treatments that they know ineffective in order to make money. It is wrong to believe that traditional healing would be cheaper than modern medicine. Offerings and sacrifices for the spirit might be costly as well as fees for the healer. One family is said to have spent 4 million kip with 16 traditional healers in a 3-year period.

There should be no major conflict with different therapists as one addresses the symptoms and the other one the causes. Performing ceremonies on one side to solve the perceived causes can help to address the problems while the patient also uses the medical care service to treat the symptoms.

5.2.4 Family care.

The survey showed the importance of family and community care. *"Family has to be associated in the clinical evaluation treatment planning and continuing care of Asian psychiatric patients"*, (Lin p 633)

In designing a mental health care program, active participation of the family should be recommended because most families are able to provide more constant and persistent emotional and material support to their sick members than any health care system, thus contributing to a better prognosis. One has to be careful about side effects such as embarrassment, resentment, criticism, excessive shame, and inappropriate intrusiveness. Information and follow up are key issues. Families cannot be abandoned but must be supported by the health and social welfare system. Economic burdens on families could be eased by MLSW handicapped pensions, although this may not be affordable in Laos at this time.

5.3 Current methods of management of mental illness in Laos through both traditional (non medical) and medical system and institutional capacity for mental health services at the various levels of the health care system.

There are dual systems, public and private medicine, and western or traditional ones. The private health care system in Laos is mainly in private pharmacies and small outpatient clinics. We did not lead any investigation into the private system and mental health care.

There is no management of mental health issues at any levels as these are not recognised as systemic issues and are addressed on a case-by-case basis. There are only two psychiatric consultation units. Different kinds of traditional healers are operating countrywide. Training and institutional development is needed to develop an institutional capacity for mental health services at the various levels of the health care system. This does not mean developing mental health institutions, but placing mental health within the context of existing institutions.

5.4 Medicine needs and cost

A rough estimate of the cost of psychiatric medication for a local area of 100,000 peoplew as made and came to US$ 43,504. This is a very rough and preliminary estimate and requires more detailed study. (See Annex 38).

6- Recommendations

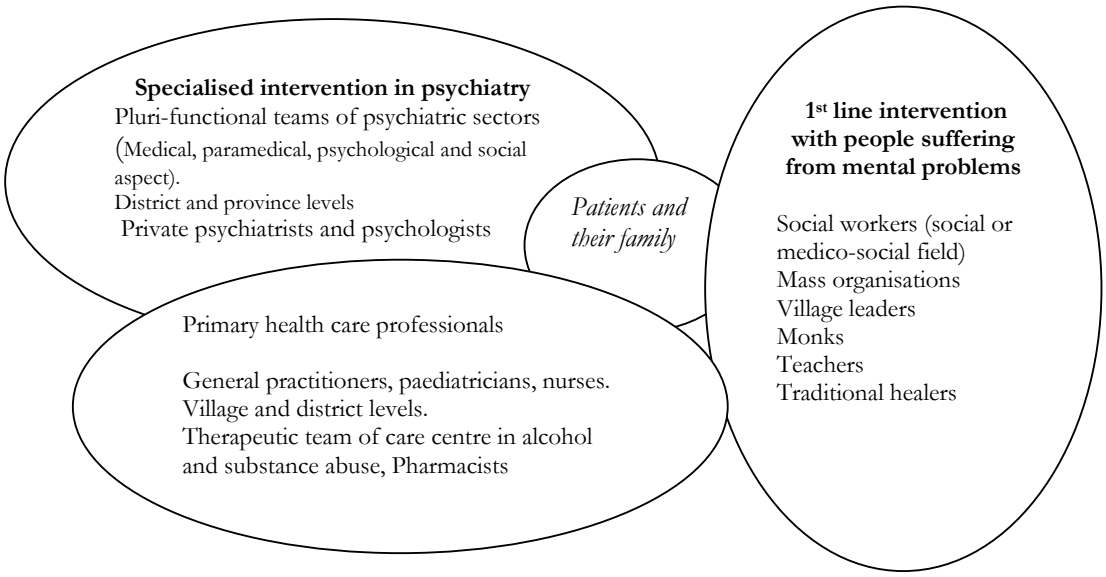
Developing pluralistic mental health services in Laos, considering its remoteness, diverse ethnicities, and the relative low general educational levels is challenging. A national mental health plan will have to work in the above context and also with severe limitations of resources. Priorities will have to be chosen carefully and realistic strategies adopted for both the short and the longer term. Our key recommendations follow.

6.1 Integration of mental health in the Health care system: key components for a mental health program

6.1.1 Integration of mental health care within pluralistic primary health care

Integration of mental health care into the general health care system and primary health care is necessary because specialized mental health care services are neither feasible nor desirable at this time.

6.1.2 Mental health care actors: Three levels of intervention



Mental health specialists are needed at provincial and district levels. In the short and medium terms generalists with mental health skills will have to fill this role.

Competences in the 3 levels of intervention in mental health care (in Annex 39)
Measures for adjustment of the level of competence (in Annex 39)

6.1.3 Community based mental health support

It is important to decentralize mental health care at grass root level and develop community-family based care with mass organisations and village leaders with the guidance of health professionals and concerned traditional healers. No other strategy will be able to provide care to the majority of the nation. The capacity of the community to recognize, address and treat mental health problems has to be

developed by teaching health promotion in the communities in order to promote self-help groups. Prevention of suicide, unwanted pregnancy, and alcohol and substance abuse in parallel with mental health promotion is a priority. Supporting families with self-help groups that go beyond saving the face but reach a stage of sharing the problems, and finding solutions together has to be developed. Effects of chronic illness on the family can't be neglected.

6.1.4 Building a pluralistic approach to mental health care.

"Although the traditional sector is a source for numerous coping mechanism, it is felt that an extra input is needed." (Eisenbruch, TPO report, 1996, p 4).

Traditional healers should be able to be integrated once it is defined who they are. What are the differences between them? What do they do? Who are their patients? What are the effects of their treatments? What are the criteria to decide what they can do and they cannot?

A deep, collegial, and respectful investigation should be held with the THs who volunteer to be involved in the mental health network. This should be done before a process of operationalizing a role for THs occurs and will be used to define their role and their limits. As for MP, some ethical guidelines have to be drawn. The investigation team should not be medical only and should include key persons in the community as well as other TH. Relations and inter-action between volunteer TH and MP should be developed. (More details in Annex 41)

6.1.5 Considering intercultural relations in the health care service.

- Courses to introduce medical anthropology, the sociology of health and illness, as well as the social sciences in general to promote a culturally sensitive clinical understanding from patient and family biographies and discourses should be part of the undergraduate and graduate training for both doctors, nurses and other health workers.
- An increase in the number of MP from different ethnic groups, well rooted in their community and culture, would lower cognitive and language distances between providers and patients.
- MP in village clinics should be able to understand the local language, at least the terms referring to sickness and pain or have reliable trained interpreters. It is realized that full-time interpreters may not be possible, but health facilities should seek to have a mix of ethnic groups so that workers can be called on to interpret.
- Patterns of distress, perceived causes of illness, and help-care seeking behaviors are related. Trained interpreters or at least interpreters from the same background as the patients could promote better understanding of mental problems including stigma that is the hidden burden.

More details in Annex 42.

6.1.6 Integration of mental health program in other institutions

- National Ministry of Education.

- It is advisable that in the future, some activities be developed in order to start education concerning epilepsy, suicide and mental retardation in the teachers training programs.
- Incorporation of mental health in the core curriculum of primary and secondary school students would be desirable. Including life skills training programs at school to promote problem solving ability, coping skills, assertiveness training and

interpersonal skills as well as programs to prevent alcohol and drug abuse amongst adolescents is desirable.
- Reinforcing the existing inclusive schools is a priority.

- Ministry of Justice.

Mental health should be considered in the jails concerning detainees as well as guards.

- Civil Society and NGO, IO.

Sensitize international agencies and non-governmental organizations to pay more attention to mental health training for human resources able and willing to cope with mental health problems such as consumers, families and volunteers, workers of social welfare services, mass organizations, mass media, and traditional healers.

6.2 Treatment of drug addicts

In mobilizing the health care system for detoxification new approaches to drug addict's treatment could be promoted to develop both morality and skills. (See Annex 43)

6.3 Treatment of mental health problems: psychiatric hospital and social psychiatry

A psychiatric ward with beds should not be introduced in the hospital without MP having received a deeper training. These units are costly and difficult to manage in developing countries. They are not the only or the best answer to treating severely mentally ill patients, even if for some families or MP, it seems easier to maintain them there. Laws should regulate internment of patients for a long stay. Innovative integrated experiences concerning community mental health care should be promoted. (More details in Annex 44).

6.4 Institutional organisation

- Links with other relevant ministries, mass organizations and non-governmental organizations, especially with the Ministry of Labor and Social Welfare (MLSW) should be established.
- Intra-ministerial links within the Ministry of Health need to be established, particularly between community services, the curative services, and training institutions.
- A national committee for mental health and subgroups for drugs, children and youth should be established.
- A mental health office should be formally recognized although it should not take its members away from clinical and teaching duties.

6.5 Visiting regional infrastructures and programs

Study tours in different institutional and community settings in ASEAN countries looking at innovative and cost effective experiences should be organized for Lao Mental Health specialists before setting any new project. (Examples in Annex 45)

6.6 Drug use, supply and policy.

A more rational use of psychoactive drugs should be promoted with a careful follow up. (Details in Annex 47)

6.7 Development of human resources and training

Training of health personnel, students at the FMS, professionals for education and mental health, for Development and rehabilitation with MOH, MLSW and MOE and

teaching Forensic psychiatry at the school of magistrate should be developed (details in Annex 46).

6.8 Setting an information system

Mental health information standard guidelines manuals and community mental health manuals have to be written.

A system for annual reporting of mental health data and information monitoring system-incorporating indicators should be implemented. (Details in Annex 48)

6.9 Quality assessment and oversight for the improvement of the mental health care system:

- Improve mental disorders treatment.
- Enhance home visits.
- Ameliorate the relationship of mental patients and their community.
- Reinsert mental patients into the family milieu and into the socio-professional milieu.
- Collaborate with monks and other TH for the moral support of mental patients in order to have a comprehensive and pluralistic approach.

6.10 Scientific research and development

- It is important to conduct applied research and evaluate the needs among health professionals and the general population.
- Data collection on mental health is necessary in order to analyse the mental health situation and to respond to clients needs.

6.10.1 Research perspectives from the National Institute of Public Health

The 5th work plan for research is one of the six majors plans for the Ministry of Health. It is stipulated that scientific research was part of the 7th resolution of the Lao People Revolutionary Party Congress as a high priority in the present period. Within the 6 work plans described, almost no entries concern mental health (given in Annex 49).

Several issues related to mental health should be considered as worth integrating into the research protocols. Mental health should be considered as one of the themes on which research capacity should be strengthened.

6.10.2 Possible research perspectives or opportunities

The list given (in Annex 50) provides large perspectives based on diseases, health care seeking behaviors, diagnosis, and epidemiology as the level of information is actually very low.

6.10.3 Future instruments to be used for research and further diagnosis have to be developed

Instruments such as tests have to be adapted to the Lao context (see Annex 51).

6.11 Finance

Being chronically ill, many mental patients are poor and their families spend a lot to take care of them before reaching hospital services. It is important for the MOH to finance mental health care in the community.

6.11 Other issues

(See Annex 52)

- Street children, need psychological support and counseling.

- Laws concerning mental illness and treatment of patient have to be developed.
- Developing organizations or association for patients and their families is a good way to help them to defend their rights and promote rehabilitation.

6.13 Persons interested in developing psychiatric and psychological training and research in Lao PDR with NUOL

Several institutions and individuals in different parts of the world have expressed their interest in developing collaboration with their Laotian colleagues. (List is given in Annex 53). It would be worth coordinating these intentions with a national workshop in which they could develop those interests.
A copy of this report could be addressed to them as a general preliminary framework.

7. Conclusion

Mental health is a new issue in the Lao PDR but policy makers and development planners should integrate it in their projects as it affects all the aspects of everyday life and if neglected might become a burden for the country.
Human resources are very limited in this field, and out of the capital no appropriate medical treatment is available.

Priority setting

- Health personnel need training in mental health to be able to detect and treat these problems. MOH should develop a plan for this training at all the levels and professions in mental health in relation with other ASEAN countries.
- Community awareness about mental health issues and treatments has to be developed; mass organizations, monks and schools could play an important role to disseminate the appropriate information.
- Delivery of mental health services must be integrated with general health care services in order to reduce the stigma associated with seeking help from stand-alone mental health services. An integrated service encourages early identification and treatment of such disorders and thus reduces disability. New and effective treatments including psychological and social treatments can induce some relief but they need qualified medical and social staff.
- Providing care in the community and providing opportunities for community involvements in care are highly recommended.
- Considering the country socio-cultural context, and people attitudes, mental health promotion and treatment should be based on a culturally sensitive, global and pluralistic approach. Monks and traditional healers who show interest in this issue should be approached and integrated in the networks.
- A pediatric psychiatry central unit is urgently needed with the appropriate qualified staff.
- Prescription and treatment with psychiatric drugs should remain under detailed protocols for patients follow up. Prescribing directly by the pharmacists is not appropriate
- Epilepsy is a major issue; a national plan should be built following ethno-epidemiological study (tracing, risk factors, clinical and biological study, pilot treatment protocol).

- Schizophrenia is a complex problem that can’t be treated at the village health unit. Before prescribing drugs for any patient, clinical investigation should be done, and taking account of the side effects.
- Drug abuse (including alcohol) prevention and treatment is a priority. Already several actions have been launched. Innovative psychosocial re-integration programs should be implemented.
- Suicide and its prevention should be considered. More information is needed.
- Somatic disorders are costly and remain unnoticed; more information should be collected on their incidence, in order to provide the appropriate training.
- Reinforcing the inclusive school program from the Ministry of Education is a valuable option to address the needs of people suffering from mental retardation, learning and intellectual disabilities.

Annexes

Annex 1. Introduction (general information concerning mental health at the world and regional levels)

- Mental health makes up 12% of the global burden of disease. The mentally ill require support so that they can lead more productive lives. Crises need to be avoided which will have a large impact on both health and economic productivity.
- A large proportion of patients consulting general health clinics have problems related to their mental health. These problems are usually increased in populations exposed to difficult life experiences and unable to cope with changes and the complexity of life. They become a burden for their families, communities, and states.
- Depressive disorders are the fourth leading cause of disease and disability in the world and despression is expected to rank second by 2020 (W.H.O, 2002 p 15). Less than 25% of those affected currently receive treatment. Depressive disorders are closely linked with substance abuse.
- In developed countries, many people do not receive any mental treatment while they suffer from psychiatric disorders that respond to therapy. For example, up to 70% of the mental health needs in Canada (Kates, p 2561) are still not met. (Rosa, 2000).
- In France, a recent report (MES, 2002), mentions that up to ¼ of the consultations with GPs are related to psychological troubles and potential violence. Co-morbid untreated depression or anxiety increases the cost and threatens the effectiveness of treatment for general medical disorders.
- In developing countries, it is estimated that 60 to 90% of epilepsy cases do not receive the appropriate treatment even though the least expensive treatments can cost as little as US$1-2 per month.
- Throughout much of the world, the majority of people with chronic schizophrenia are not receiving treatment although effective low cost interventions exist.
- In societies facing rapid transformations, changes in the social, human and economic environment are affecting mental health, increasing the risk of mental disorders. Stress lowers immunity and makes people less effective and more vulnerable.

In South East Asia

More than 50% of the countries have less than one psychiatrist and one psychiatric nurse for 100 000 people. 44% of WHO member states don't have a mental health policy and 67% do not have mental health legislation. It means that at the world level there still is a lot to do in implementing appropriate mental health promotion, policy and care.

This new challenge should also be an opportunity to develop professional network and exchanges about innovative approaches to mental health problems.

The three basic goals for the regional strategy are: (WHO, WPR, p14).

- Reduce the human social and economical burden.
- Promote mental health.
- Give appropriate attention to the psychosocial aspects of health care and the improvement of quality of life.

Six approaches are promoted:

- Advocacy, providing information and advice.
- Service provision and evaluation.
- Improving the integration of primary health care and the provision of effective interventions.
- Reorienting and training relevant personnel in mental health skills.
- Providing support for consumers and families and their inclusion in treatment and policy-making.
- Addressing the psychosocial aspects of health care.

Mental Health situation in Vietnam

The country counts 600 psychiatrists, for 80 millions people, 5000 beds in 38 services within general hospitals.

There is a national community psychiatry program in which family is considered as co-therapists, traditional medicine is accepted, and there is a care contract with the family. In town it is more difficult but there are very few hospitalisations in rural areas.

The main mental health problems are related to: road accidents, unemployment, increase of suicide.
The epilepsy rate is 0.5%, mental retardation 1.5 to 2% according to the regions, schizophrenia and psychosis 0.3% rural to 1% in town, while neurosis reaches 5-6%.

Medicine is rarely used except for the most disturbed children, ECT is applied but no psychoanalysis yet. Neuroleptics are used with small doses (5 to 10 mg chlorpromazine when crisis)
Children and teenagers suffering from mental deficiency are sent to some specialised schools.

Annex 2 Context and Economy

The Lao PDR is organised in 16 provinces (plus Vientiane municipality and Xaysomboun special area), 116 districts, and 846 communes.

Mean year of schooling:	2.9
Adult literacy rate:	60%
Literacy rate:	61.9 for males, 30.2 for females
Life expectancy at birth:	54 for males and 56.6 for females
Pop growth:	2.4% per year

The economy achieved annual growth rates averaging 7.5% between 1991 and 1996 and annual per capita GDP increased from US$ 355 in 1995 to US$ 400 in 1998. Some of this progress was reversed by the Asian economic downturn. However, the Lao People's Democratic Republic (Lao PDR) remains one of the least developed countries and is ranked 140 out of 174 according to the 1999 UNDP Human Development Index (UNDP –1999- Human Development Report).

In 1997, agriculture accounted for 52% of GDP, while 79% of the population lived in rural areas. The low per capita GDP reflects widespread poverty and minimal standards of living in rural areas. The rural economy is largely subsistence with about 75% of the country's workforce employed in agriculture. While economic performance was satisfactory at the macro level until the recent currency crisis, the benefits of the open market policies and rapid economic growth have been concentrated in Vientiane and other major cities.
While inflation was moderate throughout most of the 1990s, it increased to 140% in December 1998 following the depreciation of the currency. The banking system is in its infancy and still lacks effective controls. The principal source of export earnings is derived from timber and garment manufacture. Tourism is still small by the standards of neighbouring Thailand, but has expanded rapidly since restrictions were relaxed in 1994. The regional economic crisis of 1998/99, however, led to declining growth rates and the highest depreciation and inflation rates in Asia in 1998. The growth rate for 1998 was approximately 4% as a result of a decline in agricultural production and foreign direct investment.
According to the 2000 World Bank report (p11-13*), "compared to many Asian countries, inequality in the Lao PDR is not high. The bottom 20% of the population had a share in total consumption of 8.5% in 1992-3 while that for the richest 20% the consumption share was 42%. However, the consumption share of the bottom 20% declined to 7.4 percent in 1997-98, while that of the top 20% instead increased to 45.3%."*
The country is also flooded with cheap but bad quality Chinese merchandise such as motorbikes, costing less than a thousand dollars, that might lead the poor to be even more poor because they are not able to maintain them. Such motorbikes have been banned from import in Vietnam.

Annex 3 Health system and services in Lao PDR

Proportion of the health budget to GDP:	3.6%
Fertility rate:	6.7 children per mother
Infant mortality rate:	68 to 169/1000, 102 average
Maternal mortality:	650 per 100 000 life birth
Pop per doctor average:	8500 (from 1260 to 20800)
Life expectancy:	62 for women and 57 for men
Access to safe water:	44%
Access to Primary Health Care	67%
Malnutrition	42% of the children under the age of five

(WHO 2000)

Annex 4 Availably of psychiatric drugs

Quantity of drugs sold per week at different hospital in the capital

Quantity of drugs sold per week (tablets)	Mittaphab	Sethathirath	Military	Private pharmacy		
				Urban (5)	Rural (3)	Total
Valium	150	500	1000	530	50	580
Phenobarbital	100	200	500	110	10	120
Lexomil	50	100	100	40		40
Dormicum	20	50	50	20		20
Tranxene	150	300	700	410		410
Largactil		60	100	120		120
Haldol	20	60	100	120		120
Nozinan						
Tryptanol	100	100	100	100		100
Tegretol						
Depakine						

Annex 5 Creation of mental health unit at Mahosot Hospital

- In 1979, psychiatry was introduced in Laos by a Russian psychiatrist, Dr. Poutsai, who was in a cooperative mission, with his Laotian counterpart, a general practitioner. Consultations were organized twice a week in the morning at the Outpatients Department of Mahosot Hospital, in Vientiane. Five patients were seen per day. Acute psychosis cases were admitted at the internal medicine unit.
- In 1982, the Russian psychiatrist completed his mission in Laos. His Lao counterpart trained as a psychiatrist confronted alone people suffering from mental disorders.
- In 1983, a second general practitioner started psychiatric on-the-job training. The two of them were responsible for providing care to people suffering from psychiatric disorders for the whole country, or more accurately to those people who came to their attention.
- In 1985, the first person went to study psychiatry abroad, in Hungary, left his colleague alone for 3 years.
- In May 1988, the small psychiatric unit of 4 beds was launched in the premises of Mahosot general hospital, with a limited staff of 3 general practitioners and 2 nurses working full time.

Annex 6 The clinic at Mahosot Hospital

The patient data record is based on the form provided by the psychiatric unit. It is comprised of: (i) demography and family, (ii) reason for consultation, (iii) history of the disease as told by the patient and a member of his/her family, (iv) antecedents, (v) medical examination, (vi) diagnosis, (vii) differential diagnosis, (viii) therapeutic window, and (ix) follow-up.

Data is collected weekly by categories: inpatients and outpatients, type of illness, and length of stay for admitted patients. Data is submitted to the statistic unit of Mahosot hospital, which compiles it with all data from other units and then sends it to the department of planning and statistics of the Ministry of Health.

- By 1999, the number of patients increased steadily to 1,070 cases with a percentage of admission of 25.1% and a rate of ambulatory patients of 74.9%.
- In 2000, it is observed that the rate of admission is still increasing. Roughly, 15% of admissions are due to substance abuse, followed by schizophrenia (6.2%), bipolar disorders (2.9%) and epilepsy (2.7%). Regarding ambulatory cases, epilepsy is dominant with a rate of 14.0%, followed by neurosis (10.9%), schizophrenia (10.0%), depression (7.0%) and substance abuse (6.8%).

Table 1: Prevalence of mental disorders at the Mental Health Unit, 1996 – 2001

Year	**1996**		**1997**		**1998**		**1999**		**2000**		**2001**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**n**	**%**	**N**	**%**
Schizophrenia	174	*26.6*	208	*25.9*	201	*25.3*	192	*17.9*	157	*16.2*	71	*13.7*
Bipolar disorder	31	*4.7*	51	*6.4*	97	*12.2*	101	*9.4*	94	*9.7*	33	*6.4*
Infectious psychosis	0	*0.0*	4	*0.5*	31	*3.9*	11	*1.0*	12	*1.2*	2	*0.4*
Post-partum psychosis	0	*0.0*	3	*0.4*	47	*5.9*	1	*0.1*	7	*0.7*	0	*0.0*
Depression	96	*14.7*	118	*14.7*	53	*6.7*	81	*7.6*	81	*8.4*	43	*8.3*
Neurosis	116	*17.8*	134	*16.7*	82	*10.3*	155	*14.5*	117	*12.1*	58	*11.2*
Dementia	11	*1.7*	17	*2.1*	31	*3.9*	2	*0.2*	8	*0.8*	3	*0.6*
Substance abuse	4	*0.6*	4	*0.5*	11	*1.4*	192	*17.9*	210	*21.7*	124	*23.9*
Mental retardation	5	*0.8*	4	*0.5*	11	*1.4*	5	*0.5*	3	*0.3*	2	*0.4*
Alcoholism	8	*1.2*	11	*1.4*	70	*8.8*	23	*2.1*	29	*3.0*	20	*3.9*
Epilepsy	152	*23.3*	170	*21.2*	84	*10.6*	199	*18.6*	162	*16.7*	135	*26.0*
Organic cerebral lesion	8	*1.2*	13	*1.6*	16	*2.0*	41	*3.8*	26	*2.7*	13	*2.5*
Others	48	*7.4*	65	*8.1*	60	*7.6*	67	*6.3*	63	*6.5*	15	*2.9*
Total	**653**	***100.0***	**802**	***100.0***	**794**	***100.0***	**1,070**	***100.0***	**969**	***100.0***	**519**	***100.0***

Table 2: In-patients and ambulatory patients at the Mental Health Unit, 1996 – 2001

Year	**1996**		**1997**		**1998**		**1999**		**2000**		**2001**	
	IP	**AP**	**IP**	**AP**	**IP**	**AP**	**IP**	**AP**	**IP**	**AP**	**IP**	**AP**
Schizophrenia	86	*88*	105	*103*	109	*92*	71	*121*	60	*97*	13	*58*
Bipolar disorder	5	*26*	20	*31*	25	*72*	27	*74*	28	*66*	27	*6*
Infectious psychosis	0	*0*	1	*3*	1	*30*	2	*9*	3	*9*	2	*0*
Post partum psychosis	0	*0*	1	*2*	41	*6*	1	*0*	3	*4*	0	*0*
Depression	16	*80*	31	*87*	23	*30*	12	*69*	13	*68*	11	*32*
Neurosis	13	*103*	31	*103*	1	*81*	21	*134*	11	*106*	21	*37*
Dementia	0	*11*	2	*15*	11	*20*	0	*2*	3	*5*	3	*0*
Substance abuse	2	*2*	1	*3*	1	*10*	72	*120*	144	*66*	106	*18*
Mental retardation	0	*5*	1	*3*	0	*11*	1	*4*	0	*3*	0	*2*
Alcoholism	3	*5*	4	*7*	36	*34*	11	*12*	10	*19*	9	*11*
Epilepsy	28	*124*	39	*131*	3	*81*	21	*178*	26	*136*	25	*110*
Organic cerebral lesion	7	*1*	3	*10*	0	*16*	17	*24*	7	*19*	4	*9*
Others	1	*47*	3	*62*	4	*56*	13	*54*	8	*55*	15	*0*
Total	**161**	***492***	**242**	***560***	**255**	***539***	**269**	***801***	**316**	***653***	**236**	***283***
Percentage	***24.7***	***75.3***	***30.2***	***69.8***	***32.1***	***67.9***	***25.1***	***74.9***	***32.6***	***67.4***	***45.5***	***54.5***

IP in-patient AP ambulatory patient

Annex 7 Methodology and problems encountered.

The lead consultants and his Lao colleagues developed a questionnaire. Comments were solicited from WHO staff in Vientiane and Manila. Due to time constraints, the questionnaire was pre-tested with only 3 key informants.

The key informants chosen have lived in their community for at least 10 years and know the community well. They are regarded with respect or known in the community through participation in activities such as being a physician, teacher, or mass organisation leader.

The survey started with interviews with key informants: the district health director and village clinics, then with village leaders and teachers, monks or healers. Sick people and families were found by a snowball sampling method and selected according to the seriousness of the cases as described by the informants.

Three times, we gathered informants for focus group discussions such as at a Hmong Village, a Lao village in Vientiane, and Katu village..

Users involvement in research leads to a democratisation approach of care. An attempt was made to investigate the patient's or family's evaluation of the care received, but it was not easy in such a short time and without preliminary contacts to build trust when interviewers are themselves care providers.

Problems encountered

Most people don't know what a mental health problem is and, apart from very obvious abnormal behaviours labelled as mad, they can't recognize them. Informants had to interpret some questions and receive more information before deciding what answer was to be given. Researchers had to be careful not to provide their own interpretation.

One NGO worker with mine victims said at first that every thing was fine post operation. Once I had explained some of the symptoms expressed for a depression she recognised that it was happening in many cases. Trauma was not considered because the issue had never been suggested.

In one countryside school with over 300 children, no case of mental retardation or learning disabilities is acknowledged. It seems that in the presence of a representative of the municipality education department and a foreigner, the school director didn't feel at ease to declare any problem.

Language issues had been investigated prior to to starting the research. The expatriate consultant was not fluent in Lao but the MOH allowed one senior official to assist as interpreter and co-researcher. However, with Hmong and Mon-Khmer languages in the South, this issue due to time and resources constraints didn't receive much attention and we relied on bilingual officials from the villages only.

Cultural and political references to the questions, what are the words used and what do they mean have been explored.

Two psychiatrists joined the team as research assistants. The team had a short time to provide details about the objectives and the constraints of this research. Also being health professionals it has been difficult for them to investigate more socio-cultural dimensions of mental health issues and beliefs. Asked to interview some of the several people presenting obvious mental disorders and seen in the streets of the capital, they said that they could not find them. They are not used to interfere with persons suffering from mental health problems out of their consultation room and seemed to feel insecure to do so.

In South East Asia, speaking to others is the result of a complex interaction in which statutes, benefits, and taboos are considered. In Laos, social sciences are not well developed yet, so these processes have not been well investigated. Mental disorders force people to confront the unknown and they raise many hypothesess of different orders. People often choose what to say according to the interlocutor.

Interviewing a mass organisation leader, I understood that the comments he exchanged with his comrades in Lao concerning some of my questions differed from the official answer he was giving to me. Answersy concerning the so-called superstitions were particularly not the same!

Community-based research can be a tool for empowerment when data collection is returned to participants and when analyses and interpretation are discussed altogether with community members. Due to time constraints, we have not been able, to operate a feed back and return on the field. However, interviews with families and patients were concluded if not with a diagnosis at least withsome advice.

Annex 8 Cases report by type of mental disease

Cases report by type of mental disease (n = 38)

Mental diseases		Psychosis	Schizophrenia	Epilepsy	Drug abuse	Mental retardation	Senility	Learning disabilities	Abnormal behavior	Total
Gender	Male	1	7	1	0	10	0	1	1	21
	Female	0	7	6	0	2	1	1	0	17
Total		**1**	**14**	**7**	**0**	**12**	**1**	**2**	**1**	**38**

Mental diseases		Psychosis	Schizophrenia	Epilepsy	Drug abuse	Mental retardation	Senility	Learning disabilities	Abnormal behavior	Total
Treatment	Yes	1	6	6		3	1	0	0	17
	No	0	8	1		9	0	2	1	21
Total		**1**	**14**	**7**	**0**	**12**	**1**	**2**	**1**	**38**

Mental diseases		Psychosis	Schizophrenia	Epilepsy	Drug abuse	Mental retardation	Senility	Learning disabilities	Abnormal behavior	Total
Medicine	Modern	1	7	4		2	1			15
	Traditional		4	3		2				9
	Non-medical	1	9	6		3	1			20
Total		**2**	**20**	**13**	**0**	**7**	**2**	**0**	**0**	**44**

Mental diseases		Psychosis	Schizophrenia	Epilepsy	Drug abuse	Mental retardation	Senility	Learning disabilities	Abnormal behavior	Total
Causes	Biological		3	3		3				9
	Spiritual	1	9	6		1	1			18
	Socio-eco		1							1
	Genetic		1	3		7				11
Total		**1**	**14**	**12**	**0**	**11**	**1**	**0**	**0**	**39**

Annex 9 Some results by villages.

Village ILIK	No habitants 410	No Cases 4	Male 3	Female 1	Abnormal B 1
Psychosis 2	Neurosis	Mental retardation	Addict	Epilepsy 1	Senility

Village SUEY	No habitants 810	No Cases 5	Male 3	Female 2	Abnormal B
Psychosis 1	Neurosis	Mental retardation 1	Addict	Epilepsy 2	Senility 1

Village Ban Nok	No habitants 530	No Cases 4	Male 3	Female 1	Abnormal B
Psychosis 2	Neurosis	Mental retardation 1	Addict	Epilepsy 1	Senility

Village Hay Sok	No habitants 1100	No Cases 19	Male 14	Female 3	Abnormal B 2
Psychosis 2	Neurosis	Mental retardation 3	Addict 9	Epilepsy 2	Senility 1

Village TONSA	No habitants 783	No Cases 9	Male 6	Female 3	Abnormal B 1
Psychosis	Neurosis	Mental retardation 6	Addict	Epilepsy 2	Senility

Village Tong Vay	No habitants 1272	No Cases 12	Male 7	Female 5	Abnormal B 1
Psychosis	Neurosis	Mental retardation 9	Addict	Epilepsy 2	Senility

Village Done Chan	No habitants 350	No Cases 3	Male 1	Female 2	Abnormal B
Psychosis 1	Neurosis	Mental retardation	Addict	Epilepsy	Senility 2

Village Phone Gam	No habitants 1092	No Cases 9	Male 8	Female 1	Abnormal B
Psychosis	Neurosis	Mental retardation 2	Addict 5	Epilepsy 2	Senility

Village Ban Vat Chan	No habitants 1500	No Cases 15	Male 11	Female 4	Abnormal B
Psychosis 2	Neurosis 2	Mental retardation 1	Addict 8	Epilepsy 1	Senility 1

Village Phosy	No habitants 876	No Cases 1	Male 1	Female	Abnormal B
Psychosis	Neurosis	Mental retardation 1	Addict	Epilepsy	Senility

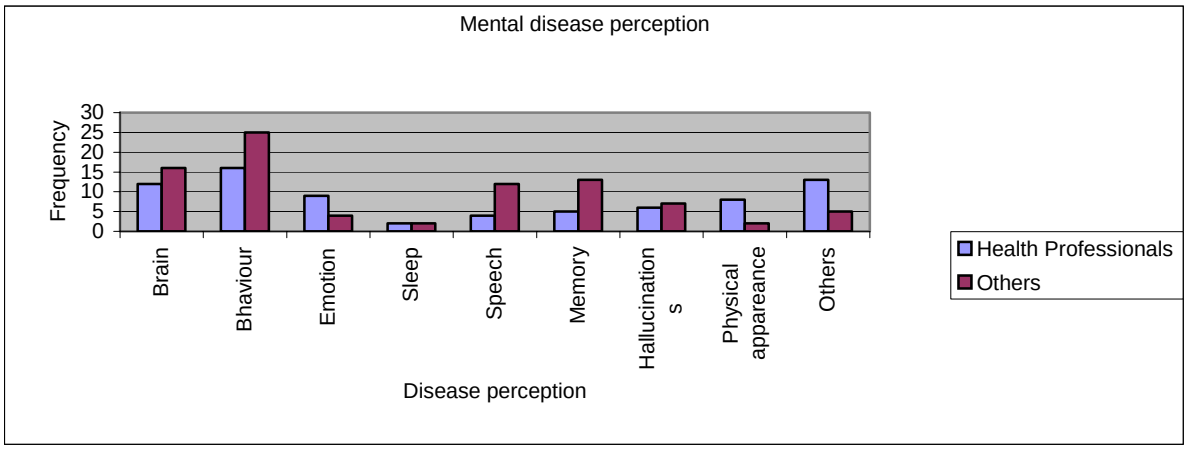
VillageSok Noi	No habitants1784	No Cases 9	Male 6	Female 3	Abnormal B 3
Psychosis 3	Neurosis	Mental retardation 1	Addict 1	Epilepsy 1	Senility

Total

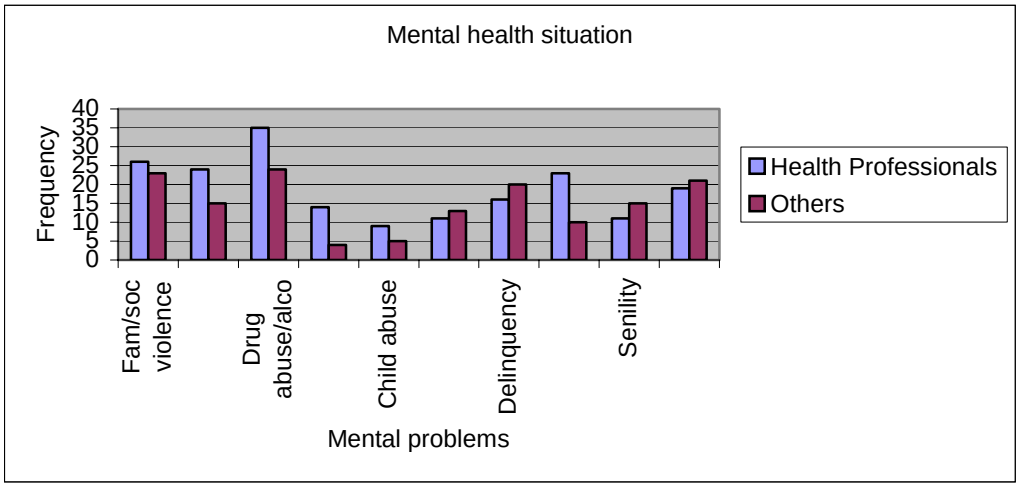
Village 11	**No habitants 10507**	**No Cases 90**	**Male 59**	**Female 22**	**Abnormal B 8**
Psychosis 13	**Neurosis 2**	**MR and learning Dis 5**	**Addict 22**	**Epilepsy 14**	**Senility 5**

Annex 10 Community perception of mental health illness.

Mental disease perception: (86 informants, 125 answers).



Annex 11 Evaluation of the mental health situation in the community
(86 informants, 383 answers)



Annex 12 Lao folk representations of mental illness

There was insufficient time to explore metaphoric understanding of mental health disease and theories of illness aetiology and this was not the purpose of the rapid situational analysis. As starting resources, a previous folk categorisation done by Westermeyer (1973) was relied upon.

Westermeyer (1981) tried to make an assessment of the two main folk categories and found some cross reliability between folk and psychiatric diagnoses such as “ba” insane or crazy and “sia chit” lost mind, (nervous problem and breakdown, sadness weakness fright crying spells) comparing psychiatric and folk diagnoses on 35 cases.

Our general findings (detailed table in annexe) support Westermeyer’s previous conclusions.

Few informants have been able to give a detailed description of the different subcategories of madness in terms of behaviour going further than the aetiology as mentioned in the name itself (ba) as it seems not to be so widely used currently and most of the cases are labelled as ba in general.

- The term phi ba is so widely used referring to major mental dysfunction that it doesn't evoke spirit possession (phi) in some people's mind. It has become a sort of common word for mad. Different kinds of spirits inducing madness are:
    - "Phi pop", from the tree called pop (ficus gibosa, Dore p 49) which still raises strong fear. These spirits are charged with magic with bad aims and they can be killers as well. *"Phi ba can be very dangerous, for example phi pop in some cases they have to leave the village or they might be killed."* Phi pop is amoral, asocial, and contradicting the natural order (Dore p 70). It is considered as very dangerous and victims can be innocent persons. People called Phi pop by extension are not always considered as mad as such but they present some dangers to the community.
    - "Phi kha" are supposed to be even stronger. They are said to be the worst. They don't speak but they might kill and they can be found in many villages according to a famous specialist of Lao culture who added, *"I don't believe but I am afraid"*. (Kha -meaning slave- is the name given to Mon-Khmer indigenous peoples before they were recognised as Lao Theung.
    - "Phi phay" lives in the blood and saps energy.
    - "Phi tai hong" are the souls of victims from violent death such asaccidents, suicides, and crimes. They are wandering around and they can be harmful.

Then one could find "phi" living in many different places such as rice fields (phi na), streams (phi houey), or non irrigated rice fields, (phi rai).

Annex 13 **Table of Lao folk diagnosis of mental problems**
(86 informants)

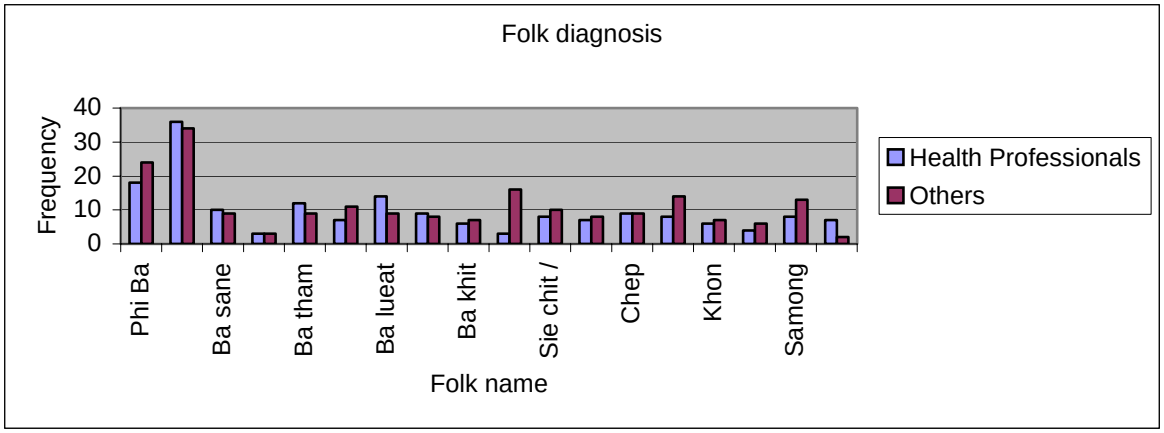
Folk diagnosis	**Translation**	Description - causes
Phi Ba Ba Phi sun PhiBa Phi Pop Phi pao Phi phom	Evil spirit madness Ghost madness	Argue lazy, walk, don't talking or talk too much, talkative but incoherent, say non sense, cannot control him/herself, cry, shout, aggressive behaviour, violent, don't recognise his mother during the crisis, bit Buddha in the temple, see or hear things not perceived by others, can't recognize things or events. Spirit can't go out, it is in the bones and the blood. Fragile after loosing belonging, phi got in him easily Spell from mother in law Look for spirit with chillies to make diagnosis.
Ba mu	Pig madness, epilepsy	Phi attacked and destroyed brain. Comes from genetic (kamapathan) After high fever
Ba sane	Magical spell	One who wants to attract attention does it. Sane is sent when another refuses to love in order to attract. Then the person loves too much the one who sent or miss it too much. It can be made from very different things. Need to know who did it to explain and send it back. .
Ba katha	Magical diagram madness	Doing something wrong when wearing the katha, breaking taboo or non-respect of the rules related to it. Such as walk under one's house
Ba Visa akhom	Black magic (science) skills madness	Mad by learning magic
Ba lin khong	Magic amulet (Object to play), madness	Mad while wearing a dryed human foetus supposed to give protection (and listen him asking for food if not fed at the altar). Madness of the person who made the amulet.
Ba khong	Madness from magic amulet	Amulet sent by somebody, induces thoracic pain or other somatic disorders without abnormal clinical or paraclinical sign.

	or talisman	Has to be referred to Mo phi, Mo pao and Mo ya boran. Frequent among Katu, Alak in the South
Ba Tham tek	Broken dharma madness	Usually concerns a monk who studied too much, has too much theory in his mind. It can be reactivated by bad influences. Dharma is difficult to reach for someone who has great ambition and get mad in its desire to study it. Refers to a person who doesn't have the capacities to reach his goals and tries without success, could be cured and able to work manually but his the mental status is deteriorated.
Ba nyan vethmone	Magical protection madness	Mone being mantra magic words. Talkative, not afraid of anything. can't do anything with this people We should educate not to go to see the sorcerer
Ba ngan mia gap louk	Mad about work wife and child	a kind of joke made to one man by his colleagues when he refuses to join them for fun. Refers to somebody seen as too much family and work orientated.
Ba lueat	Blood madness	- Angry person wants to see blood - Having bad blood or too much blood and so being angry, red face and red eyes, aggressive, unreasonable - Madness in the blood - Person who cannot see the blood (after accident for example) and got mad if there is blood. - Person presenting delirium when having a lost of blood
Ba khit lai	Thinking too much madness	Study or work too hard, had too many worries that may lead to a lost of souls.
Ba neo kit	Thinking madness	Same as khit lai.
Ba yak dai	Craving, madness	Someone who always wants to get more, who is greedy.
Ba se lek	Lottery madness	Someone who always plays lottery and thinks about that.
Ba lao	Mad about alcohol	Related to alcohol addiction more than alcoholic dementia.
Ba lin	Mad of playing	A kind of joke referring to people, who are not serious, could rather be understood as a neurosis.
Ba bay	Delirium madness	Saying non-sense, delirium.
Ba oc hak	Broken heart	Someone who is not successful in love.
Ba hak	Love madness	Someone in love always thinks about his/her lover. Love obsession.
Ba chit	Mind madness	Thinking too much can lead to brain disorders and delirium.
Ba het hai	Spell madness	Too much blood came to the head
Ba kame	Nymphomania	Too much sexual desire, sexual obsession
Ba muan	Happy mad	Euphoria
Ba ti	Biting madness	Aggressive behaviour.
Ba khithi	Stinky madness	Person who does not want to give to anybody, who is greedy.
Ba niot	Megalomania	Mad of honour and dignity, one who got a good position and takes over
Ba sia sen	Mad of lost nervous fibres	Can be the result of spirit action Don't work with others at collective work Stay at home; don't do anything, don't go with others
Ba puang	Delirium	Delirium, hallucination, fugue. Acute psychosis

	Madness	
Ba samong	Brain madness	From hopelessness, excessive worry Example a person who borrowed some money and could not give it back.
Sibo sibe	Does something non understandable	Does everything wrong, popular saying based on behavior.
Chom buei	Self talkative	Talk to himself and nobody can understand, popular saying based on behavior
Non-mad category		
Sie chit	Lost mind	Have strange ideas, usually temporary after shock or accident. Can become mad.
Sie sen	Lost nervous fibres	Person saying bad things, bad words, cannot sleep and have bad dream, can become megalomaniac in speech, disrespectful to others. Sie sen is less severe than Sie chit.
Sie chai	Lost heart	Hopelessness. Very disappointed cannot achieve his goals/ lost Widely used for minor incidents but can also refer to serious problems.
Sen pasath	Nervous fibres	Someone who does not feel well towards himself and others.
Labob pasat	Nervous system	Newborn child can be affected by medicine taken by the mother during her pregnancy.
Chep samong	Brain pain	Can't think, don't know how to solve his problems, think, study too much and brain is too hot and too heavy. Comes from a tumour after accident, head injury/ cancer, and cyst. Is used as a pejorative for headache.
Chep sen	Nervous fibres pain	Pain at different parts of the body.
Khon sa, Khon seu sa	Slow person	Attributed to several reasons genetic including heredity family. Not always seen as a mental illness.
Khon gueuk gak, khon ngo	Debility	The person takes time in answering or doing something and sometimes can't do it. More severe than khon sa.
Bo tem, Bo tem sam sa leung, Bo tem baht	Not full	Refers to idea of incompleteness. Has only 3 saleung while you need four saleung to get a baht of gold
Khon San	Shaking person	Parkinson's disease Because they ate a lot of chicken bottom (one informant)
Khon khiet	Irritable person	Person who becomes angry, too much stressed, when other don't let them do what they want.
Bo sa lat	Not clever	Slow, not clever, can't do anything by himself, is not autonomous.
Samong one, Panya one	Soft brain, Soft cleverness	Unability to learn from birth or accident. Uncleverness, believe easily other persons, is innocent. When parents takes contraceptive before the childbirth.
Samong seuam	Degenerated brain	Severe mental retardation.
Pasath seuam	Degenerated nervous fibres	Refers to bad memory.
Pasath tek	Broken nervous fibres	Neurological system is damaged due to spiritual thing (lin khong) can lead to madness
Mi khon xay	Somebody did	Somebody sent a spell that might lead to madness as well.

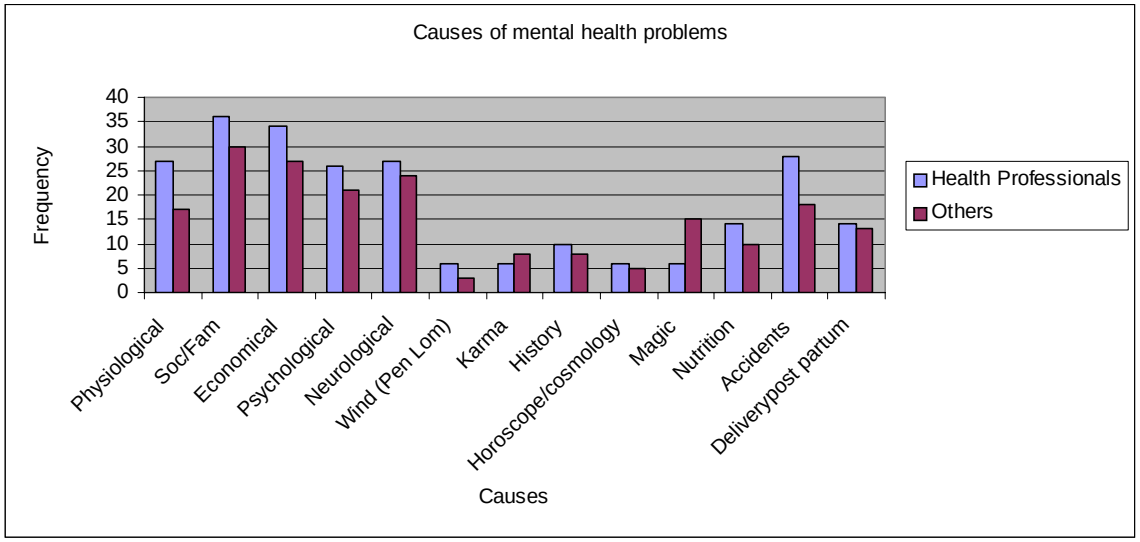
khong	bad thing to someone	
Seum sao	Depressed	Not happy, feel sad
Tou yen kheuane thi	Mobile fridge	Somebody who never worries and is always late or miss important events

Table Folk diagnosis: 86 informants, 363 answers.



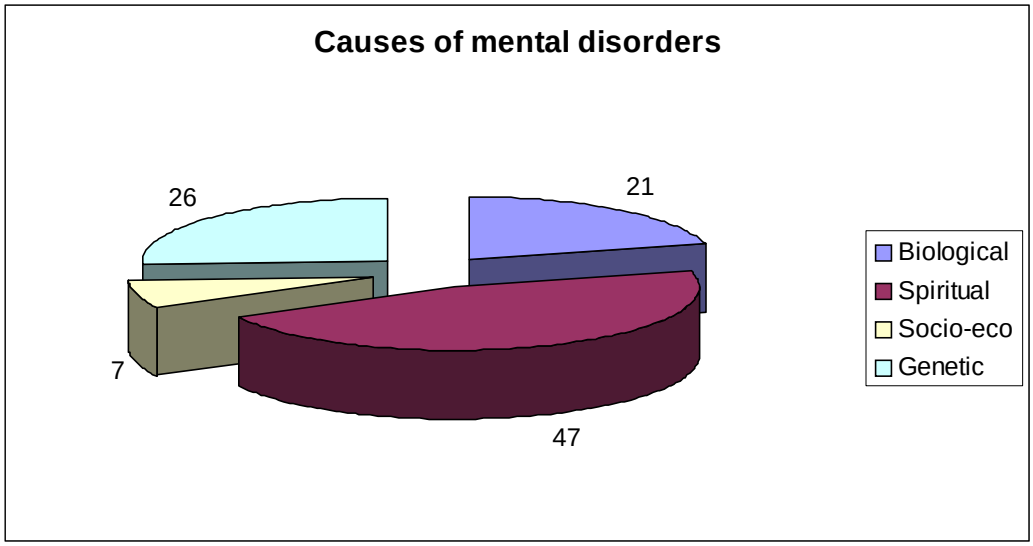
Annex 14 Main causes attributed to mental disorders

According to the key informants (86 informants, 472 answers)



- Wind (pen lom): outside the frame of reference of physician and nurses, wind refers to organic pathology as well as psychosomatic disturbance, spirit possession or a combination of these. In Thailand, Muecke (p 268) mentions severe acute or chronic episodes of paralysis, hyper-agitation, loss of consciousness, and catatonic withdrawal related to wind. Causes of wind can be alcohol, spirits, drugs, post-partum, customs being breached, hunger, or accidents. The effects are sharp pain feelings, fainting, seizures, and episodes of violent or disoriented behaviour. Muecke shows that they are not explained nor cured by magic or biomedicine but referred to traditional medicine mostly. She finds that emotional disturbance associated with inadequate social and economic support is related to wind perturbations. Wind has usually not been recognised as a potential cause for mental disease (only 9 answers/86 informants) but it is still a usual explanation for common health problems such as colds or the flu.

Annex 15 **Causes of mental disorders according to the cases interviewed** (38 cases, 43 answers).



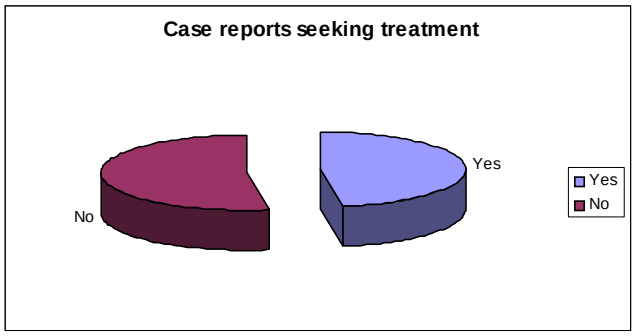
Annex 16 **Examples of sequential diagnoses.**

- In a 14 years Katu girl, spirit from then rice field (phi rai) or spirit from the stream (phi houey) in other 16 years old Lanten girl caused loss of nervous fibres or nervous system (sia sen, sia sen pasath) after a high fever resulting in epilepsy.
- In a 42 years old woman, 20 years ago, somebody did something severe her (sent a spell, het hai), which lead blood to the head and provoked mind madness.
-One 45 old man is suffering from spirit attacks (Phi phet) while he was digging irrigation canals, 15 years ago. Spirit destroyed his nervous fibres and caused madness of nervous fibers (ba sia sen).
- Once recognising fever as a physiological origins of the disorder (madness of nervous system) affecting their 17 years old girl, the parents went to meet diviner (mo do) to understand why it happened to their child and if anything else can be done.

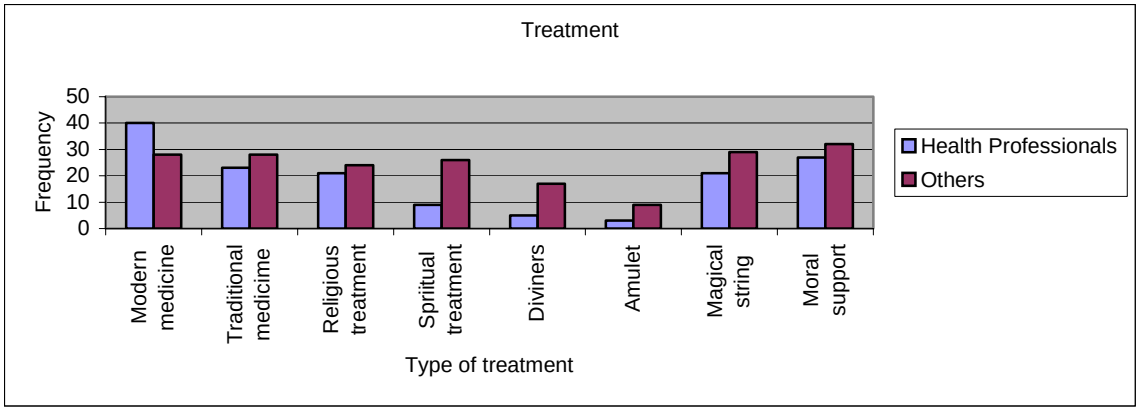
One open-minded doctor tries to find some explanation to what he belives to be the efficiency of mediums practices :
"Spiritual, magical treatment with traditional healers (Nang Thiem) is equivalent to classical psychotherapy. Most of people who believe in spiritual treatment will choose Nang Thiem. This type of treatment is used when the patient is acutely affected mentally. Nang Thiem will use a red stick to beat hardly the patient in order to exorcise the demon from the patient's body. The patient will yield… This is equivalent to electro-convulsion-therapy (ECT)."

Annex 17 Treatment

Case report on seeking treatment or not,
(38 cases, 38 answers)



Treatments supposed to be effective,
(Informants 86, answers: 342)

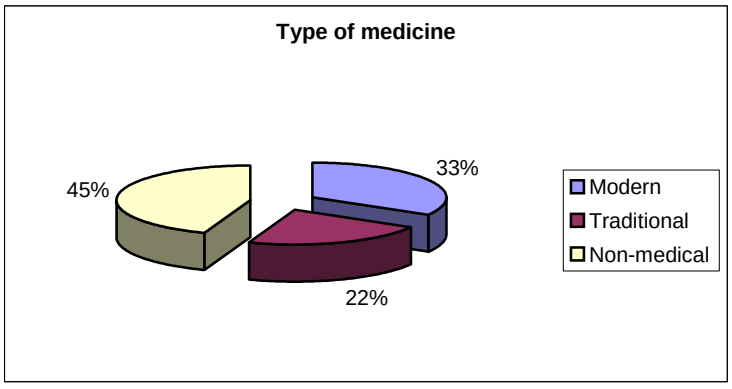


- The ceremony of calling the souls (suk khuan) is mentioned as important in preserving the natural balances of the body and mind. Tying cords around the wrist or neck for children are usual practices of protection.

One doctor explains: *Attaching the strings (kan phuk khen) is helpful in order to induce the feeling of safety, happiness, and satisfaction. The monks should formulate the phai phuk khen or Mo Phone. It is qualified as a Chit Niyom (spiritual belief). There are many colourful phai phuk khen. The white one is transparent, clear, nice, and very popular among the Lao Loum. The red one is popular for the Lao Deng, the black one for Phu thai, the yellow one for the Thai Yuan.*

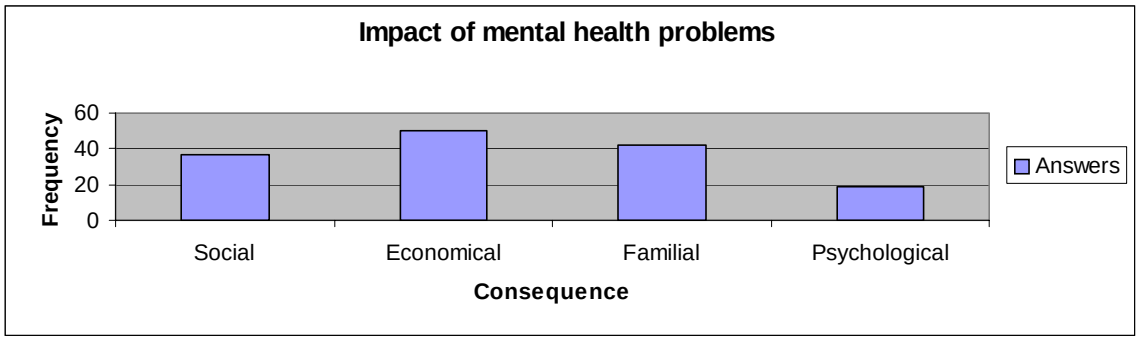
- Tattooing carries immunity but it is not widely practiced with this intention currently. It has not been mentioned expressly as such but it is understood as a preventive action against spirits.
- Astrological notions of bad luck (khock) are often considered as a kind of bad karma (Pottier p 182), and a cause of disease. Khock is derived from the Sanskrit graha that means planet (Pottier p 178). In the Indian astrology, one individual fate depends on 8 divinities corresponding to the 7 days of the week plus one.

Case study: treatment sought
(Cases: 38, answers 44)



Our results show that more than half of the cases didn't seek treatment. This result might be biased by the fact that the interviewer, being a doctor, when asking about treatment, it has been understood as medical treatment. Answers reveal that non-western medical treatment has been sought by a large majority of patients or their family.

Annex 18 **Impact of Mental health problems**



(Informants: 86, answers: 150)

- Handicap International survey results *How do people in your community look at you?*

Handicaped people answers are:

- Uncomfortable 4.7%
- Feel pity 71.6%
- Equal to non-disabled 16%
- Dislike 2.87%
- Afraid 3.5%
- Admire 1%

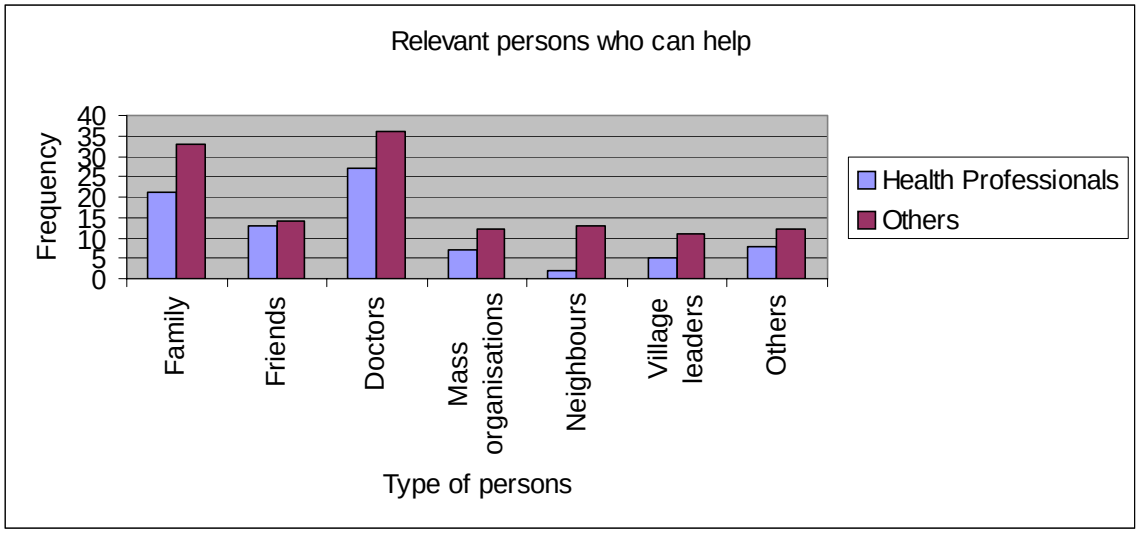
The major problems they expressed are job seeking and medical care access as well as school access for children.

- Bad integration of persons suffering from disabilities in the villages: other testimonies.

- According to one informant working with COPE, in Luang Nam Tha province, people handicapped due to poliomyelitis do not get out of the house and hide themselves because they feel ashamed having a member suffering from handicap. Most of the people consulting the national rehabilitation centre feel guilty, disabled, and useless in the society and have a complex of inferiority.

Annex 19 **Who can help?**

(Informants: 86, answers: 214)



Annex 20 Major mental illnesses: schizophrenia and neurosis

Psychosis and schizophrenia

- Schizophrenia can be described as self-neglect, presenting as a loss of contact with reality, withdrawal, delirium, hallucinations, and logorrhoea with verbal incoherence. In Laos, they might present ideas or experiences of spells and black magic issued from cultural beliefs.
- The average lifetime risk of schizophrenia is about 1 percent in most societies.
- Compared to its incidence and prevalence, the social and economic costs of schizophrenia are disproportionately high. The condition causes greater chronic disability than any other mental disorder. Both the positive and negative symptoms of the disease interfere seriously with a person's capacity to cope with the demands of daily living. Patients with schizophrenia experience particular difficulty in dealing with complex demands and environments, especially those that involve social interaction and decoding of social communication such as industrialised societies. This can be exacerbated when people are removed from familiar villages environments. Moreover, the onset is usually at a developmental stage of incomplete social maturation, educational attainment, and results in a severely truncated repertoire of social skills and lifelong socio-economic disadvantage. These factors are exacerbated by the societal reaction to individuals manifesting the behaviour associated with "insanity", which generally involves stigma and social exclusion.
- In both developed and developing countries, schizophrenia is associated with excess mortality from a variety of causes associated with poor self-care, inadequate nutrition, heavy smoking, and medical neglect. At least part of this excess mortality is preventable.
- Numerous investigators have reported a high proportion of better outcomes for schizophrenia in developing countries. The reasons for this may involve interactions between specific genetic and environmental factors. Research on this topic could have fundamental implications for the critical assessment, the management and the treatment of schizophrenia in both developing and developed countries.
- Schizophrenia and other psychotic illnesses can be controlled with a variety of treatments that offer significant returns in terms of symptom improvement, quality of life, and reintegration into the community. The choice of an anti-psychotic therapeutic agent, however, must involve a balance between several potentially conflicting factors: clinical efficacy, profile and incidence of adverse effects, acceptability and likelihood of treatment adherence, and cost-effectiveness.

First causes of madness according to families or patients (cases: 14, answers: 15)

Mental diseases		Psychosis	Schizophrenia
Causes	Biological		3
	Spiritual	1	9
	Socio-eco		1
	Genetic		1
Total		**1**	**14**

Case of schizophrenia

Mr. D, 45 years old, unemployed, single, living in the countryside of Vientiane Municipality, with his mother and two brothers, suffers from a very severe case of schizophrenia, he is chained at home since 1992. Mr. D had been a very bright student in administrative study. He was very hard working.. He could take care of the family after the death of his father. He has 2 brothers. He is the eldest in the family. His second brother suffers from schizophrenia too. His father had also been schizophrenic and he has already died.

Mr. D's schizophrenia first appeared when he was in Administration College in 1990. He has never been treated with neuroleptics. He received mostly spiritual, religious and magical treatments and his family spent a big amount of money to cure his schizophrenia. This family has had to change its place of living

because a traditional healer told them Mr. D became psychotic due to the land spirit. Now, this family lives in a small house. Once they were rich but they sold most of their belongings, including rice fields, the former house, and buffaloes.

CC: Mr. D, let's talk about your symptoms. Could you begin by telling me about your hallucinations?

Mr. D: Hallucinations have been a major part of my illness. The first hallucination that I have was the sound of a snake in the field. It seemed like someone whispering to me. It is nice to hear this sound. I hear it all time; it will be increased during night time.
The second hallucination that developed was the war occurred in 1936 between Laotian and Burmese, in Myanmar. I am the leader of the Laotian soldiers. Due to my great command, we win the war.

CC: Do you think that you are possessed by a good demon?

Mr. D: Yes, you are right! This demon looks like a mythic animal that is very strong and listens to all my orders. He helps me a lot, otherwise, we would lose the war!

CC: Are you always in contact with this mythic animal?

Mr. D: Sure, he is on my side, don't you see it? He is very kind to me!

CC: Have you had other hallucinations?

Mr. D: Sometimes, I feel something running under my skin dilating my vessels and at that moment, I gather all my energy… The awful hallucination I had and still have is the snake in my stomach swimming in the abdominal liquid and finally causing a back pain due to its venom…
CC: How do deal with this? What do you do when it happens?

Mr. D: I try to chase the snake and sometimes I can catch by hitting my spine hard.

CC: Do you feel having delirium (bay)?

Mr. D: I am possessed by a spirit, capable to dominate certain severe circumstance. As I mention above the mythic animal looked like a semi-horse semi-bird.

During the interview, it is observed that there is an idea-verbal incoherence. His speech is interrupted from time to time. Sentences are not well constructed, difficult to follow and understand. He is undressed, chained in his room. He eats, defecates and baths there. He has sleep disturbances sometimes he makes noise, sings… His self-care is poor, he has inadequate nutrition, and he becomes heavy smoker. His expectations are to be unchained and having an ordinary life like other people in the village.
His family takes good care of him, his old friends still visit him sometimes but the neighbourhood is quite frightened as he once showed aggressive behaviours such as going to destroy the Buddha statue in the pagoda.

Neurosis and anxiety disorders.
"North Americans may feel freer to express negative affect than do South East Asians, who although they clearly have the same emotional experiences may rely on subtle forms of expression" (Devins p 798)
It is a difficult problem to be recognised by informants.

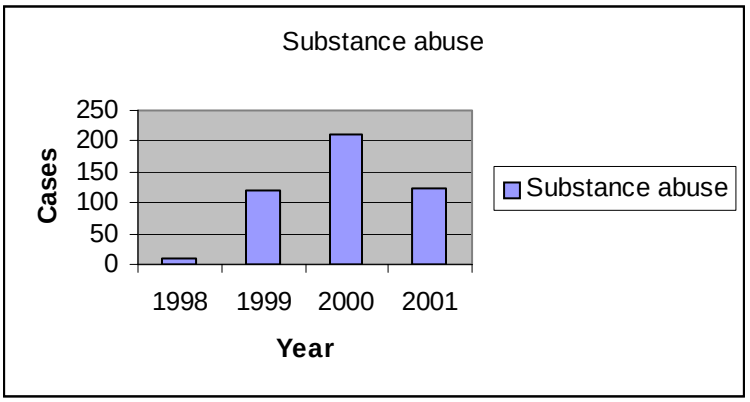
- Kleinman showed that in China somatization is a channel of communication for the experience of helplessness and even despair while Chinese would not complain or express sadness or being depressed to their medical doctors.
- In Thailand, depression is a growing health menace. The 1999 survey found that the incidence rate reached 3.4% in communities and for anxiety disorders it reached 9.5%. This might be indicative of natural responses to economic conditions. (National Mental Health Report, 2001, p 53-54).
- Depression (that should not be linked with sadness) should be established as a separate category.

- Generally, in Asia, we find low a prevalence of eating disorders; no cases are referred to in Laos according to Tsai (2000,184).
- Anxiety disorders as well as Post Traumatic Stress Disorders, in the spectrum of Anxiety, deserve better attention.

Annex 21 Substance abuse

The lifetime reported prevalence of all drug use among the Vientiane school population was 175 per thousand, followed by Savannakhet at 76 per thousand, and Luang Phrabang at 55 per thousand. The highest lifetime reported prevalence of ATS use is in Vientiane at 48 per thousand. The lowest lifetime reported prevalence of ATS use is in Luang Prabang at 11 per thousand. Current reported prevalence of any drug use is highest in Vientiane at 72 per thousand whereas the prevalence is quite similar in Luang Prabang and Savannakhet. Chasing the dragon is a way of smoking drugs by heating aluminium foil on which the crushed substance evaporates while the user inhales the fumes. It remains the most fashionable route of ATS administration among these 3 groups.

Number of cases of substance abuse, from 1998 – 2001, at the Mental Health Unit, Mahosot Hospital



(Source: Mental Health Unit, December 2001)

- ATS and other drugs use

In Vientiane, the use of Ya-Baa in combination with different types of drugs is also analysed for the age group 15 to 19 years old with a total number of 1,429 students. Males using Ya-Baa with other illicit drugs are 3.3% and 0.1% among females. The total number of all students using Ya-Baa together with illicit drugs is 1.8%. Ya-Baa with a specific drug, such as opium, marijuana, and prescribed drugs does not seem high among the students interviewed, except for solvents, which are in the range of 1.6% for both males and females.

- Treatment seeking

The majority of ATS users who seek treatment do so at the Mental Health Unit of Mahosot Hospital since 1998. Opium users are treated in their community at detoxification centres. The method used for opium detoxification is tincure of opium while ATS detoxification is based on the symptomatology.

Treatment statistics show that substance abuse rose from 1998 to 2001. In 1998, there were some cases of cannabis and solvent use. From 1999 to 2001, among those being treated for substance abuse, the most fashionable drug of use was methamphetamine or Ya-Baa.

The main reasons for seeking treatment were: pressure from parents/family; school difficulties; psychological problems and physical problems being out of control.

Annex 22 Mental retardation, intellectual disabilities and acquired brain syndrome.

- Retardation can occur with or without mental disorders but the prevalence of mental illness is 3 to 4 times higher in this population.
- Identification is closely associated with the assessment of intelligence but one should be cautious about the methods available to assess intelligence in the Lao setting.
- Four degrees of mental retardation are usually recognised: mild, moderate, severe, and profound.

- The prevalence is 4-6% in developing countries for all types and 0.5-1.5% for severe retardation. The cause is unknown in 50% of cases, while 15% is usually due to genetic causes, and 36% due to environmental causes.
- Down's syndrome risk is 1/2000 for mothers aged 23-25 to 1/30 if over the age of 45.
- The effect of Agent Orange and other products used during the American war should be investigated as their consequences on mental development are acknowledged in Vietnam.

Noun, 14 y, Female, Vientiane suburb, mentally intellectually delayed and sexually abused recently.

Her mother and neighbours describe Noun as a quiet, polite, gentle girl *(chay di)*. We used to see her wandering around mostly in the temple compound near her mother's house. Sometimes she spends hours in the trees there. She can speak normally and understand people and shares feelings. She rarely cries. Sometimes she has a crisis and she feels tired, shakes, doesn't know herself, and she has difficulties to breath and vomits.
She is diagnosed as suffering from destruction of nervous fibres (sia sen, laboh pasath, panya on). There is one case of mental retardation (bo them) on the father's side that is not related to the patient.
She can become more anxious and nervous if people shout at her or try to take her belongings.
She went to school without success for three years unsuccessfully remaining at the same level and would like to get a professional training now. At home, she can do the usual work if asked and guided, but she doesn't take any initiative by herself.
When she was born in 1988, after the 18th day, she spent 3 months in Mahosot hospital because she presented an external excrescence on her skull. Her mother spent most of her time with her. She received blood transfusion(s).
Later, when she was 4-5 years old, she got a high fever and was sent to the district hospital. She had no hair until she was 6 years old and didn't speak until 7. Her parents separated. Her junior brother who is normal stays with his father. Both parents remarried.
She has received some holy water blessing at the temple.
In order to prevent any new crisis a local doctor was consulted and prescribed some white tablets and vitamin B1. The package for a month costs 20 000 kip and the family doesn't have enough money to buy it regularly. The patient does not like the treatment as it makes her sleep too much.

Her mother was using oral contraceptives before her daughter's birth and she believes that this is the cause of the problem, as she believes this medicine can become poisonous when one is pregnant. Also, poverty is mentioned, as she had no means to buy good medicine and food.
Recently Noun has been sexually abused by several married men according to the mother, a neighbour and the women's union and by a mentally retarded man living in another village according to the village security office. They gave her some sweets or a little money in order to attract her. It is difficult to know the age of the first abuse incident and the impact of trauma on Noun's physical and intellectual development.
More recently, Noun became pregnant. She was already 4 months pregnant when her mother found out the problem. Then in order to be allowed to process an abortion and sterilization that is usually forbidden in Laos her mother brought her to the psychiatric clinic at Mahosot hospital where she was labelled as irremediably sen prasath (nervous fibres damaged) and left without treatment.

This case illustrates the need to develop information and protection programs for mentally disabled children and their families including community awareness as well as professional training.

Annex 23 Epilepsy

- In developing countries, the prevalence is three times higher because of bio-geographic conditions, and economical reasons. There is under treatment due to the lack of resources).
- At least 50% of cases begin at childhood or adolescence.
- 70 to 80% of people with epilepsy could lead a normal life if properly treated.
- In developing countries, many cases of epilepsy are related to preventable parasitic diseases, although the exact contribution in Laos is not known.

- 60 to 90% of people with epilepsy receive no treatment due to inadequacies in human resources and health care delivery, which are aggravated by social stigma (WHO, 2001).
- Phenobarbital has become WHO's front line anti-epileptic drug in developing countries, where it is the most commonly prescribed anti-epileptic. This may be in part because phenytoin, carbamazepine, and valproate are up to 5, 15, and 20 times as expensive respectively (Bulletin of the WHO, 2001, 79 (4), p346)). Phenobarbital was first used as a sleeping medicine and is characterised by inducing a slowing of mental activities and in overdoses affecting all the vital functions. It can induce tolerance, dependance and numerous side effects. Prescribed for children it can slow down the nervous system and might affect their learning abilities. Paradoxically, it may cause excitement, depression, or confusion in children, elderly or weakened individuals.
- More wealthy families, who can afford the cost of newer kinds of anti-epileptics, should be encouraged to do so if Phenobarbital is causing problems for their family members.

Belief that epilepsy can be a communicable disease

In Ban Thongvai, Muang Thateng, Sekong Province, one Katu people (Lao Theung) reported a belief that epilepsy is a communicable disease transmitted through the pork meat.
It is said that one woman, aged 42, suffers from epilepsy for many years because of a piece of pork given to her by a soldier affected during an epileptic psychotic phase.
This young soldier was locked up in a cage. One day, this woman went to visit him, and accepted this piece of pork to eat. Since then, she had seizures three times daily. A traditional healer in the village treats her but she still has seizures. Villagers admit that the spirit does not cause epilepsy and that the cause is something wrong in the brain that can be transmitted through the meat. She is not authorized to cook or to share meals with others although she can work in the fields like other people.

Annex 24 Women and mental health

In two Katu villages, leaders have reported two cases of abnormal behaviours. Both are old men in their sixties who want to get a 13 year old girl as a new wife. While not being condemned as such by local tradition this desire is not welcomed and the village leader mentioned it as a problem as they believe that these girls are too young. One is not living with the girl as she refused and her father, being a representative of the National Front, did force her. The other is already living with the girl and we don't know if a traditional wedding has been performed, as the informant was not really cooperative with the female interviewer. The last wife doesn't dare to say anything against it and she is not allowed speak in any case.
This case raises different questions concerning several issues such as:

- Legality as what has been related in other countries would be child abuse and the perpetrator condemned to jail imprisonment. What is the age of a child and an adult in this community? The national law doesn't permit such a young age for marriage but some adaptation can be requested with special authorisation as regards traditions for minority groups.
- The status of the old man's mental health. He looks very authoritarian and egocentric, although we have not been able to check if for him, as in other cultures such as Chinese, to get a young wife was a kind of regenerating process.
- The status of this child-adolescent-wife's mental health. She has not been interviewed but she didn't look sad or afflicted as villagers said she accepted the situation.
- To which point cultural practices can be allowed and how far this situation is mentally harmful for the girl?

Post partum

- Mental health professionals define post partum as a feeling of inadequacy, the inability to cope with the care of the baby, fatigue, complaints of poor health with irritability, mood swings, impaired concentration and poor memory.
- The influence of culture on post partum mental health has been demonstrated in several studies. The level of social support to women is one of the most important variables. Considering that many women still deliver traditionally at home with their relatives supporting them, we might anticipate that the rate is low.

- Post-partum seems not to be major problem, as post-partum troubles are not much reported although they might not be recognised as such by non-medics. An appropriate method of investigation should be used to learn more about this question.

Annex 25 Children and mental health

According to a Unicef survey (2001):
-10% of the street children interviewed had a disability, mostly related to mobility, also including socio-emotional states (p 17). One of the long-term effects of being in the street can be a psychological problem.
- Many of the children talked negatively about themselves and seemed depressed and resigned to their fate (p 17).
- Asked, "have you ever felt or had the following feelings during the past months?" 9-17 years olds answers were: trouble concentrating on task (27%), thoughts about suicide (6%), depressed (13%), worthless (15%), anxious or frightened (35%), and happy (4%).
- Asked, "How do you think people view you?" answers are: with pity (51%), they dislike us (31%), with fear (10%).

Pilot projects for street children and child beggars and community based services to support children and families at risk would need to get support from a psychologist to work with community and train key people counselling and both physical and mental rehabilitation. Counselling and psychological intervention should be a strong component of activities focusing on street children

Annex 26 Disabled children and adults.

The four major contributors to disability are:
- Congenital or perinatal, 15-20%.
- Communicable disease, 20%.
- Non-communicable and mental conditions, 40-45%.
- Trauma-injury, 15%.

The occurrence of sensory-developmental psychological and intellectual disabling condition is 28 per 1000 representing 103600 people according to the results from community based rehabilitation samples.
In 15 of 17 provinces there is a rehabilitation unit therapist trained in the national health school.
The aims of the rehabilitation centres are to develop community based rehabilitation services with an enlightened focus on children (1/6 of the disabled individuals); self help groups, vocational training, and jobs creation.

Annex 27 Elderlies

Senile dementia and delirium.

Mrs. A, 65 years old, housewife married ha a daughter, lives in Ban Phone Gam Neua with her husband. During the interview with the patient, she is not cooperative at all. Contact with her is not possible. She can't answer question. She seems to be in another world. Her attention is low. She loses her eye contact. Her husband reveals that she presented mental disturbances since February 2002:

(1) Memory impairment: she did not recognize anyone in the family, even her husband.
(2) Some cognitive disturbances such as:

- *Her speech was confused nonsense.*

(3) Behavioural disturbances as follows:

- *She wandered several times. Each wandering lasted at least a week. She did not know how to return.*
- *She became aggressive, she abused her son-in-law saying that he is lazy she tore up her dresses and threw them into fire.*
- *She did not sleep at night, keeping arranging things, repeating the same acts*

(4) Mood disorders:

- *Her mood was labile. She spends much of her time singing, dancing alon, and sometimes, she was felt to be in depressive phase.*

(5) Perception disturbances:

- *She had audio-visual hallucinations. She had delirium regarding someone who has already passed away for many years. Sometimes, she was talking to herself like answering someone.*

Before she was healthy, he did not have any vascular or cerebral problems. One of her biological relatives presented symptoms. She liked to go to pagoda but now she is not interested in religion. She has been locked in the house in order to avoid fugues. She has her space where she can move easily in the house. She is doing nothing at home even routine housework.
She was treated at the mental health unit at Mahosot hospital for two weeks. After the admission, she did not follow strictly the treatment due to side effects of neuroleptics that she didn't bear.
Her husband believes that this situation is due to her karma. She received three types of spiritual treatment:
The first time with Mo Mone by using an egg, which revealed that, her parent's spirit expect to possessing a wax castle so this expectation was offered but her illness was not ameliorated.
The second with a Mo Tham telling that it was due to her karma caused in her past time. The third with another Mo Tham revealing that she chained a cow and she did not feed him. She had served five hundreds years but no success, so she has to compensate her karma now.
Her husband says that there is no need to bring her to the hospital to seek mental health care but he will try for the last time a spiritual treatment with a Mo Tham at Houai Nam Yen who seems to be very popular in curing people with mental disorders.
Her physical appearance is deteriorated. She is very thin, undressed and quite dirty.

Annex 28 UXO and land mines victims

- A Survey by Sumasondaram (1998) in Cambodia with UXO and land mines victims showed PTSD, anxiety disorders and depression, acute stress reaction, somatoform disorders, alcohol or drug dependence, and relationship problem.
- According to one NGO, working in Xieng Khuang with UXO related issues, and community economic development, some of the symptoms mentioned in Cambodia do appear as well, but they are not directly addressed because of the lack of adequate professional skills.

"After accident, people stay just sitting, they don't want to see others, and they feel that they can't do anything, they are hopeless."

- It is well known that accident victims need psychological first aid, debriefing, and counselling during recovery.

- The rehabilitation programme could promote group self support for creative expression of emotion and trauma, and traditional relaxation methods including massages and work with the community to avoid stigmatisation and rejection of the victims.

Annex 29 Other issues

Psycho-somatic disorders.

- Moore's results (2001, p481) dealing with Lao and Mien patients in U.S support the notion that "physical pain complaints in psychiatric patients contribute to psychopathology and deserve careful attention. Culture strongly affected presentation and the study supports the identification of Mien somatic complaint syndrome." The most common primary complaint for Mien in the psychiatric program was pain while asked specific questions they reported clear symptoms of psychiatric disorders. The ethnic Lao described spontaneously emotional problems and put less emphasis on their physical complaints. The psychiatric treatment has been more successful for them.
- While chronic somatic pain should be evaluated in depth, a mental health assessment can provide pertinent information in terms of psychiatric or psychosocial causes of distress.
- Neverthless the psychiatric treatment being not clearly understood, its acceptance as well as the tolerance of the side effects are variable.

Amok or Sudden Mass Assault (burn out)

Described as a sudden mass killing of unknown persons, amok is one of the famous so called culture bound syndromes found at first in South East Asia (the archetype being a Malay or Indonesian man running and killing with his Kris). It is interesting to consider that nowadays mass killings occur regularly in USA and increasingly in Europe. Westermeyer studied several cases of sudden wholesale killing and maiming of unsuspecting victims with hand grenades, in working or public place, during daytime. The men didn't present acute mental health symptoms or psychopathological out puts (psychosis, convulsion, mental retardation).

The majority are single men, soldiers or having access to weapons. Marital discord, divorce, broken love affairs, financial losses, death of a family member and social embarrassment drunkenness and public quarrels preceded the amok. The burnt out men had few psychosocial resources in a context of social and geographical mobility. It seems that loss precipitates the event. They knew 50% of victims. Political and economical motifs are important to consider.

One case of amok

In Xieng Khuang, 5-6 years ago, a man who had been criticized by the local authorities for fishing with hand grenade got mad and killed several people with a gun at a village meeting. He was sentenced to the death penalty

Amok cases are very rare nowadays according to the advisor at the Ministry of Justice.

Trauma and PTSD

- Vietnam war veteran then SEA refugees in the US who complied to the diagnoses that brought them some benefits in the care system were at the origin of the widely used PTSD diagnosis that became a kind of market both for pharmaceutical companies and NGO. It is strange to see that in the countries of origin, the concept doesn't show much prevalence. It leads us to consider that the individual story of war and trauma is reactivated in exile facing acculturation in a context where it can be useful to present these symptoms.
- In order to account for differential diagnosis across the spectrum of psychotic episodes, anxiety disorders and depression, it is essential to consider the interaction between cumulative trauma and symptoms presentation and to explore personal histories to find out if there was any traumatic events.
- It is recognised that immediate psychological-psychiatric intervention with victims after a disaster will help to relieve from further mental suffering and psychosomatic disorders. In Laos students have started to be trained on disaster prevention and first aid, so it would be wise to include a psychological module in this curriculum.

Annex 30 Ministry of Education

Description of one integrated school

Phonesavath School in Phon On district belongs to the inclusive scheme and integrated 10 children presenting various handicaps (polio, Down syndrome, deaf and dumb, mental retardation. Only 6 teachers have been trained during summer holidays.

According to the director, poor families can't afford to send their children to the rehabilitation centre in Vientiane, and it is good that these children can stay with their families at home.

The school receives support from the Handicap International rehabilitation program concerning physical disabilities. One child received now a wheel chair. It is difficult for the teachers to pay special attention to these children, as there are already many pupils in one classroom.

Some of these kids did start to learn and they can write or read; going to school they can socialise with other children who are taught to treat them well and respect them. It is also a burden relief for the families as many of them at first felt some shame and didn't let these children go around with others.

School is free for these children as the village leader who is also a community rehabilitation worker for HI developed solidarity with villagers. For the poorest ones, books and materials would also be provided.

The main problem that remains is the treatment and appropriate rehabilitation for the pupils suffering from mental retardation or intellectual disabilities as nobody is an expert and general education is sometimes difficult for these kids who deserve special attention.

Annex 31 Health Insurances and mental health.

- Social Security Organisation (SSO) for people with salary in the formal sector started in June 2001. As a wide package including pension for disability, care taker (for example, mother who takes care of affected child). It covers all diseases, apart from cases of accident, drug overdose, suicide attempt and auto-mutilation. Routine care is provided if necessary for Lao population. CTscan that might be important for psychiatry is excluded yet. Psychiatric care in the province might be excluded if it not usually or readily available for people in the rural area. Hospitalisation not longer than 3 months for the same reason is covered. The decree on SSO, medical section is only 15 pages.
- Community Based Health Insurance (CBHI) is starting now, it should be more or less the same conditions; mutilation and drug abuse are excluded.
- The Civil Servant Scheme or public service insurance from MLSW, should be covering for care, medicine on the essential drugs list, and all diagnoses from doctor and hospital fees. It is not functioning well, partially because the contributions will not cover all of the costs.
- For AGL, (the Lao-French joint venture) that has the monopoly on vehicles insurances, damages and disability due to traffic accidents, including mental health sequelae, will be covered, provided that there is a medical diagnosis, and according to the type of contract. Mental health, including epilepsy, is excluded from their health insurance package.

Annex 32 The Faculty of Medical Sciences FSM

- In 1969, the Royal School of Medicine established a bachelor degree in general medicine in partnership with the Medical School of Montpellier, France. The duration of medical study of the first class(1969 – 1975) was 7 years.
- From 1975 to 1977, French and Laotian experts taught in French. The duration of medical studies in general was 6 years.
- From 1978 to 1986, the Faculty of Medicine received much support from Russian medical experts.
- From 1975 to 2002, the Faculty of Medical Sciences has produced 3,047 medical professionals in general medicine, approximately 108 per year.
- Since 1998, the Faculty of Medical Sciences has introduced a credit system, with respect to the rule of undergraduate education of the National University of Laos. The number of credits is based on the regulations of the National University of Laos on the requirement for the bachelor degree program. Credits hours allotted for each course are based on:
  - Didactic lecture of teaching: one hour per week throughout a semester
    And Self-learning two hours per week: one credit.
  - Laboratory practice is 2 – 3 hours per week throughout semester: one credit.
  - Clinical clerkship is one-week experience is given as one credit.

The duration of the medical doctor degree program is limited from 7 to 10 years. An academic year is comprised of 2 semesters. Each semester is comprised of 18 weeks.

- The first and second years are the period of premedical courses in basic sciences, so students have to study in the School of Foundation Study, which is not on the FMS campus.
- The 3rd and 4th years are the period of pre-clinical sciences. Students study at the Faculty of Medical Sciences including lecture are laboratory practice, although laboratories are not functioning.
- The 5th and 6th years are the period of clinical sciences. This period is divided into two parts as follows:
  - The first part students have to complete clinical practice teaching in the morning and in the afternoon at the Faculty of Medical Sciences for the 5th and 6th years.
  - The second part students have to practice in the field the theoretical course by attending the lecture at the Faculty of Medical Sciences for the clinical practice. Students have to achieve clinical rotations in four main services of a teaching hospital including medicine, gynaecology/obstetrics, paediatrics and surgery.

The medical curriculum consists of the following courses:

- **Premedical courses** comprised of 70 credits: basic sciences and mathematics (40 credits), basic social sciences, humanities, foreign language (30 credits).
- **Professional courses in medical sciences** composed of 197 credits: pre-clinical course (89 credits), clinical course (108 credits).

The problems in the medical education are:

- Limited human resources in terms of number and skills.
- Lack of teaching materials.
- Lack of medical books in Laotian.

Internship and resident training are available at the Faculty of Medical Sciences, mainly in paediatrics, surgery, internal medicine and gynaecology/obstetrics in collaboration respectively with the Case Western Reserve University of the USA and the University of Strasbourg in France. There are two parts to these studies: theoretical and practice at the Faculty and the Mahosot hospital which is the teaching hospital. Resident training takes 3 years.

Undergraduate training in mental health

Psychiatry has been taught for the fifth year of general medical students at the Royal Medicine School since 1974; first, by a French psychiatrist without practice, and after 1979 by a Russian psychiatrist, including practice at the outpatient department of Mahosot hospital.
Sixth year general medicine students

Psychiatry is comprised of 4 credits equivalent to 20 theoretical hours taught at the Faculty of Medical Sciences and 20 practical hours at the mental health unit. The curriculum is as follow:

- Psychiatric semiology (3 hours): consciousness, emotional, speech, thought, perception, memory and intelligence disturbances.
- Psychiatric syndromology (3 hours): organic brain syndrome, mental confusion, catatonic syndrome, hallucinatory paranoid syndrome, affective syndrome and neurotic syndrome.
- Mental nosography (7 hours): neurosis, schizophrenia, bipolar disorder, organic psychosis, mental retardation, psychopathic disorder and substance use.
- Psychiatric therapeutic (1 hour).
- Psychiatric emergency (2 hours): acute anxiety, delirium, mental anorexia, suicide attempt, acute psycho-motor agitation;
- Mental health (4 hours): definition, primary mental health care and psychiatric community.

- The teaching method for the theoretical part is mostly lectures and sometimes small working groups are proposed.

- During 4 weeks of practice at the mental health unit, students have to attend the interviews done by the psychiatric teams, write patient reports, and present the case to their colleagues and discuss it under the supervision of the psychiatric team. The evaluation system is short questions in order to test students' level of knowledge and comprehension.

Fifth year dentistry students
The objective of teaching psychiatry / mental health to these students is to provide basic understandings on these subject in order to recognize at least some psychiatric symptoms and how to deal with them.

Annex 33 College of HealthTechnology
Medical technician students include nurses, hygiene, pharmacy and laboratory students. They have to pursue the study for three years and they are graduated as nurses, hygiene, pharmacy and laboratory assistants. Psychiatry is taught to nurses and hygiene students at the third year with 3 credits in order to be able:

- to explain principles and mental health nursing towards individual, family and community;
- to recognize abnormal behavior of a person and a group of people;
- to provide mental health care and rehabilitation.

Contents of the curriculum (27 h) are as follows:
a) Psychiatric semiology (5 hours): introduction to psychiatry, emotion, desire, thinking, and speech disturbances.
b) Psychiatric syndromology (5 hours): psycho-organic syndrome, mental confusion, catatonic syndrome, hallucinatory and delirium syndrome, neurasthenia.
c) Mental disorders (3 hours): schizophrenia, psycho-genetic, bipolar disorder.
d) Mental health nursing (7 hours): introduction to psychiatric nursing, role, responsibilities, and characteristics of psychiatric nurses.
e) Mental health (7 hours): mental health and mental problems, stress and stress management, factors favoring mental health disturbances, mechanism of psychological prevention, infant of the family, communication, principles of nursing in psychiatry.

The total number of practice hours is 14 hours.

Annex 34 The Psychology department at the faculty of education sciences in the National University of Laos (NUOL), Dong Dok Campus

- In 1979, Psychology was introduced in Lao P.D.R associated with Pedagogy at the Institute for Teachers Training.
- In 1995, this department was divided and a new department of Psychology was opened within the Faculty of Education Sciences with 9 professors in charge of teaching psychology.

- Four teachers have a bachelor degree from NUOL.
- One has a master of general psychology from Russia (Mr Khemphet Boulomsay, Dean of the department)
- One a master of psychology and education in Konkaen (Thailand): Mr Khamseng Thansy, deputy director.
- One a master of counselling psychology in Thailand
- Two have a master of guidance in Thailand (Mrs Vongsendeuane and Mrs Chounlamany)

Future projects include:

- Writing a document on mental health and clinical psychology adapted to the teachers' needs in Laos
- Survey on teachers' mental health in NUOL
- Following a training on mental health and getting in touch with professors of psychiatry at the Faculty of Medicine
- Finding a setting to practice counselling and guidance as skills learned in the University have never been practised.

Psychology as a science of human and social behaviour and experience is originated in the Western Judeo-Christian societies. Adjusting theories and practices to a new environment and culture, addressing the specific socio cultural problems of the Laotian people, is needed.

Annex 35 National Centre for Medical Rehabilitation / COPE / Handicap International

We met the project manager for Cooperative Orthopaedic and Prosthetic Enterprise (COPE) an NGO working closely with the National Rehabilitation Centre of MOH.

Three types of patients are recognised with different psychological dynamics and expectations toward care:

- Government officers (soldiers, police, veteran): very agitated and claim a lot.
- Government officers in ancient regime: calm, feel shy (guilty?).
- Lao citizens: try to be familiar with the staff and grateful.

Work team includes: an international physiotherapist, an international prosthetic orthopaedist, a Lao prosthetic orthopaedist, a Lao surgeon, a Lao physiotherapist, and a Lao prosthetic orthopaedist technician.

Annex 36 The role of monks and temple *(watt)*

- Monks feel concerned by the increasing problems met by the contemporary Lao society that are leading to mental illness such as drug addiction, family violence, suicide, child abuse etc. The monks we met said that they would like the Buddhist message to be taught in the schools. It should be difficult to promote these ideals in this time of globalisation and market turned economy, but to teach how to deal with craving can be useful for the ones who suffer of the desire to have (ba yak dai). They are ready to be involved in the promotion of healthy mental life styles using TV and radio or manuals as well as youth gatherings in the temple,as in July 2002 for the national campaign against drug abuse.
- Monks refer to the morality developed in Buddha teaching. *"If we follow the precept we should not have mental problems,"* explains Ajarn Veth. The main idea about Vipassana is to keep kindness in your heart and then you can be happy.
- Karma is another explanation for the causes of the misfortune that one is facing. It is not always helpful to be told that your problems are coming from your bad actions in your former existence. Referring to one's karma as being responsible for what happens to you is not very effective as ordinary people are rather looking usually to external causes that they feel are easier to manipulate. Dore (1979) reports the inefficiency of classical Buddhist counselling referring only to karma and moral advices, Mrs Chanti is possessed by spirits (phi), and shows violent disruptive behaviour, classical monks not using magic, can't do anything and the family had to find another healer.
- One should distinguish between meditation, counselling, holy water aspersion, and magic practices performed by monks.
- Humoural theories derived from Buddhism describe the human body as composed of four main elements: earth, water, fire and wind. These theories are used in the understanding of daily minor ailments but have not been mentioned as such for mental health problems. The main reason is probably that we didn't investigate deeply enough in this direction.
- Exorcism and chasing spirits, even if performed by many monks, is not part of their duty according to their rules of life. The position that has been explained by the two monks we met regarding exorcist rituals (chase phi or spirits) is very much classic as they condemn the monks practicing these rituals which are considered as non-Buddhist and Brahmanistic.

"The people need more education even if they come to receive some holy water the monk should not let them believe that he has some power to transmit in the water. He should take advantage of their coming to teach them about their life,' if you do good you receive good, if you do bad you receive bad" (tham di dai di, tham sua dai sua), they need more education".

Perception of a monk towards mental health issue

"Severe or minor mental disorders are occurring everyday. People always complain about their sadness and rarely express their happiness. Factors causing mental health problems are family conflicts, love and hate, high envy, stress at the workplace… To avoid mental health problems, people should learn to meditate in order to calm themselves and try to find a better way to deal with constraints happening in their

daily life. An individual should also be conscious of his acts, for example: if he walks, his spirit should follow this act.
Man spirit is comprised of four parts: Vin Gnane or soul, vetthana or mood, Sanya or memory, Sangkhane or perception. 189 spirits inherit our body. In Sanskrit, "Chit" means, "heart" in Laotian and "Vin Gnane" or "soul" for Brahmanism.
A person is composed of material or "objectivity" or "Loubpatham" and name or "Namchit". For example: eye has its own soul, if a person falls sleepy, his eyes have no soul.
Four main factors leading to mental health problems: alimentation, accommodation, dress, medicine and locomotion, which are strongly linked to an individual's daily life.
Family institutions are very important. They represent both paradise and hell. For example ATS abuse among young people is due to family conflict, parents having enough time for their children, try to recompense this negative point by giving money… children do not understand this intention, try to hide a missing part by abusing drug…
There are four types of people coming to the temple:
1. *Ordinary people who expect to calm themselves*
2. *People who want to get luck*
3. *People who are afraid of having bad lucks*
4. *People having psychological (heart) problems*

Annex 37 The role of Traditional healers

Our survey shows that patients typically consult a large range of traditional healers such as:

- *Mo ya* preparing herbal medicine or traditional medicine.
- *Mo pau* blowing specialist, supposed to have magical skills.
- *Mo phi* maintains close relation with spirits, and refers to them for healing practices and rituals. He is expelling bad spirits (phi).
- *Mo tham* uses special words to communicate with the spirit world, bargains on the behalf of the patient with spiritual entities. His practice being based on dharma (tham), he can't practice black magic.
- *Mo mone* prepares amulets or talisman, can send spells, gives holy water to drink and cotton strings attached to the wrists. Considered as a sorcerer. Dore (1979) described how one Mo mone revealed that the spirit of one ancestor from the house became angry because Mrs Chanty didn't make offering to him.
- *Mo thiem* and *Mo Son* are mediums calling spirits possessing them such as the one from Phosy mount to solve problems publicly asking for offering ceremonies.
- *Mo do* is a diviner or fortune teller, he can refer to horoscope (hora), reads in the hands, cards etc…He is not recognised as a healer as such but he can provide advices and information concerning the causes of health problems.

Annex 38 Medicine needs and cost.

The following calculations take into account the needs of the 694 cases identified in the local population of 100 000 people. Average number of psychiatric cases from 1993 to 2001 at the mental health unit, Mahosot Hospital

- Antidepressants

Of the 74 annual cases of major depression, it can be assumed that:

10% are treated 365 days per year
20% are treated 180 days per year
20% are treated 90 days per year
50% are untreated

Using a standard dose of 75mg tricyclics, the annual need for antidepressant medication is:

74 x ((0.1 x365) + (0.2 x 180) + (0.2 x 90)) x 75 = 502 275mg
In 25mg tablets = 502 275 / 25 = 20 091 tablets

Assuming that tryptanol costs 600 kip, the cost of antidepressants for the region can be estimated as: 20 091 x 600 = 12 054 600 kip or **USD 1 143 per year.**

- **Antipsychotic drugs**

The following estimation can be made, assuming that 70% of the patient population would use an oral preparation (average 10mg per day) and 30% a sustained release preparation (25mg per 4 weeks fluphenazine decanoate).

The total number of people suffering from psychosis is 216. Assuming that 80% are on antipsychotic drugs throughout the year, the number treated would be 173 for a full year. Assuming that the cost of haloperidol is 1 500 kip per tablet of 5mg, and the cost of 25mg vials of fluphenazine decanoate is 18 000 kip, the following calculations can be made:

Number of 5mg haloperidol tablets needed:
173 x 0.7 x 10 x 365 = 442 015mg
In 5mg haloperidol tablet: 442 015 / 5 = 88 403 tablets
Estimated cost of haloperidol:
88 403 x 1 500 = 132 604 500 kip or USD 12 569
Number of 25mg vials of fluphenazine decanoate needed:
173 x 0.3 x (365/28) = 677 vials
Estimated cost of fluphenazine decanoate:
677 x 18 000 = 12 186 000 kip or USD 1 155

Total estimated cost for antipsychotics = **USD 13 724 per year**

- **Anti-Parkinsonian drugs** (for use only in conjunction with antipsychotics)

Assuming that 50% of patients on antipsychotics would need antiparkinson medication, that the average dose is 10mg daily, and that the cost of artane is 1 500 kip per tablet of 5mg, the following calculation can be made:

Number of 5mg tablets of artane needed per year:
173 x 0.5 x (10/5) x 365 = 63 145 tablets
Estimated cost of antiparkinsonien drugs:
63 145 x 1 500 = 94 717 500 kip or **USD 8 978 per year**

- **Mood stabilizing drugs**

Assuming that 70% of 55 people with bipolar disorder (or 39 are on tegretol, that an average dose is 400mg per day, and that the cost of a tablet of tegretol 200mg is 2 000 kip, the following calculations can be made:
Number of 200mg tablets needed per year:
39 x (400/200) x 365 = 28 470 tablets
Estimated cost of tegretol as mood stabilizing drugs:
28 470 x 2 000 = 56 940 000 kip or **USD 5 397 per year**

- **Antianxiety drugs**

Assuming that an equivalent of 1% of the population (1 000 people) are being treated with benzodiazepines continuously for approximately 6 months, that the average dose is 10mg diazepam daily, and that the cost of diazepam 5mg is 200 kip, the following calculations can be made:
Number of 5mg diazepam tablets needed per year:
1 000 x (10/5) x 180 = 360 000 tablets
Estimated cost of diazepam:
360 000 x 200 = 72 000 000 kip or **USD 6 824 per year**

- **Antiepileptics**

The total number of people suffering from epilepsy is 130. Assuming that 70% are on phenobarbital 200mg daily throughout the year (or 91 for a full year). Assuming that the cost of a tablet of phenobarbital 100mg

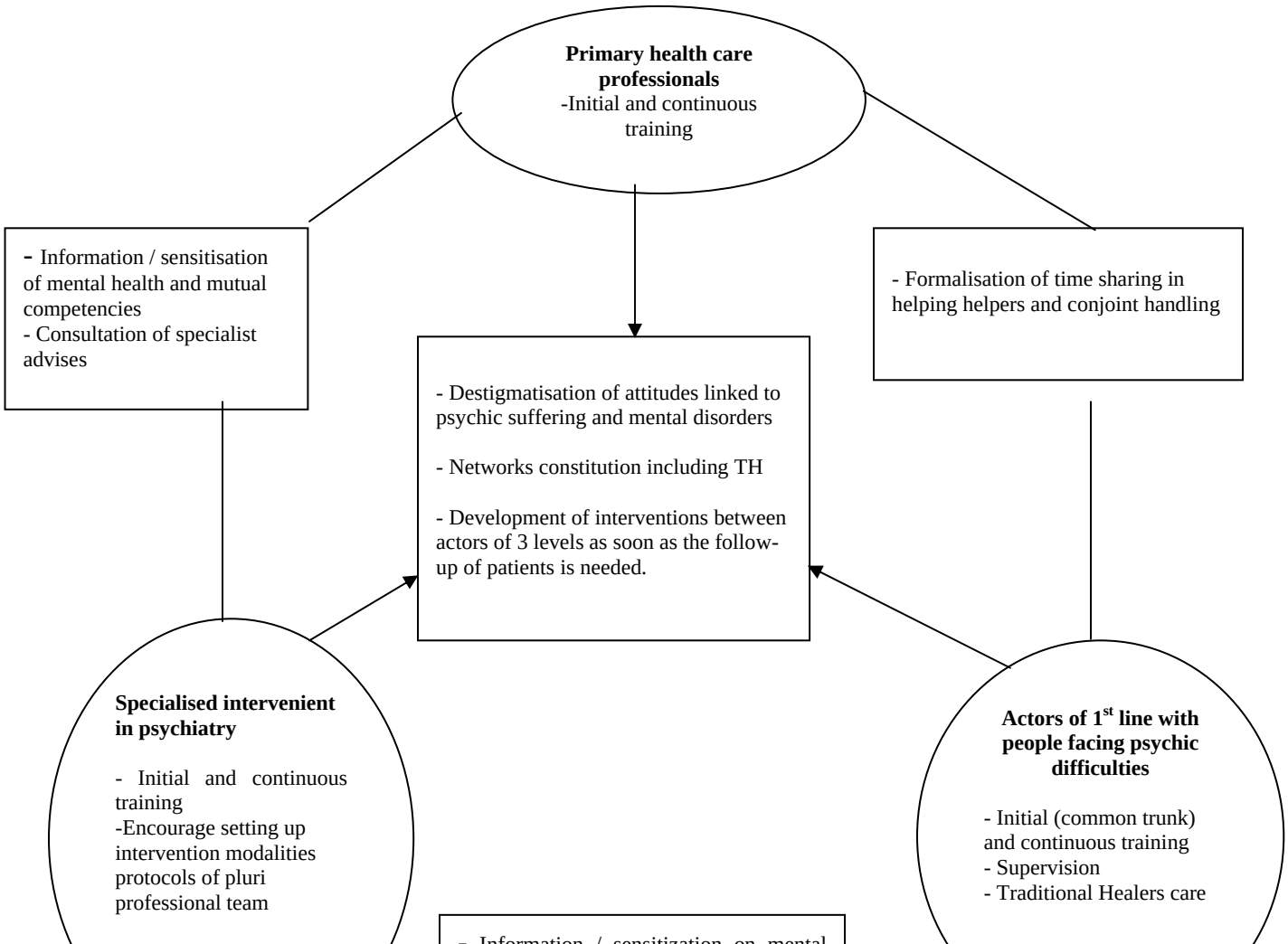
is 500 kip. Assuming that 30% are on tegretol 400mg throughout the year (or 39 cases) and a tablet of tegretol 200mg is 2 000 kip, the following calculations can be made:
Number of 100mg phenobarbital tablets needed:
91 x (200/100) x 365 = 66 430 tablets
Estimated cost of phenobarbital:
66 430 x 500 = 33 215 000 kip or USD 3 148 per year
Number of 200mg tegretol tablets needed:
31 x (400/200) x 365 = 22 630 tablets
Estimated cost of tegretol:
22 630 x 2 000 = 45 260 000 kip or USD 4 290 per year

Total estimated cost for antiepileptics = **USD 7 438 per year**

- The total estimated cost of psychiatric medication for the local area of 100 000 people per year is:

Antidepressants	USD 1 143
Antipsychotics	USD 13 724
Antiparkinsonian	USD 8 978
Mood stabilizers	USD 5 397
Antianxiety drugs	USD 6 824
Antiepileptics	USD 7 438
Total	**USD 43 504**

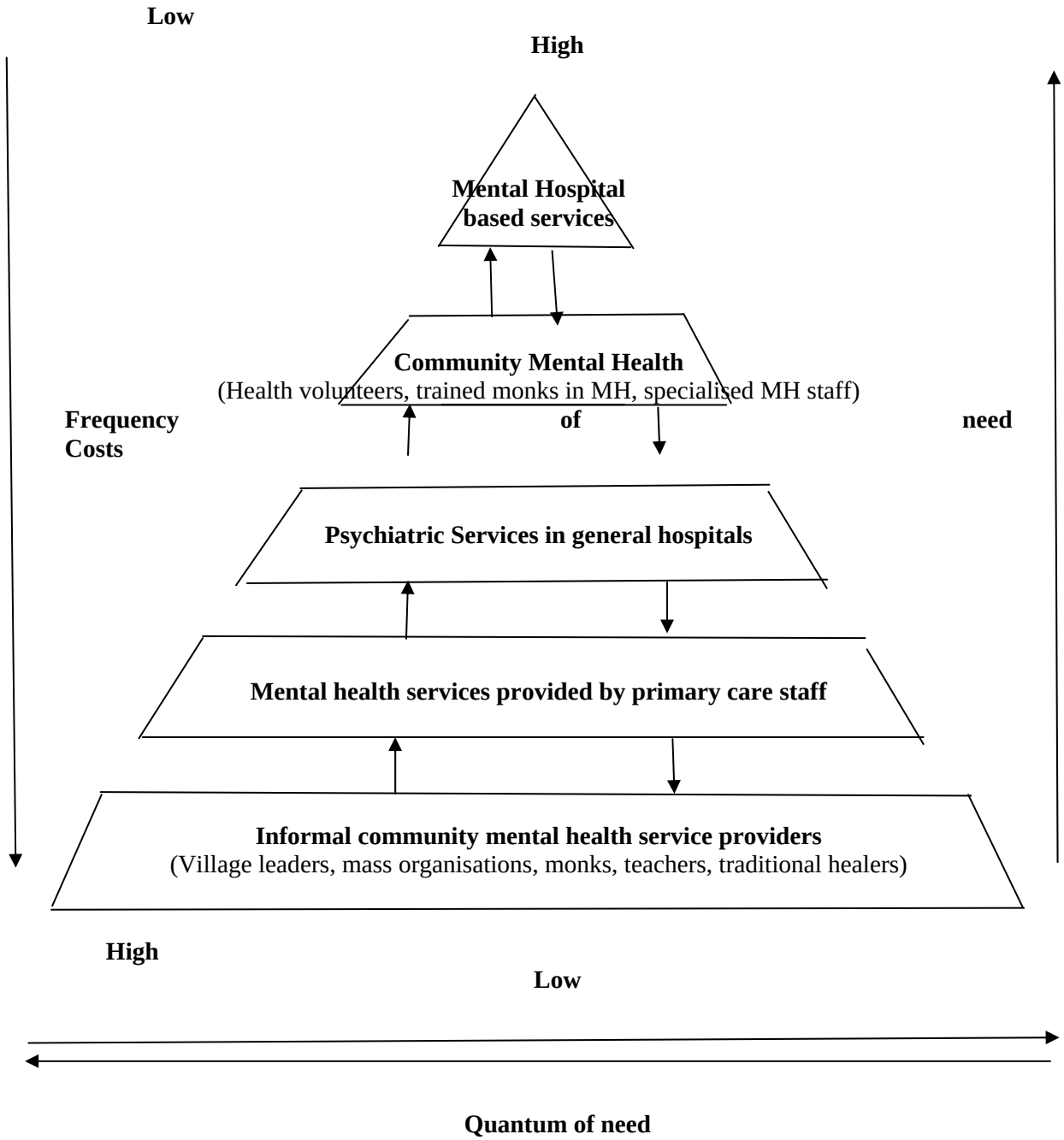
Annex 39 Integration of mental health in the health care system.
Three levels of intervention, measures for adjustment of the level of competence.



Competences in the 3 levels of intervention in mental health care

Specialised professionals in psychiatry	**Primary health care professionals**	**Intervention of 1st line with persons suffering from mental problems**
Prevention Certifies the quality of preventive actions. Co actors of prevention actions. Care In depth psycho-pathological evaluation and diagnosis. Prescribe treatment. Advise on warranty of global strategy in handling patients. Insure the information feedback to patients. Reintegration Co-Animators of readaptation and reinsertion. Respond to demands formulated by the levels 1-2 of intervention. Help to manage crisis situation. Insure supervision of the practices.	Prevention Health education Patients guidance Psychological listening Care Evaluation of the situation and semiological elements. Handling of patients by providing the immediate protection measures if necessary / 1st diagnosis. Referring to needs at the specialised intervention level (for advise) Treat / care Treatment provided by specialist. Accompany psychological handling and/or care Reintegration and: follow up	Prevention and insertion Social and educative approach Listening Support Collective prevention and social reinsertion with the participation of levels 2 and 3. Identification of psychological stress indices Orientation if needed to non specialised or not Care and reintegration Combining psychological handling and/or care of relationship with the person within family and community.

Optimal Mix of different Mental Health Services



Mental health care actors: Three levels of intervention

- Mental patients should have the same rights as other patients and deserve the same consideration and care.
- Orientation to the Serious and Permanently Mentally Ill (SPMI) and priority in the access to care, at the district or province level has to be implemented.
- The major issues that can be approached in primary care are depression, anxiety; sleep problems, chronic tiredness, unexplained somatic complaints, and alcohol use disorders.
- Most family, community, or general practice physicians can and do prescribe psychiatric drugs and they are the ones who are referred the problems from lower levels of health workers. The role of general physicians as primary providers of mental health services has to be reinforced, increasing access to advice and treatment.
- Strong personal contact is important in Asia in the relation with the care provider. Partnership with psychiatrists and general practitioners who know better the patients has to be reinforced. In risk reduction strategies to be implemented from the family, community physicians are more likely to be effective rather than support from a psychiatrist who can be used as a consultant.

Annex 40 Community based mental health support

- The capacity of the community to recognize, address and treat mental health problems has to be developed by teaching health promotion in the communities in order to promote self-help groups. Prevention of suicide, unwanted pregnancy, and alcohol and substance abuse in parallel with mental health promotion is a priority.

- It is important to decentralize mental health care at grass root level and develop community-family based care with mass organisations and village leaders with the guidance of health professionals and concerned traditional healers. No other strategy will be able to provide care to the majority of the nation.

- Raising awareness on mental health among the community will make it easier to build a community approach based on primary health care. Incorporation of mental health in the core curriculum of primary and secondary school students would be desirable.

While setting up such a program, it is advisable to:

- Pay attention to different groups of villages or communities. Languages spoken, history of the settlement, ethnic composition, remoteness, economy, and migrations, have to be considered and their incidence on mental health and support evaluated.
- Find out what are the resources for help in order to propose further training, to strengthen and mobilize them as potential referees who can make links with other forms of support. Who can prevent family violence, child abuse and intervene? To whom are people referred to first if they are suffering from mental troubles?
- Determine what are the main areas of concern, discerning MP concerns, TH opinions and people's priorities and worries.
- Reinforce ties, solidarity, good mutual understanding, and conflict solving in order to develop psychosocial education.
- Create awareness concerning mental health and psychosocial related problems. Supporting families with self-help groups that go beyond saving the face but reach a stage of sharing the problems, and finding solutions together has to be developed. Effects of chronic illness on the family can’t be neglected.

Annex 41 Considering intercultural relations in the health care service.

It is well known that people feel they have better access to health services if they find professionals speaking their own language (Brainard p 849). Language skills contribute to a better cultural

understanding of their health problems. However, comparing mental health care in UK and France for Vietnamese refugees, Bertrand (2001) showed that in a medical care unit, some MP from the same ethnic group might reject the non-medical explanation of illness and presentation of symptom. Education has created a gap in understanding. Developing cultural awareness and sensitivity for health care services in a multiethnic context is a real challenge.

Illness is an experience that gives meaning to behaviors. Trying to focus on the illness experience, as an interpretative framework would support mutual understanding. Mental Health professionals knowledge on clinical evaluation, diagnosis and assessment, should also refer to local cultural formulations so that the cognitive distance between patient and medical doctors would be reduced. Interactive teaching in the various ethnic communities could help health professionals to learn about peoples' explanatory models and representations of illness and care, as well as what are their main concerns, and their health care seeking behaviors.

Annex 42 Building a pluralistic approach to mental health care, supporting cooperation between MP and TH.

- Set up collaboration with TH in which the therapeutic experience of these local specialists can be effectively utilized and equally recognized with mutual respect.
- Organize regular meetings between TH and MP, and exchanges on cases studies.
- MP as well as TH should be able to define what they can do or not do, whom they can treat and whom they can't.
- Understanding of spiritual beliefs should be increase for MP while TH knowledge of modern treatments can be developed.
- Support experiences of mutual referring of patients between TH and MP. Not so much in terms of blending indigenous and western therapies that co-therapy and complementary treatments. It is likely that much of this interaction will occur on an ad hoc basis. It important that teaching and experiences in health worker training provides opportunities for students to learn about theoretical models of such interactions as well as the opportunity to observe practical implementation of such cooperation. This would be the responsibility of the core team of psychiatric trainers.

It is necessary to work within the traditional or cultural belief system and explanation in order to enhance patient access to multiple types of services and satisfaction with the treatments.

Hmong people and mental health, the role of the shamans.

The Hmong inhabit usually mountainous areas where they practice slash and burn agriculture. Traditionally they are animist and believe in an after death world where the family members are be reunited. Spirits of dead ancestors and animals require offerings in order to get protection and prevent accidents. Altars are present in most of the households. Post partum rituals are important.

A wide range of healers, shaman, sorcerers, herbalists, and fortune-tellers are consulted when health problem occurs.

Shamans have a diagnostic function; they heal by fighting against malevolent spirits or recapturing the lost souls so that they can return to the sick person, and help to restore imbalance in the inner world.

Ideas about illness causation and patterns of responses are referred to traditional healers (souls and spirits), biomedicine, Chinese medicine and practices are not always separated.

Humoural medicine is not so important.

The Hmong recognize different kinds of mental problems with categories that don't fit exactly to the Lao ones. The most typical explanation is that souls left the body and it is then the shaman's duty to perform a ceremony in order to find them and bring them back from the outer world. Any kind of shock of fever might induce the soul's departure.

Fright illness associated with the loss of soul after accidents are frequent. Rituals are performed to call back the soul associated with herbal treatment and massages. Soul calling ceremonies are performed with relatives, neighbours and friends as well as guests from the surrounding villages so that the patient feel reintegrated in his community as well as his body

Hmong people, as Low Land Lao people, place high value on having a social harmony and good relationships within the members of the community

Most of the Hmong have never seen a physician and they don't know about western medicine. It is usually very difficult for them to understand what the doctor is saying (difficulty is increased by language problems).
Usually even in exile, Hmong use all their resources before seeking westernised health care.

Sudden Unexplained Nocturnal death syndrome (SUNDS)
Understood as a result of the interaction of psychological cultural and physical factors SUNDS affected mostly Hmong in exile in the US (Lemoine, p 83). Associated with nightmare and intense emotional stress SUNDS presents an ethno-medical pathogenesis (Adler p 1627) and the Hmong understand it as a disharmony between body and mind.
Victims of feared spirits visit them in their dreams and make them die.
SUNDS does occur in Laos, it could be understood as common PTSD syndrome (often reported for the Hmong while in US) related to bombing of villages during the war.

Annex 43 Treatment of drug addicts

In mobilizing the health care system for detoxification new approaches to drug addict's treatment could be promoted to develop both morality and skills. Approaches that might be useful are:

- Learning new skills to reduce or eliminate consumption (OHave, p 74) and examining the cognitive schemas of addicts.
- Self-monitoring and control inducing personal initiatives in treatment.
- Teaching effective social skills for a better reorientation.
- Teaching stress management skills to lower anxiety with Asian techniques.
- Paying attention to the degree of shame and guilt as well as the quality of family communication and relation.
- Insisting on the respect for hierarchy and tradition.

Annex 44 Treatment of mental health problems: psychiatric hospital and social psychiatry

- Small psychiatric clinics should be introduced in provincial hospitals after looking at innovative integrated experiences in the region. Follow-up of the patients and outreach work as well as social-rehabilitation programs have to be thought of as an integral part of the project from the beginning. It is likely that non-psychiatrically trained health professionals would staff these provincial clinics for some time.
- ECT should not be introduced before a strict regulation is issued and MP receive the appropriate training with a real concern on ethics, as misuse and abuse have been reported in many countries in the world.
- Stress the importance of simplicity and clarity in the treatment of schizophrenic patients. They are easily confused by complex interaction and contradictory or ambiguous rules of living.
- Have a more balanced view of schizophrenia between a disorder unrelated to social factors or dominated by them. It means that psychiatrists and other caregivers should pay attention to the socio-economic-cultural context. In some cases, when people are so anxious because of their everyday survival, it is more appropriate to give a bag of rice rather than an anxiolitic.
- Make clear the effects of some psychiatric drugs to patients and families and let them some choose whether to use it or not. When given without information it is unlikely that treatment will be continued for a long time anyway.

Annex 45 Visiting regional infrastructures and programs

Examples might include:

- In Cambodia; Child pediatric consultation in Takhmau, Cambo-kids: psychosocial program for children, Transcultural Psychiatry Organization: community mental health care.
- In Viet Nam: social psychiatry program in the Mekong delta.
- In Indonesia: culturally sensitive village based experience in Bali.
- In Nepal: Trauma centre for the victims of torture and all traumatic events.

In Japan: Morita Therapy Unit, Jikei Kai, University Hospital, Tokyo (Buddhist based community psychiatry).

Annex 46 Development of human resources and training

Training of health personnel - the following actions should be taken:

- Training primary health care staff of all cadres about mental health is a priority.
- Organize complementary training in psychiatry for general practitioners, paediatricians, and nurses.
- Upgrade the knowledge of existing psychiatric team in order to ameliorate mental health service delivery.
- Intensive short-term courses should be provided for already graduated doctors, nurses, and medical assistants.
- Start postgraduate course for medical doctors and then specialization in psychiatry including child psychiatry, geriatric, and neuropsychiatry.

Training for students at the FMS- the following actions should be taken:

- Set up an undergraduate course in FMS with clinical and theoretical approaches that include some applied behavioral sciences and medical anthropology insights.
- Develop the curriculum in FMS and National Public Health Institute concerning neuro-psychiatry, child and adolescent psychiatry.
- With the new curriculum, each student has to write a mini-thesis at the end of his 6 years training. Some students should be encouraged to do so in psychiatry.

Annex 47 Drug use, supply and policy.

A more rational use of psychoactive drugs should be promoted with a careful follow up. This includes:

- Determining exactly which drugs can be prescribed at each level of health care.
- Providing adequate training to health professionals before they can prescribe psychoactive drugs.
- Using appropriate patient files.
- Standardizing assessment tools, with evaluation of side effects.
- Making provision for subsidization of medication cost as needed.
- Considering the use of traditional medicine where it is deemed to not be harmful.
- Developing appropriate information for the patient and their families about these special medicines, explaining how they can be effective, the conditions of use, and side effects.

Annex 48 Setting an information system

Developing a Mental health information system with standard guidelines for:

- Basic mental disorder checklist and assessment guide.
- Treatment of epilepsy.
- Working with traditional healers.
- Links with police and prisons.
- Mental health promotion in schools.
- Working with ethnic minorities.
- Minor mental health issues to be included at the primary health care level such as depression, anxiety, sleep problems, chronic tiredness, unexplained somatic complaints, and alcohol use disorders.

- Traditional healers practices and ethic.

Develop a community mental health manual focusing on the use of non-pharmaceutical treatments, self-help groups (for alcoholic, widow, etc), mindful breathing, Buddhist meditation, and repetition of religious sentences.
Develop a system for annual reporting of mental health data and an information monitoring system incorporating indicators such as:

- Major demographic and socio-economic determinants of mental health,
- Mental health status of the general population and those in treatment (including specific diagnostic categories by age and sex and health systems, e.g. number of psychiatric and general hospital beds, number of hospital admissions and re-admissions, length of admission, duration of illness at first contact, treatment utilization patterns, recovery rates, number of outpatient visits, frequency of primary care visits, and frequency and dosage of medication.

Annex 49 Research perspectives from National Institute of Public Health

1st work plan: Disease prevention and health promotion.

- Health status of adolescent migrants in Vientiane municipality.
- Study on cervical cancer.
- Aids.
- Behavioural risk survey on STD/HIV/AIDS.

2nd work plan: curative care and rehabilitation.

- Combination of treatment with modern and traditional medicine.

3rd work plan: consumers' protection and essential drugs supply.

- Study on drug addiction among student in primary and secondary schools.
- Clinical trial on opium detoxification by traditional medicine.
- Accessibility for essential drugs of population in Lao PDR.

4th work plan: development of human resources for health.

- Factors affecting the learning and teaching process at college of health technology.
- Study on factors promoting on efficient performance on health staff.

5th work plan: data collection

- Development tools for information on population drug use in Lao PDR.
- World health survey.
- Prevalence of non-communicable disease in Lao PDR.

Annex 50 Possible research perspectives or opportunities

- Epidemiological survey
- Incidence of child malaria fever
- Iodine deficiency and mental retardation
- Mental sequelae of traumatic accidents and UXO-mines victims
- Links with UNFPA at NUOL on the demography survey in order to insert mental health in the general health questionnaire
- Mental health situation of students facing difficulties at NUOL, Dong Dok campus.
- Suicide looking at several issues such as generation conflicts and young urban migrants,
- Somatic disorders
- Indigenous theories of causation, classification, and treatment of maladjustment and misfortune
- Test standardization
- Studies in psychiatric epidemiology comparing medical professional approach and traditional local cultural epidemiology.

- Study of Ban Nakasang, the village where people suffering from dementia as well as traditional healers gather in the South; in order to develop a better understanding of this community and see if any thing can be useful and duplicable in terms of indigenous management of mental health affected persons.
- Effective use of traditional medicine related to mental health issues, (anxiety, sleep disturbances, nervousness, stress etc…)

Annex 51 Future instruments to be used for research and further diagnosis have to be developed

It is understood that these instrument will be adapted before being used in the Lao context.

- WHO QOL
- WHO CIDI
- Mental disorders explanatory model (MDEMI, M Eisenbruch)
- General health questionnaire GHQ 28 questions or 60 covers four domains somatic anxiety and insomnia social dysfunctionning and depression
- Way of coping check list 27 or 29 items in French
- Life orientation test LOT to evaluate how optimistic people feel about their life cope with changes and explain his expectancy for the future

Annex 52 Other issues

- Street children

Pilot projects for street children and child beggars and community based services to support children and families at risk need to get support from a psychologist to work with the community and train key people in counseling and both physical and mental rehabilitation. Counseling and psychological intervention should be a strong component of activities focusing on street children.

- Mental illness and law.

The legally uncharged mentally ill should not be kept in jail or prisons and all criminally charged or convicted persons should have access to mental health services.
Legislation concerning hospitalization and treatment of the mentally ill is a priority before opening new beds for psychiatry in the hospital.

- Developing organizations or association for patients and their families

It is often thought that due to the impact of mental health on decision-making, people suffering mental health problems are unable to make decisions and they should have no voice. This is harmful to their long-term prognosis and it is not true. Mental health associations can help give patients and their families a voice.

Annex 53 Persons interested in developing psychiatric psychology training and research in Lao PDR with NUOL

- Prof. Isidore Pelc, Psychiatry, Universite Libre de Bruxelles, Belgium
- Prof. Bartes, CHS de Perray-Vaucluse, Association scientifique franco-vietnamienne de psychiatrie et psychologie medicale, Paris, France.
- Mrs Vanida Dausse, psychologist, Association scientifique franco-vietnamienne de psychiatrie et psychologie medicale, Paris, France.
- Dr Luong Can Liem, Psychiatrist, President, Association scientifique franco-vietnamienne de psychiatrie et psychologie medicale, Paris, France.
- Prof Odette Lescarret, Child psychology, University Toulouse, France
- Prof Hector Rifa, Prof O Lescarret and Dr H Larroze Marracq, Asia Link project (under submission)
- Prof Peg Levine, Monash University, Australia, Psychological Medicine, Cultural Clinical psychology
- Dr Somchay Inthavong, Psychiatrist, Aix-en-Provence
- Prof. Harry Minas, Melbourne University, Australia
- Dr Kazyuma Yamamoto, Dpt of Neuropsychiatry, Faculty of Medicine, University of the Ryukyu, Japan.

- Prof. Martin Gittelman, Dpt of psychiatry, NYS/NYU program for advanced studies in psychosocial rehabilitation.
- Prof. Shinfuku Naotaka, International centre for medical research, Kobe university, School of Medicine, Japan.
- Prof.M.Parameshvara Deva, Head of Dpt of Psychiatry, Perak College of Medicine, Malaysia.
- Prof. Lourdes Ignacio, Dpt of Psychiatry, College of Medicine, University of the Philippines.
- Prof. Valery N Kraskov, Moscow research Institute of Psychiatry, Russia.
- Dr Suryo Dharmono, Psychiatrist, Dpt of Psychiatry, faculty of Medicine, University of Indonesia.
- Dr Driss Moussaoui, faculty of Medicine, Casablanca, Morocco.
- Dr. Didier Bertrand, Associated Research, IRSEA-CNRS, Universite Toulouse 2, France

Annex 54 Terms of Reference, APW contract for Situation Analysis of Mental Health in Lao PDR.

The issue of mental health is becoming more prominent in the international health agenda. It is a leading cause of disability and an important part of the over-all burden of disease both in the developed and the developing world.

WHO in conjunction with the MOH wishes to conduct a situation analysis concerning mental health in Laos. The purpose is to have a concise and up-to-date description of the current situation as it is known, and to identify areas that are unknown and may need further study. This could then be used as a basis for the government and potential donors to begin planning how to approach the mental health needs of the people of the Lao PDR.

The situation analysis should include:

- A general description of the general health situation.
- Estimates of the mental health situation, including an estimate of the size of the need. Ideally this would be from actual figures from Laos but since much data may not be available there can be some extrapolation from epidemiologic data from similar countries where more reliable information might exist.
- A brief description of what is known about current prevailing societal attitudes towards mental health and mental illness in Laos.
- A description of the current methods of management of mental illness in Laos today through both traditional (non-medical) and medical systems.
- Current human resource capacity in mental health in Laos, both specialists and non-specialists. This will include a description of current health worker training and experience concerning mental health. An analysis of other possibilities for human resources, such as non-medical workers or traditional professions should be included.
- Current institutional capacity for mental health services at the various levels of the health care system. This would include a brief assessment of the essential drug list and its availability in regards to mental illness.
- Summary of the challenges to developing mental health services, including remoteness, general educational levels, diverse ethnicity, etc.

- Recommendations as to the next steps which take into account all of the information gathered above as well as the socioeconomic realities of the Lao PDR.

The final report will be disseminated and discussed, most likely in a workshop format.

The methods will be primarily from secondary sources, including the review of documents and key informant interviews. The situation analysis will be conducted with the full participation of the MOH staff working in mental health who will be co-authors. The final product will be the responsibility of the APW contractor however.

Annex 55 Tentative schedule, Dr Didier Bertrand

Tentative Schedule
Dr. Didier Bertrand, a Mental Health Specialist of WHO Laos Office
Visiting Lao and International Organization from 30 Sept to 4 Oct. 2002.

No.	Date	Day	Time	Name of Organization	Contact Person	Phone	Accompany
1	September 30th 2002	Mon	9.30	Ministry of Justice	Dr. Houy Pholsena	414402	
2			11.00	IRD	Dr. Daniel Benoit	214028	
3			13.30	Youth Center	Ms. Viengsay Nola	252886, 504157	
4			15.00	National Youth Union	Director	417107	Dr. Chantharavady
5	October 1st, 2002	Tue	9.00	Handicap International	Director	412110,451295	
6			10.00	Health Unlimited	Director	415610	
7			11.00	Ministry of Education	Director	216004	
8			13.30	UNICEF	Director	315200-4	
9			15.00	UNFPA-FNUAP	Director	413467	
10	October 2nd, 2002	Wed	8.30	Faculty of medicine (curricumlum development off.)	Director	214055	
11			10.00	Public Health Institute	Dr. Bougnong Boupha	216884	
12			11.00	IFMT	Dr. Degremont	219346	
13			13.30	Department of psychology and education, NUOL	Mr. Kham Ane Sayasone, and Prof. of psychology	413473	
14	October 3rd, 2002	Thu	8.30	Soknoy primary and secondary school	Director	252353 (Municipality Education)	Mr. Bounyord
15			11.00	Institut de Recherche sur la culture	Mr. Oumphanh Rattanavong	212009	
16			13.30	Wat Sisakhet	Ajarn Veth	212622	
17			15.00	Wat That Foun	Ajarn Pisa	216057	
18	October 4th, 2002	Fri	8.30	Hygiene dept. MOH	Dr. Bounlay	217607, 517522	Dr. Chantharavady
19			10.00	Curative dept. MOH	Dr. Sommone Pousavath	214011, 217849	Dr. Chantharavady
20			13.30	CPU, MOH	Dr. Pasonsith	214061, 214059	Dr. Chantharavady

Please confirm wtih Mr. Phoubandith Soulivong at: 413431, 414264, 413023

Annex 56 Tentative Schedule Dr Chantharavady Choulamany

Tentative Schedule
Dr. Chantharavady, and a team of WHO Laos Office
Visiting Lao and International Organization from 30 Sept to 4 Oct. 2002.

No.	Date	Day	Time	Name of Organization	Contact Person	Phone	Accompany
1	Septeber 30th 2002	Mon	8.30	Chanthabury District Hospital	Director + village leaders	213902	
2			10.00	Sisatanak District Hospital	Director + village leaders	312611	
3			13.30 15.00	Sikottabong District Hospital National Youth Union	Director + village leaders	212340	
4	October 1st, 2002	Tue	8.30	Mother and Child Center	Dr. Bouavanh & Dr. Bounlua	214038,214037	
5			10.30	School for medical technician	Director	217080	
6			13.30	Lao Women Union (Municipality)	Dr. Bang Aon	214303-7,215432	
7	October 2nd, 2002	Wed	8.30	National liberation front	Director	213756,212320	
8			10.00	Trade Union	Director	222473,212752	
9			13.30	COPE (rehabilitation center)	Director	218427	
10			15.00	Mine advisory group	Director	414086	
11	October 3rd, 2002	Thu	8.30	Red Cross (IFRC)	Director	215762	
12	October 4th, 2002	Fri	8.30	Hygiene dept. MOH	Dr. Bounlay	217607, 517522	Dr. Didier
13			10.00	Curative dept. MOH	Dr. Sommone Pousavath	214011, 217849	Dr. Didier
14			13.30	CPU, MOH	Dr. Pasonsith	214061, 214059	Dr. Didier

Please confirm wtih Mr. Phoubandith Soulivong at: 413431, 414264, 413023

Annex 57 **Schedule for visit in PronHong district with Handicap International**
Annex 58 **List of the persons interviewed**

List of key informants, 46 persons, 16 women.

M	47	Village leader	Ban Vat Chan
M	63	Neo Home	Ban Vat Chan
F	52	LWU	Ban Vat Chan
F	47	Director	Mixay school
M	72	Vice president	LFU
M	55	Vice president	LTU
F	50	Director	LWU Cabinet (VTE)
M	45	Deputy chief of the village	Ban Phone Gam
M	25	LYU	Ban Phone Gam
M	50	Traditional healer	Ban Phone Gam
M	28	Teacher	Ban Phone Gam
M	35	Monk	Vat Na Khoune Noi
M	48	Police	Muang Thateng
M	52	Chief of village	Ban Nong Vai
F	45	Teacher	Ban Oubmung
F	42	Mo Phi	Ban Oubmoung
F	48	LWU	Ban Oubmoung
M	47	Village Leader	Ban Oubmoung
F	41	LYU	Ban Oubmoung
M	45	Police	Ban Oubmoung
M	32	Dpt Director Thateng Sec school	Muang Thateng
F	70	Retired primary school teacher	Ban Haisok, VTE
M	22	student	Sok phaluang VTE
M	50	farmer	Don Chan, VTE
F	45	Women union	Ban Haisok, VTE
M	50	Village leader	Ban Haisok, VTE
M	40	Monk	Wat Nakou Noi
M	50	Teacher+village security	Ban Haisok, VTE
M	50	Village leader	Ton Sa, Sekong
M	20	Primary school teacher	Tonvay, Sekong
M/F	45	Primary school teachers	Ban Sok Noi, VTE
M	55	Chief of Cabinet, LPRYU	Vientiane
M	*45*	*Village leader*	*TonVay, Sekong*
F	45	Youth Centre manager	Vientiane
F	55	LHWCA	Vientiane
M	55	NLPDA	Vientiane
F	45	Head of village Phosy	Ban Phosy
F	36	LWU	Ban Phosy
M	37	LYU	Ban Phosy
M	56	LFU	Ban Phosy
M	30	Police	Ban Phosy
M	34	Police	Ban Sikhay
F	50	Teacher	Ban Phosy
M	35	Monk	Vat Nahai
F	48	LWU	Ban Oubmoung
M	41	Agriculture	Ban Phone Hong

List of mentally ill cases, 38 cases, 18 women.

Sex	*Age*	*Profession*	*Place*
F	19	Student	Ban Thateng, Sekong
F	36	Private sector	Ban Phone Sa Ath
F	24	Unemployed	Ban Phonsavnh
M	40	Farmer	Ban Lik, Sekong
F	20	Farmer	Ban Suey, Sekong
M	10	Pupil	Tonvay, Sekong
F	21	Unemployed	Ban Napho
M	28	Private sector	Ban Vat Chan
F	42	Housewife	Ban Vat Chan
M	38	Unemployed	Ban Hatkieng
M	50	Unemployed	Ban Phonehong, Saythani
F	18	Unemployed	Ban Phone Gam
M	3	Child	Ban Phone Gam
M	30	Unemployed	Ban Phonekham Neua
M	16	Unemployed	Ban Napho
F	70	Unemployed	Ban Phonekham Neua
F	34	Unemployed	Ban Phonekahm Neua
M	5	Child	Ban Phonekham Neua
M	19	Unemployed	Ban Nong Lao
F	20	Unemployed	Ban Kapeu
M	30	Unemployed	Ban Napho
M	16	Unemployed	Ban Napho
F	60	Housewife	Ban Napho
F	34	Housewife	Ban Phone Kham Neua
M	5	Child	Ban Phone Kham Neua
F	58	Housewife	Ban Vat Chan
F	42	Teacher	Mixay school
F	85	Housewife	Ban Vat Chan
F	56	Housewife	Ban Phone Gam
F	70	Housewife	Ban Phone Hong
M	75	Farmer	Ban Phone Hong
M	40	Farmer	Ban Nong Vai
M	45	Police	Ban Nong Lao
M	42	Health volunteer	Ban Phone Gam
F	70	Housewife	Ban Napho
M	25	Unemployed	Ban Phone Kham Neua
M	50	Unemployed	Ban Phone Kham Neua
M	35	Unemployed	Ban Phone Kham Neua

List of Pharmacy, 7 informants, 6 women.

Sex	*Age*	*Profession*	*Place*
F	38	Pharmacy	Settha Hospital
F	36	Pharmacy	150 beds
F	35	Pharmacy	Sikhay
F	36	Pharmacy	Military Hospital
F	48	Private Pharmacy	Sikhay

F	35	Private Pharmacy	Sikhay
M	40	Private Pharmacy	Ban Napho

List of Case Informants, 31 persons, including 16 women.

Sex	*Age*	*Profession*	*Place*
F	42	Mo Phi	Ban Oubmoung
F	48	Housewife	Ban Kapeu, Sekong
F	41	Unemployed	Ban Pho Geun
F	73	Housewife	Hat Kieng
F	69	Housewife	Hat Kieng
M	51	Unemployed	Ban Phonesi Tay
M	62	Unemployed	Ban Phosy Tay
F	55	Housewife	Ban Phonesavan
F	41	LYU	Ban Oubmoung
F	60	Retired primary school teacher	Ban Haisok, VTE
F	40	Mother handicap child	Ban Haisok, VTE
M	40	Father	Phon Hong
M	45	Father	Ban Lik, Sekong
M	40	Brother	Ban Lik, Sekong
M	35	Brother	Nong Nok, Sekong
M	23	Nephew	Nong Nok, Sekong
M	35	Uncle	Nong Nok, Sekong
M	40	Brother	Ban Suey, Sekong
M/F	40-50	Parents	Pon Hong
F	22	Sister	**Pon Hong**
F	40	Neighbor	Saythani
F	45	Sister	Saythani
M	45	Father	Sekong
M	39	Father	Phon Hong
F	35	Housewife	Ban Done Sane
M	57	Health Prof	Mental Health Unit
F	40	Unemployed	Ban Mai
F	30	Health Prof	VTE Hospital

List of Heath Professionals, 40 Informants, including 18 women

Sex	*Age*	*Profession*	*Place*
F	42	Doctor, OPD	Mahosot hospital
F	45	Pharmacist	Mahosot hospital
F	37	Doctor, OPD	Mahosot hospital
F	32	Nurse, MHC	Mahosot hospital
M	44	Neurologist	Mahosot hospital
F	24	Nurse, ER	Mahosot hospital
F	25	Nurse	Mahosot hospital
M	26	Doctor, ER	Mahosot hospital
F	25	Doctor	Mahosot hospital

F	28	Doctor	Mahosot hospital
M	35	Doctor	Thateng Hospital, Sekong
M	25	Nurse	Sekong
M	23	Nurse	Sekong
M	55	Director NPH Research Institute	Vientiane
M	40	Community Health trainer, Health Unlimited	Attapeu
M	30	Hospital Luxemburg	Pon Hong
M	50	Director Hospital + district	Pon Hong
M	49	Health Prof	150 beds
F	30	Health Prof	150 beds
F	33	Health Prof	150 beds
M	55	Health Prof	Military hospital
M	49	Health Prof	Military hospital
F	44	Health Prof	Settha Hospital
M	39	Health Prof	Settha Hospital
F	28	Health Prof	VTE Hospital
F	34	Health Prof	VTE Hospital
F	31	Health Prof	VTE Hospital
F	52	Deputy Director	Mother & Child Center
M	60	Director	Medical technician school
F	45	Director	Sisatanak hospital
M	48	Director	Chanthaboury hospital
M	46	Director	Sikhot hospital
F	36	Nurse	VTE Provincial hospital
M	52	Deputy director	Hygiene Department
M	40	Project director	COPE
M	40	Director	Saythani Hospital
M	40	Deputy director	VTE Provincial hospital
M	42	Director	Provincial Health Department
M	65	Director	Lao Red Cross
M	38	Deputy director	Thateng Health Department

Other informants interviewed without questionnaire, 18 persons, 8 women

M/F	**Profession**	**Place**
M	Program director HI	Vientiane
M	CBR Coordinator, HI	Vientiane
M	Vice dean NUOL, FSM	Vientiane
M	Officer in charge, FNUAP	Vientiane
M	National Program officer FNUAP,	Vientiane
F	Reproductive health program	Vientiane
F	Project Officer, UNICEF	Vientiane
F	Representative UNICEF	Vientiane
F	Assistant project officer, UNICEF	Vientiane
M	Ministry of education, Dpt planning	Vientiane
M/F	Professors of psychology NUOL	Vientiane
M	Deputy Dir Gal, MOH	Vientiane
M	MOH	Vientiane
M	Director IFMT	Vientiane
M	Hmong Shaman	

M	Ministry of Justice	Vientiane
M	Research for development Institute, researcher	Vientiane
M	Institute for research on culture, director	Vientiane
M	Wat Sisaketh	Vientiane

Annex 59 **Questionnaire used with MP.**

Mental Health Situation Analysis in Lao PDR

Questionnaire for doctors, nurses, and health related professionals

Profession Place M-F Age
Number of mental health patients (one year)
Number of habitants in the district

1. What do you know about mental health in general?

2. What is a mental health problem?

3. How do you evaluate the mental health situation in your practice?

family/social violence	
Conflict	
drug abuse including alcoholism	
sexual abuse	
child abuse	
abnormal behaviours (description)	
Delinquency	
suicide (what are the reasons?)	
senility (behavioural problems due to aging)	
insanity (describe different kinds of *ba*)	
Gambling	
Others	

4. How do you understand the word mental illness *(lok chiet)*?

5. Do you recognize different kinds of mental illnesses? Describe them

Mental disease	Clinical description	Causes	Treatment
Schizophrenia			
Psychosis			
Neurosis			
Depression			
Epilepsy			
Post partum			
Bipolar disorder			
Paranoia			

Alzheimer			
Mental retardation			
Others			

6.1 What about this local folk classification? Please explain each term:

Folk diagnosis	Symptoms	Causes	Treatment	Who can help?
Ba				
Ba mu				
Ba sane				
Ba katha				
Ba tham tek				
Ba Ngan Vet mon				
Ba lueat				
Ba oc hak				
Ba khit lai				
Other Ba				
Sie chit/sen				
Sie Chai				
Chep samong				
Khon Sa				
Khon San				
Khon khiet				
Samong One				
Other				

6.2 Do you use it for your professional practice? YES ◊ NO ◊

6.3 <u>If not mentioned above</u> how far these can be causes of mental health problems? (Refer to nosography if possible)

Causes	YES/NO	Comments
Physiological		
Social/family		
Economical		
Psychological		
Neurological		
Wind (Pen Lom)		
Karma		

History		
Horoscope/cosmology		
Magic *(sayasath)*		
Nutrition		
Accidents		
Delivery and post partum related problem *(pith kham)*		

6.4 If not mentioned above how far these treatments can be effective to cure mental health problems?

Treatment	YES/NO	Comments
Modern medicine *(ya luang*)		
Traditional medicine *(ya phuean muang)*		
Religious treatment at the pagoda *(na mone,)*		
Spiritual, magical treatment with traditional healers *(Mo Phii, Mo Thiem, Mo Mône Mo thevada)*		
Diviners *(Mo do)*		
Amulet *(Katha)*		
Magical string *(Fai pou khen, Souk Khouan)*		
Moral support and counselling *(hay kham puksa* *Family?* *Monks?* *Others?*		

7.1 In your practice, how many persons suffering from mental illness do you meet in one year? (Give number of persons)

7.2 Provide some information about the cases

	Diagnosis	Causes	Treatment
Case 1			
Case2			
Case3			

8. Who can help people suffering from mental health illnesses and how?

9. What can be your role in helping people suffering from mental illness? Give example

10.1 Do you refer to a psychiatrist? YES ◊ NO ◊
10.2 Why?

11.1 Do you prescribe the following drugs?

Name of the drug	*YES/NO*	*Diagnosis*
Valium		
Phenobarbital		
Lexomil		
Dormicum		
Tranxene		
Largactil		
Haldol		
Nozinan		
Tryptanol		
Others		

11.2 Do you have a follow up of the patients using these drugs?

11.3 How do you evaluate the result and side-effects?

11.4 Do you know if people use the following drugs without prescription?

Name of the drug	*YES*	*NO*
Valium		
Phenobarbital		
Lexomil		
Dormicum		
Tranxene		
Largactil		
Haldol		
Nozinan		
Tryptanol		

Others		

11.5 How do they get them?

12. How do people in general feel with persons suffering from mental health problems?

13. How do people in general behave with persons suffering from mental health problems?

14. What about the relation between persons facing mental health problems and their family?

15. What is the impact of their problem on their everyday life? (Social, economical and psychological)

16. What could be done to improve the situation?

17. What could be done within the National Health System to hand up patients with mental health problems?

18. Do you have any other comments or issues or questions related to mental health?

Would you mind to report one case in details ?
Cf case report sheet

Annex 60 **Questionnaire used with Key informants**

Mental Health Situation Analysis in Lao PDR

Questionnaire for field key informants to be used with hospital director, mass organisations, police, village leaders, teachers, monks, etc….

Profession Place M-F Age
Number of habitants in the district

1. What do you know about mental health in general?

2. What is a mental health problem?

3. How do you evaluate the mental health situation in your surrounding/ village/district?

family/social violence	
Conflict	
drug abuse including alcoholism	
sexual abuse	
child abuse	
abnormal behaviours (description)	
Delinquency	
suicide (what are the reasons?)	
senility (behavioural problems due to aging)	
insanity (describe different kinds of *ba*)	
Gambling	
Others	

4. How do you understand the word mental illness *(lok chiet)*?

6. Do you recognize different kinds of mental illnesses? Describe them

Mental disease	Clinical description	Causes	Treatment
Schizophrenia			
Psychosis			
Neurosis			
Depression			
Epilepsy			
Post partum			
Bipolar			

disorder			
Paranoia			
Alzheimer			
Mental retardation			
Others			

6.2 What about this local folk classification? Please explain each term:

Folk diagnosis	Symptoms	Causes	Treatment	Who can help?
Ba				
Ba mu				
Ba sane				
Ba katha				
Ba tham tek				
Ba Ngan Vet mon				
Ba lueat				
Ba oc hak				
Ba khit lai				
Other Ba				
Sie chit/sen				
Sie Chai				
Chep samong				
Khon Sa				
Khon San				
Khon khiet				
Samong One				
Other				

6.2 Do you use it for your professional practice? YES ◊ NO ◊

6.3 <u>If not mentioned above</u> how far these can be causes of mental health problems? (Refer to nosography if possible)

Causes	YES/NO	Comments
Physiological		
Social/family		
Economical		
Psychological		
Neurological		

Wind *(Pen Lom)*		
Karma		
History		
Horoscope/cosmology		
Magic *(sayasath)*		
Nutrition		
Accidents		
Delivery and post partum related problem *(pith kham)*		

6.5 If not mentioned above how far these treatments can be effective to cure mental health problems?

Treatment	YES/NO	Comments
Modern medicine *(ya luang*)		
Traditional medicine *(ya phuean muang)*		
Religious treatment at the pagoda *(na mone,)*		
Spiritual, magical treatment with traditional healers *(Mo Phii, Mo Thiem, Mo Mône Mo thevada)*		
Diviners *(Mo do)*		
Amulet *(Katha)*		
Magical string *(Fai pou khen, Souk Khouan)*		
Moral support and counselling *(hay kham puksa* *Family?* *Monks?* *Others?*		

7.1 In your village/district/surrounding, how many persons suffering from mental illness do you know ? (Give number of persons)

7.2 Provide some information about the cases

	Diagnosis	Causes	Treatment
Case 1			
Case2			

Case3			

8. Who can help people suffering from mental health illnesses and how?

9. What can be your role in helping people suffering from mental illness?

10.1 Do you know what is a psychiatrist? YES ◊ NO ◊
10.2 If yes explain?

11.1 Do you know people using the following drugs?

Name of the drug	*YES/NO*	*Why?*
Valium		
Phenobarbital		
Lexomil		
Dormicum		
Tranxene		
Largactil		
Haldol		
Nozinan		
Tryptanol		
Others		

11.2 What do you think about these drugs?

11.3 Do they get them with prescription ? YES NO

19. How do people in general feel with persons suffering from mental health problems?

20. How do people in general behave with persons suffering from mental health problems?

21. What about the relation between persons facing mental health problems and their family?

22. What is the impact of their problem on their everyday life? (Social, economical and psychological)

23. What could be done to improve the situation?

24. What could be done within the National Health System to hand up patients with mental health problems?

Do you have any other comments or issues or questions related to mental health?

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