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Stories Without Endings:

A Study of Illness and Disability Narratives in Rural Laos

by

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Abstract

Public health care utilization in rural Lao People's Democratic Republic (Lao PDR) is very low despite indicators that place the health status of Lao people amongst the worst in the world (CIA, 2006). A national health survey conducted in 2001 found that 53% of ill people in Lao PDR did not seek help for their health problem from a public health care facility. In rural areas, only 61.7% of villages had at least one doctor or nurse available to assist with health problems (Kanashiro, 2004). Between January and June 2007, ethnographic data were collected from Vientiane district in rural Lao PDR to examine the question: *"When poor Lao villagers discover themselves to be ill or disabled, what types of treatments do they seek and why?"* Data derive from participant observations, informal and formal interviews and discussion groups. Analysis of the data revealed that health seeking in rural Lao PDR is complex due to three interconnected factors. These factors are: the cost of accessing public health care and the complex processes surrounding choosing health care options and paying for them; cultural interpretations of illness and disability and the influence these have on health seeking; and complex bureaucratic processes that are bewildering to poor and rural people. Reasons for low utilization of public health care in rural Lao PDR are very complex and cannot be fully understood through any one of the discussed

factors. Illness and disability narratives collected during research for this study are woven into the discussion presented in this thesis. Concluding remarks include key statements that present the main findings discovered from this study and also implications for future practice.

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CHAPTER ONE: INTRODUCTION

This thesis examines health seeking and health care utilization in rural Lao PDR. These data consist primarily of illness and disability narratives, in addition to numerous other formal and informal interviews, that I collected from Phatang village and surrounding areas between January and June 2007. I was drawn to conduct this project because I understood that public health care utilization in rural Lao PDR is very low despite high levels of illness and disability. I was also interested in deepening my understanding of how disability is understood cross-culturally.¹

The Phatang Health Centre, where data for this project were partially collected, offers public health care² services to 18 rural villages and approximately 8,500 people. It is staffed by trained health workers but receives, on average, fewer than 10 patients per day (Lao PDR, 2006a). The underutilization of public health care in Lao PDR is juxtaposed next to indicators that place the health status of Lao people amongst the worst in the world (CIA, 2006). A national health survey conducted in 2001 found that 53% of ill people in Lao PDR did not seek help for their health problem from a public health care facility.

¹ Disability is referred to throughout this thesis although it is not always named. Discussions about health seeking and health care utilization refer to people who are ill or disabled who are looking for a solution to their problem. In some instances terms such as “health problem” or “illness episode” are used to describe people who are suffering from an illness, either short-term or chronic, or a disability. To reduce wordiness in this thesis, the term “illness” is sometimes used in isolation although it is intended to encompass disability.

² For the purpose of this thesis, public health care refers to the government and donor funded health system that operates non-privatized health centers and other public health care facilities that administer Western-based medicine as well as public and curative health services.

These indicators are compounded and explained by reports that only 61.7% of Lao villages have at least one doctor or nurse available to rural villagers (Kanashiro, 2004).

A participatory map developed by this project reveals startling rates of illness and disability in Phatang village. Of the 300 households in Phatang village, this project found 42 households with members who had chronic and often untreated illnesses or disabilities. Some of these households were caring for multiple family members who had significant health problems. In many cases, these individuals might experience relief from their health problems from simple and often inexpensive health care interventions. This project also encountered countless villagers who experienced day-to-day illnesses (sick babies, broken bones and so on) for which treatment from a public health care facility was not sought.

Much of what is understood about health seeking amongst rural people in Lao PDR is anecdotal. Rural areas in Lao PDR are difficult to access due to remote and rugged mountainous terrain. Major linguistic and ethnic diversity also adds to the complexity of accessing the rural population in Lao PDR. Available data, however, suggests that poor Lao villagers refrain from using public health care facilities due to cost, impassable roads, poor quality of services, local suspicion of Western medicine, religious beliefs, and diverse ethnic and language groups (Kanashiro, 2004). While these explanations for poor health care utilization seem like common sense, my previous experiences conducting qualitative research led me to wonder whether the lived experience of being poor and sick or disabled

in rural Lao PDR might be a more complex and nuanced experience than common-sense explanations can account for.

This thesis is about illness, disability and health seeking in one of the poorest countries in the world. It offers an examination of health seeking and health care utilization in rural Lao PDR. The data presented in this thesis offers a localized view of how illness and disability are experienced in a rural village in Lao PDR. The question this thesis seeks to answer is: *“When poor Lao villagers discover themselves to be ill or disabled, what types of treatments do they seek and why?”*

The localized perspective discussed in this thesis, however, requires a global perspective of how public health care is delivered, funded and received by poor people who live in poor nations, and some of the challenges of health care reform in such places. The purpose of this introductory chapter is to present global issues related to public health care reform that influence health care utilization and health seeking in Lao PDR.

Development in Lao PDR

Lao PDR is one of the least developed countries in the world and faces serious challenges to development. Malnutrition, stunted children and seasonal hunger are major concerns in Lao PDR, where a large percentage of the population are subsistence farmers (Ducourtieux, 2005; Lao PDR, 2006b; Taylor, 2006). Development in Lao PDR is also

highly unbalanced, with lowland areas along the Mekong River valley receiving disproportionate amounts of developmental assistance, despite lesser need (Evans, 1999; Pholsena, 2006). Health indicators in highland areas reflect the highly distorted distribution of developmental assistance. Rural people, and especially people who live in remote highland areas are significantly poorer and less healthy than people who live in lowland or urban areas. Child and maternal mortality rates, for example, are two to three times higher in some rural areas than in urban areas. Many people who live in rural areas are ethnic minorities (Bouapao, 2005; Taylor, 2006).

In 2007, 45 organizations operated approximately 173 health projects in Lao PDR, many of which were small-scale projects valued at less than \$1 million dollars (Dodd, 2009). Poor coordination between organizations offering similar projects exacerbates the situation (Barennes, 2009). Taken together, the development landscape in Lao PDR is highly fragmented and difficult to navigate due to high expectations put on the government to operate and report on many projects and organizations whose processes are poorly coordinated.

The status of Lao PDR as a least-developed country places it within a historical framework of development practice that has for half a century tried to address the problem of poverty and the consequences of it. More recently, efforts to alleviate poverty in poor places such as Lao PDR have had to grapple with an increasingly globalized world and rapidly escalating gaps between rich and poor. While half a century has produced a lot of

knowledge about what works in development, much remains to be learned. Despite decades of work and trillions of dollars invested in development for poor nations, poverty levels are higher than ever before, more poor people are sicker than ever before, and more illnesses spread faster and are deadlier than ever before (Easterly, 2006). There is a growing awareness that improved outcomes for development practice require better knowledge about the lived experience of people who are the intended beneficiaries of development projects. The thesis that follows is an exemplar of one such examination of lived experience.

Global Health Inequalities

Of all the problems in the world, perhaps none are more troublesome than health inequalities. While the new millennium has witnessed unprecedented growth in knowledge about illness and disability, massive inequalities exist in how public health care resources are distributed (McMichael, 2000). Developed countries spend as much as 155 times more on health care than do developing countries, where health needs are the greatest (Hahn, 2009). Some low-income countries have populations that can expect to live half as long as citizens in high-income countries, a disturbing trend that is escalating due to war, natural disasters, HIV/AIDS and other pandemic diseases that concentrate in countries that have the fewest resources to manage large-scale and complex illness epidemics.

It is estimated that five billion people in the world live without access to vital health or education service; they are undernourished, undereducated, and they have poor or no access to health services, clean water or sanitation (Bhargave, 2006; Collier, 2007; Easterly, 2006, , 2007; Kim Yong, 2000; Klein, 2007; Rigg, 2003). Their mortality and morbidity rates are high and their lives unnecessarily short. One billion of these people live precariously perched between life and death. They are extremely vulnerable to even small changes in their environment (Collier, 2007).

In poor nations, one out of five people live with a disability. Half of these disabilities are thought to be a direct consequence of poverty (Hartin, 2006). Altogether, four out of five people who have a disability live in poor countries, where resources to assist them are limited or nonexistent (Japan, 2002). Knowledge about the lived experiences of people who are disabled is limited. Very little is known about how communities, families and individuals cope with disabilities, or how their needs might be better met. Disability in the international context is seriously under researched (Ingstad, 1995).

Health inequalities are by far the most pressing dilemma facing the world today. In the developing world, 55% of deaths occur from six communicable diseases including HIV/AIDS, malaria, tuberculosis, pneumonia, diarrheal disease and measles, while 37% percent of deaths occur from non-communicable diseases, many of which are parasitic infections ((Brundtland, 1999). And yet, treatments exist for most of these diseases. However, these diseases remain deadly in the places where they proliferate. In some

countries, for example, an entire generation of children is left to rear themselves, schools have no teachers, and hospitals operate with insufficient staff because of the relentless spread of HIV/AIDS. People in developing countries die from preventable, treatable and curable diseases, not because of a lack of knowledge about these diseases, or even a lack of capacity to produce a necessary supply of medicines, health facilities or trained medical professionals, but from an ongoing systemic failure to engage in social innovation and discover locally relevant strategies to meet challenges (Helman, 2007; Khun, 2008; Levine, 2007).

Poverty and Health

Poverty and ill health are connected problems (Braveman, 2003; McIntyre, 2002). The consequences of not having enough food to eat, access to clean water, basic education, a safe house to live in, or good proximity to a health centre, are children who are stunted, a disproportionate number of women who die in childbirth, and populations who suffer from preventable, curable and treatable illnesses and disabilities. Reduced levels of poverty always occur in tandem with improved levels of health, and vice versa.

Health is now understood as an indicator of sustained development (Von Schirnding, 2002). While individuals benefit personally when they are healthy, countries are able to grow economically when their population is healthy enough to engage productively in the social and economic milieu of their lives. It is no coincidence that the places in the world

that experience poor health also struggle with war, economic crisis, social upheaval, environmental degradation, political strife and long-term collapse due to natural disaster (Chen, 2004; Kim Yong, 2000; McMichael, 2000; Prilleltensky, 2003)

Prior to 1982, the problem of poverty was addressed through measures that assumed that prosperity would automatically occur in countries that embraced democratic principles (So, 1990). Starting in 1982, however, poor countries began to declare that they could no longer pay back their loans (Kim Yong, 2000; Klein, 2007). The ensuing debt crisis resulted in a conceptual change in how poverty was understood and dealt with. The focus on poverty moved away from providing for the people who were poor to reforming the economic system in which impoverished people lived (Easterly, 2006; Kim Yong, 2000; Klein, 2007). It was rationalized that reforms to the economic structure of poor countries would increase overall prosperity. Overtime, increased economic growth would trickle down and benefit the very poorest people.

Structural adjustment policies guided how wealthier countries addressed poverty in the post-1980 era. Poor countries were given loans in exchange for commitments that they would adjust their economic policies to reduce overall levels of debt, and adhere to debt repayment regimens. Many of these policies required poor governments to rein in spending and reduce public programming (Kim Yong, 2000; Klein, 2007). With regards to health, structural adjustment policies in many countries, including Lao PDR, required that countries abolish their free health care systems, which were seen as unsustainable. By

the 1990s, many countries had implemented user fees as a core cost-recovery strategy in their public health care systems (Meessen, 2006; Patcharanarumol, 2009; Segall, 2002).

By 1991, 75 countries were receiving structural adjustment loans worth more than US\$14 billion. However, poor countries were 50% more in debt than they were in 1983, and many countries were paying more to their creditors than they were receiving in assistance (Gershman, 2000; Klein, 2007). The consequences of continued or increased poverty in poor countries were demonstrated by deteriorating health outcomes. By 2000, mortality rates for children under five in poor countries were as high as 160/1000 live births, and life expectancies were as low as 38 years. By 2000, the problems of health inequalities, extreme poverty and deprivation in the world far exceeded anything previously recorded (Chan, 2008; Kim Yong, 2000; WHO, 2006b)

Two decades of economic reforms have demonstrated that not everyone benefits from increased national revenues. In 1998, the World Health Organization (WHO) published its annual report, which celebrated 50 years of development. Between 1955 and 1998, life expectancy worldwide increased 18 years, and infant mortality rates fell from 148/1,000 live births to a world average of 59/1,000 live births. Ten million fewer children died before their fifth birthday (Kim Yong, 2000). What are missing from these figures are calculations that put the numbers into perspective. Health gains have disproportionately benefited wealthy countries. In Canada, for example, 4.6/1,000 infants will die in infancy. The children who survive can expect to live for 80 years, and each female can expect to have 1.6 children. By comparison, in Swaziland, 102/1,000

infants born today will not survive infancy. The ones who do can expect to live for 42 years, and each female can anticipate 3.8 children of her own. In Swaziland, a child born today lives in a world where nearly 40% of the population is infected with HIV. In Lao PDR, the picture is different. In Lao PDR, 81.4/ 1,000 infants born today will not survive. Those who do can expect to live to 56 years, and each woman can expect to bear 4.6 children of her own (CIA, 2008). Other figures abound. Of the 10 million children under the age of five who died in 1997, 97% of them lived in the poorest 46 countries in the world. Half of these children died of hunger-related causes. Since the 1980s, malnourishment in Africa has doubled and in some places in Asia, 50% of children experience malnutrition (Kim Yong, 2000).

Even within countries, economic reforms disproportionately benefit some segments of the population while others benefit only slightly or not at all (Gershman, 2000; Millen, 2000). Some populations suffer reduced standards of living when they are forced off their land or required to change farming practices to make way for development projects. In Lao PDR, for example, the construction of the Theun-Hinboun dam in 1998 displaced 4,282 households in 10 villages, affecting approximately 25,000 people. These people lost their land, fishing locations, and river gardens, for which they were never compensated.³ They are reported to continue to suffer severe poverty and ill health as a result. In 2000, this dam generated US\$23 million in revenues (Rigg, 2003). Pervasive poverty amongst displaced villagers indicates that the profits of this dam do not benefit the poor people who made way for the project. Despite reports that detail the devastating

³ In 2001, 10 villages were given 160 tonnes of rice as compensation.

consequences of dam construction in Lao PDR, dams continue to be a central focus for future economic development in Lao PDR (Virtanen, 2006).

Other economic development projects in Lao PDR have resulted in similarly devastating increased levels of poverty and ill health. Massive efforts to eradicate poppy agriculture in upland areas of Lao PDR, which were supported by large international grants, sent government officials to upland areas to burn and slash opium fields, with no plans to provide the poor farmers who survived off these fields with alternative options to generate income (Ducourtieux, 2005). Other projects developed from economic rationales have relocated thousands of rural villagers from their upland villages to more accessible locations closer to roads, health centres and schools. Many of these people are now landless and very poor. The devastating health consequences of these relocation projects are well documented (Baird, 2007; Baird, 2005; Ducourtieux, 2005; Evrard, 2004; Ireson, 1991; WHO, 2005a). Constructing dams, eradicating opium agriculture, and moving people to places where public services can better help them are examples of development practices that are built from global development rhetoric that asserts that macroeconomic restructuring of poor economies will eventually benefit whole countries. Until now, data indicate that macroeconomic development strategies result in remarkably unequal benefits within countries, and that very poor and rural people might even experience increased poverty and poor health as a result (Kim Yong, 2000).

Global Efforts to Address Health Inequalities

Since 1990, the problem of poverty began to emerge into the collective consciousness as a global problem that resulted from massive worldwide inequalities. The issue of global health inequalities is of particular concern. Epidemics such as HIV/AIDS, TB and SARS have brought with them a realization that deadly illnesses that spawn in a globalized world require globalized solutions (Chen, 2004; Gunn, 2005; Khun, 2007; McMichael, 2000; Skolnik, 2008). In 2001, Kofi Annan confirmed this realization in his speech to UN delegates at the African Summit. He declared that “[t]here has been a worldwide revolt of public opinion.” (Jacobsen, 2008p.19). His message was that the world was no longer willing to accept that people who were sick and dying should remain so because they were poor.

In 2000, the Millennium Development Goals (MDG), established by the United Nations, offered a blueprint for how the world might come together to solve pressing development problems by the year 2015 (Sachs, 2005a; Watkins, 2005). The MDGs were developed on the heels of two decades of failed attempts to eradicate poverty, and its resulting poor health (Blas, 2002). In particular, the 1978 Declaration of Alma-Ata committed the world to a primary health care protocol that would raise the health of every person in the world. By 2000, the goals of Alma-Ata were fully unmet (Chan, 2008; Kim Yong, 2000; WHO, 2006a).

The MDGs, however, take a more holistic approach to the improved livelihoods of poor people by including benchmarks for education, gender equality, environmental sustainability, and global partnerships, in addition to health outcomes. Improved health outcomes, however, are at the centre of the MDGs, with four of the eight goals directly related to improving the health of the world's poorest people. Health-specific goals include the eradication of poverty and hunger, reduced child mortality, improved maternal health, and commitments to combat HIV/AIDS, malaria and other diseases (Skolnik, 2008). Again, similar to the goals of Alma-Ata, many of the MDGs are unlikely to meet their targets and some are expected to recede even further from the 2001 indicators. War, unanticipated health pandemics, a global economic and food crisis, and a paucity of will from wealthy nations are all widely acknowledged reasons for poor progress toward the MDGs (Bhargave, 2006; Campbell, 2010; Hulme, 2010; Sachs, 2005b; UNDP, 2010).

The magnitude of the problem is profound. By 2015, the world's population will have increased by three-quarters of a billion people, and many of these people will be born into poor households (Chuhan, 2006; Sachs, 2007). The inequalities are massive. For example, the richest 5% people of the world's population receive 33% of the world's income, while the poorest 5% receive just 0.2% (Chuhan, 2006). A UNDP report helps clarify how great these inequalities are. From this report we are informed that "*...it would take less than 4% of the combined wealth of the 225 richest individuals in the world to achieve and maintain access to basic education, basic health care, reproductive health*

care, adequate food, safe water, and adequate sanitation for all the people living on the planet.” (Kim Yong, 2000 p.7-8).

How to deal with increasing poverty in a globalized world is a heated controversy. Those who stand behind the MDGs as objectives that are still achievable by 2015 argue that world poverty can be solved through increased levels of aid donated by wealthy countries. This aid would fund badly needed development projects (Hulme, 2010; Sachs, 2005b, , 2007, , 2008; UNDP, 2010). Others impugn the idea that more aid given to poor countries can solve the problem of poverty. Easterly (2006), for example, calculates that the world has spent US\$2.3 trillion on aid over the past 50 years, and that most of this aid has disappeared with little or no effect on economic growth or reduced poverty. These proponents suggest that countries can develop without aid, and that interference by international aid organizations has done more harm than good to poor countries and their citizens (Easterly, 2006; Guth, 2008).

Western Medicine

Until recently, distributing Western-style health care to the poorest people in the world was taken for granted as the most obvious strategy to generate improved health outcomes in impoverished nations. However, decades of failed attempts to establish even primary health care services in poor nations (Chen, 2004) calls attention to the challenges of transferring Western-style health systems into non-Western cultures. Many excellent

programs based on sound scientific knowledge, led by passionate people and funded generously by donors, have crumbled when they met the economic, political and social realities of the communities in which they were intended to function (Skolnik, 2008).

There is a rising awareness that global health inequalities require nuanced social and cultural solutions (Durham, 2008; Hahn, 2009; Hettne, 1995). While improved distribution of Western-style medicine is an important precursor to improved health outcomes in poor nations, the goal of importing Western-style health facilities into poor nations as a panacea to improved health outcomes has sometimes overshadowed, or even eliminated, the necessity to understand the social context in which illness and disability are understood. The problem with importing Western-style medicine into poor villages lies not in the knowledge itself, but in the inability to envisage that the knowledge upon which it is based might become irrelevant or even fundamentally wrong when it mixes with village ways of being (Kleinman, 1978b).

Culture and Medicine

Anthropologists have long noted that health and illness are culturally bound phenomena and that humans perceive their health within the context of their cultural existence. How an illness is explained, the root causes of an illness, stories that circulate within a culture about treating an illness, the degree to which a culture values an ill person, or the pain and suffering caused by the illness together create a cultural perception of illness (Ingstad,

1995; Morris, 1997; Whyte, 1988). All cultures have established core beliefs about illness and disability and their relationship to the universe. Such perceptions are not easily changed.

For hundreds of years, Westerners have searched for medicines that cure or relieve suffering caused by illness or disability. The result of this search is an elaborate medical system that deeply reflects the cultural history of Western civilization (Joralemon, 2006). Deeply ingrained within Western culture and medicine is the notion that health and illness exist *within* the body and that illness is cured by altering the body with medicines or procedures (Kleinman, 1978b).

Almost without exception, the villages in the poorest places in the world have for thousands of years danced, called on and enlisted the powers of magical spirits to return them to or keep them in good health. Deeply ingrained within many traditional societies is the notion that health and illness are phenomena largely controlled by forces *outside* the body, and that these forces must be appeased to ensure good health (Kleinman, 1978b). Many cultures in the world have severe aversions, fears or strong cultural beliefs around cutting or containing (casting) the body, spilling blood, or exposing or touching the body (Kleinman, 1997b). These aversions sometimes make it difficult to incorporate Western medicine practices and knowledge into local health seeking.

People make sense of health innovations that treat illnesses or disabilities by generating stories about these innovations amongst their families and neighbors (Rogers, 2003). In order to adopt new healing strategies, people need to narrate miraculous stories about their experience of being healed as a result of these innovations. Moreover, people need to relate these stories to what they and their ancestors have always known about illnesses and disabilities and what can be done about them (Blas, 2002; Kleinman, 1995; Kleinman, 1978a, , 1997b). For many people who live in the poorest places in the world, Western-style medicines are innovations that have not yet accumulated a repertoire of miraculous stories necessary to create widespread adoption.

Global health innovation is beginning to understand that the best strategy for reducing the staggering poor health of five billion poor and ill people in the world is to discover how existing programs and facilities might become more culturally relevant in the lives of the people they are intended to assist (Sachs, 2007). There is a growing recognition that the science of Western medicine functions only in the presence of cultural buy-in. Innovative global health practices are pioneering strategies to deliver health knowledge and services to poor villagers through culturally accepted means.

The System of Health Care Delivery

Poor people everywhere are looking for a solution to their pain and suffering. They live in a world where medicines exist to treat complex illnesses, yet their children still die

from diseases that are easily treated. They know that a solution to their health problem might exist elsewhere in the world, but their poverty makes the solution inaccessible to them. They also live in a time when their long-held beliefs and practices around illness and disability are melding with new knowledge and practices about how health problems might be resolved (Eckerman, 2006).

This time of change is compounded by governments that lack the capacity to manage the change (Khun, 2007, , 2008). Poor monitoring and registration processes create an environment in many poor countries where unlicensed practitioners proliferate, where fake or substandard drugs are commonplace, and where so-called trained health care workers demonstrate widely varied capabilities (Barennes, 2009). In countries where large numbers of people are desperately poor and ill, selling health has become a moneymaking business. Unlicensed pharmacies that will sell anything that poor villagers will buy, and in quantities they can afford, abound in poor places all over the world (Mayxay, 2007; Nonaka, 2009; Paphassarang, 2002). Health care workers who are paid impossibly low wages by their governments often moonlight in private practices, where they can legitimately charge for their skills. Alternatively, these people cope by charging unofficial fees to their patients at public sector health facilities (Khun, 2008; Soeters, 2003; Van Damme, 2004). Many others, who have an entrepreneurial flair for healing, have discovered that it is possible to walk through the poorest places in the world and sell desperate people nearly any concoction, so long as it is sold with a promise to relieve

suffering. In places where people are most in need of solid health care delivery, nearly no regulation exists to protect them from substandard or fraudulent practices.

The result is a complex landscape of health care delivery that poor people must navigate in their quest to find a solution to a health problem (Barennes, 2009; Dodd, 2009; Lao PDR, 2006c). Poor people who have the fewest resources to spend on health care contend with health systems that are rarely straightforward. In an ideal world, poor villagers would make informed decisions about where to spend their very limited health budgets. They would choose the most qualified health care workers in facilities that have the right types of infrastructure to manage their health problems. They would travel to the facility only once. In the real world, poor villagers stagger from health care option to health care option, often for reasons based on cost or location, and with no real notion as to the efficacy of the service being offered to them. This bouncing from health care option to health care option is made more complicated by the diversity of health-seeking options from which villagers can choose (Khun, 2007). The result is villagers who spend disproportionate amounts of effort and money on waylaid health-seeking journeys that often leave them even more destitute and still living with the consequences of an unresolved health problem.

Summary

This chapter contextualizes the study that follows within a global perspective on important issues related to health seeking and health care utilization in poor nations. This global view offers important insights into high-level processes that frame the lived experience of being ill or disabled in a poor nation. The chapters that follow move the focus from the high-level discussion offered in this chapter to a close-up look at the circumstances experienced by people who are poor and vulnerable when they look for a solution to their illness or disability problem.

Global perspectives that examine illness and disability in terms of health inequalities created by poverty and addressed through multinational strategies that employ best practices in development offer an important wide-angle view for how health care reforms might meet with better outcomes. Certainly, staggering health inequalities in the world demand a globalized perspective and large-scale efforts to find solutions. Often, however, globalized perspectives lack sufficient knowledge about the lived experience of illness and disability that could usefully inform how health care reforms might unfold and become relevant within local contexts.

This is a study about what poor people did with the health care that was delivered to them through policies and programs that conceptualized their problem through a globalized lens. While global policies influence health seeking and health care utilization in nuanced ways, poor villagers who informed this study never talked about global initiatives to solve

their problems. Villagers never expressed hope that the MDGs might solve their health problems, nor did they discuss how their plight is shared by billions of people in the world. Villagers only ever spoke about their individual health problems, and how they had tried to solve them.

As an onlooker, I did see the marrying of global initiatives to improve health outcomes in Phatang village with local practice. A one-drop disposable blood test for malaria available at the village health centre is certainly a result of millions of dollars invested to fight malaria in poor countries. An insulated backpack to keep immunizations cold while health workers travel by motorcycle to distant villages is another example. The medicines kept cold in these backpacks deliver life-saving immunization programs that are coordinated by massive global efforts to improve the health of the poorest people in the world. Clearly, improved health outcomes in poor nations require a global perspective on health care reform that is informed by localized knowledge about how health care is experienced in poor communities.

The tension between globalized perspectives and local knowledge is illustrated by the following story. Once, during data collection for this project, I met with the director of a non-government organization (NGO) that was providing health services to poor villagers. I met with him because I had discovered that a strategy developed by the NGO to exempt villagers from user fees had not surfaced. Poor villagers who should have been exempt from user fees at public health care facilities were still required to pay for services,

although most had never accessed a public health care centre because they had absolutely no money to do so. We met on a beautiful veranda perched on the edge of the Nam Song River, where we sipped wine under fig trees as our conversation unfolded. When I told my informant about my discovery, he shook his head with disappointment. After nearly two decades of working in Lao PDR to improve health outcomes, he was disappointed to learn that the exemption strategy had so blatantly met with failure. After thinking about it, he looked at me and told me his perspective. It went something like this. He said it was disappointing that the exemption program was not working, but that the new hospital could now do Caesarean sections, and that overall immunization coverage had increased in the area. We needed to look at gains from the bigger perspective and understand that change comes in steps.

During this discussion we also talked about some of my experiences collecting data for this project. He asked me to talk about my experiences accompanying health centre staff to remote villages where they conducted mobile immunization clinics. He said that he had always wanted to go along on one of those trips, but after 19 years of working in Lao PDR, he had never managed it. It was at this moment that I realized that our conversation was unfolding on completely different levels. The only thing I knew about Lao PDR was what I had learned from looking at the problems up close. I met people who were poor and suffering. I looked into their eyes and I wanted to help solve the problems that were in front of me. My informant had mostly looked at the problems of Lao PDR from a larger perspective. He looked at big systems and tried to imagine how those systems

might one day function better. In that moment, I realized that we could both learn a lot from each other.

Global health stands to benefit from projects that join global perspectives with village-level inquiries into lived experiences. Village-level inquiries offer a close-up look at the issues that matter to villagers, how they cope with them, and what they imagine a better future to look like. This project offers a unique close-up look at health seeking and health care utilization in rural Lao PDR. It also offers an examination of the experience of disability in Lao PDR and contributes to a scant pool of research that aims to understand the social construction of disability in poor countries. The close-up look offered in the thesis that follows moves explanations for health seeking and health care utilization in Lao PDR from obvious and wide-angle explanations to include nuanced and complex conceptualizations of lived experience.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this literature review is to examine pertinent research related to main themes presented in this thesis. Topics discussed contextualize the data collected. The chapter begins with an overview of Lao PDR and key challenges to delivering health care in Lao PDR. Donor involvement in health care and health policy in Lao PDR is reviewed. Data on international health offer an overview of key issues related to global health initiatives. Regional data from SE Asia, and data from impoverished countries in other regions are included and offer perspectives on common issues related to delivering health care in poor nations, including Lao PDR.

An attempt was made to focus the data included in this review on the challenges of health care reform, delivery and utilization for people who are poor, remote and vulnerable. Also included is literature that examines the relationship between culture and health care uptake, and how culture influences health care utilization in Lao PDR. Data further reviews different sectors of health care in Lao PDR and elsewhere—including home-based, traditional and public health care—that were identified as commonly utilized by the poor villagers who informed this study. Barriers and facilitators to health care utilization within these sectors are examined.

Data on health care in Lao PDR are limited, although the past few years have witnessed a small surge in published articles. In order to supplement the data and provide a regional context for understanding issues related to this thesis, a concerted effort was made to thoroughly examine articles from other countries in Southeast Asia that have similar economic and health challenges. In Southeast Asia, Cambodia, Myanmar and Lao PDR all face major political, economic and health challenges. Of these countries, Cambodia has by far the most published data on health care issues. These data are heavily represented in this literature review. Data from Myanmar is extremely limited. Data from other countries in Asia, and from other poor nations, are included if the data could usefully contribute to understanding health care issues in Lao PDR.

LAO PDR IN CONTEXT

Prior to 1893, the area which is now called Lao PDR was ruled by the Lan Xang Kingdom for 350 years. During that time, jurisdictions within Lan Xang were ill-defined and frequently overlapped, split or absorbed into new territories as tribal chieftains rose and fell from power (Evans, 2002a). Villages throughout the Lan Xang centuries are thought to have remained mostly isolated and autonomous (Ireson-Doolittle, 2004). Even during French colonization (1893-1954), rural areas were mostly untouched and continued to function as they had for hundreds of years.

Lao PDR has a population of 5.9 million people, 80% of whom live in rural areas and rely on subsistence agriculture (ADB, 2006; Mansfield, 2005; Patcharanarumol, 2009). Thirty-nine percent of the population is under the age of 15. There are 47 distinct ethnic groups. The ethnic Lao comprise 53% of the population. They predominantly live in lowland areas, they practise Theravada Buddhism, and they sustain themselves using wet paddy rice farming techniques. They are heavily represented in the economic and political fabric of the country. The remaining 47% of the population represent tremendous diversity. Many of these people speak languages that are remarkably dissimilar to the national language (Lao), and from each other. They live predominantly in upland areas, where they use slash-and-burn dry rice farming techniques, and many of them practise animist religions. Because dry rice yields are less than wet paddy rice yields, many upland farmers rely heavily on forest products to supplement their diets for survival (Ducourtieux, 2005).

After 1975, when the Lao People's Democratic Republic declared Lao PDR a communist state, the Lao government tried to take control of even the most remote villages. Village leaders were replaced by communist party members, and dissenters were sent to re-education camps, where many of them stayed for 10 to 15 years; some never returned (Evans, 2002a). For many rural people, the post-1975 government programs in Lao PDR were their first encounter with a national government that had already existed for more than 75 years (Bouapao, 2005).

After 1975, Buddhist and animist practices were banned in Lao PDR as the government tried to reinforce communist principles. While the policy was eventually rescinded, the consequences of outlawed animist practices are still evident. In Lao PDR, animist practices are widely regarded as backward and something that only uncivilized hill tribes partake in (Evans, 2002b). Interestingly, however, Theravada Buddhism is widely recognized as a blended religion which incorporates animist practices into Buddhist rituals that trace to Hindu religions (Dammen, 1985; Evans, 1999). Animist practices that are incorporated into Buddhism have escaped the negative connotations associated with other animist traditions practised by non-Buddhist rural people (Evans, 2002b).

Landlocked between Cambodia, Thailand, Vietnam, Myanmar and China, Lao PDR is an important centre point in Southeast Asia (Evans, 1999; Pholsena, 2006; St John, 2006). However, unlike many other countries in the region, Lao PDR remains crushingly poor and isolated. Its small geographical size, its dispersed and largely rural population, its communist government, and its position in a region where many other countries are experiencing rapid economic growth have caused Lao PDR to be off the radar for development initiatives (Evans, 1999). While Lao PDR has an abundance of natural resources—water and forest products in particular—its primary benefit to the area, especially since the recent lifting of border restrictions, is roads that move products and connect neighbouring countries that are in economic exchange with each other (Evans, 1998; Lao PDR, 2006b).

Rural Lao PDR

Rural Lao PDR consists of rugged mountainous terrain that is difficult to access. Few roads pass through the area, causing many rural villages to be inaccessible for several months of the year. People who live in upland areas, the majority of whom are ethnic minorities, have significantly lower health indicators, higher levels of poverty and less access to public services than do people who live in lowland areas. In rural Lao PDR, levels of poverty and ill health are directly correlated to road and river access (WHO, 2005a).

In an attempt to bring remote people under government control, the Lao government has, since 1975, adopted a policy of village relocation (Ducourtieux, 2005; Mansfield, 2005). In 1990, the Tropical Forest Action Plan adopted a resolution to permanently relocate three quarters of a million upland people who were engaged in slash-and-burn cultivation at that time. Today, migrations from highland areas to lowland plains outnumber migrations from rural areas to main cities (Evrard, 2004). Village relocation schemes are justified, and supported by donor agencies, through environmental and economic rationales that point to the devastating effects of slash-and-burn agricultural practices, the proliferation of poppy agriculture in rugged mountainous areas, and the cost-effectiveness of building schools, health care facilities, sewers and other infrastructure in centralized areas.

Relocation schemes are also intended to facilitate land tenure reforms that would protect forests and boost the process of establishing land titles (Baird, 2007; Baird, 2005; Evrard, 2004).

The catastrophic social, economic and health consequences of relocation programs are well documented. Out of seven studies that examined village relocation in Lao PDR between 1997 and 2005, not one study reported positive outcomes for relocated people (Baird & Shoemaker, 2005). Evidence illustrates that village relocation programs nearly always result in food shortages, high rates of illness despite closer proximity to public health care facilities, and environmental damage to lowland areas. Several studies reported conflict between communities that were encroached upon and the newcomers with whom they were expected to share resources (Baird, 2005; Evrard, 2004; Ireson, 1991; WHO, 2005a). One study found that relocated villagers described themselves as, “newly poor,” and that their new poverty was a result of their relocation. Interestingly, these people also reported that they did not necessarily want to move back to their upland farms because they still hoped that the land and supports they were promised would transpire. They also hoped that their children would benefit from the schools and health centres that they were now closer to, and that their current suffering would pay off with future gains (Pholsena, 2006).

Mortality rates within relocated villages in Lao PDR are very high. An Asian Development Bank (ADB) study in 2000 found that in Luang Namtha province, 80 out of

194 relocated people died within the first year of being relocated. In Sing province, another 300 people died after 500 households were consolidated into one village (Chamberlin, 2001). In some relocated areas, mortality rates are 30% higher than in other areas of Lao PDR, and incomes in these areas are half of those in unresettled upland communities (Baird & Shoemaker, 2005). In their report, Baird and Shoemaker (2005) summarized resettlement programs in Lao PDR as “...*disastrous for people and communities*” (p. 3). Relocated villagers are the very poorest people in Lao PDR, and also in the world. Their large presence in rural Lao PDR presents significant challenges to health care reform and development in general.

The connection between poverty and health is evident. In Lao PDR, 55% of children under five years are reported to be underweight while 41% are stunted (Taylor, 2006). Although Lao PDR achieved rice self-sufficiency in 2000, between 34% and 70% of rural people are reported to experience rice shortages and hunger every year (Ducourtieux, 2005; Lao PDR, 2006b). Only 30% of Lao villages have access to safe water (Ducourtieux, 2005; Japan, 2006). In 2000, a national health survey collected information from 6,449 households in 264 villages. The report sheds light on the uneven distribution of health resources in Lao PDR. Infant mortality rates in rural areas are more than double the rates in urban areas (86/1,000 and 42/1,000 respectively), and women in some rural areas are up to three times more likely to die in childbirth than are women in urban areas (Taylor, 2006). Seventy-eight percent of women in urban areas receive antenatal care compared to just 17% of rural women. Only 7% of villages in Lao PDR have a health centre. The

majority of Lao villagers must travel between 4 and 96 kilometres to arrive at the nearest public health care facility. (Bouapao, 2005; Taylor, 2006).

The 2002 Lao National Growth and Poverty Eradication Strategy (NGPES) (Lao PDR, 2002) offers a localized definition of poverty. In Lao PDR poverty is defined as a “*lack of ability to fulfill basic human needs such as not having enough food, lacking adequate clothing, not having permanent housing and lacking access to health, education and transportation services*” (p. 4). The document also outlines additional indicators of poverty such as insufficient resources to purchase or produce 16 kg of rice per person per month; lack of access to a school, a road, or a pharmaceutical dispensary; poor access to safe water; or more than six hours required to reach a hospital. In 2005, 72 out of 140 districts in Lao PDR were classified as poor, 47 of which were classified as priority districts. All of these districts are located in rural areas.

Economic Support in Lao PDR

Lao PDR is classified as one of the least developed countries in the world and faces serious obstacles to development. Twenty-seven percent of the population live on less than US\$1 per day, and 71% live on less than US\$2 per day (ADB, 2006; Patcharanarumol, 2009).

During the past 50 years, Lao PDR has received economic and strategic support from various countries, often for different political reasons. In the 1960s, the American war against Vietnam was partly staged from secret posts in Lao PDR, an act that defied the Geneva Convention. During this time, two million tons of bombs were dropped over Lao PDR, the equivalent of one planeload of bombs every eight minutes for nine years (Kanashiro, 2004; Lovering, 2000). To escape the bombs, people fled their villages and hid in caves. (Bouapao, 2005; Ducourtieux, 2005). The serious economic, health and environmental consequences of these bombs are still reflected in the social and economic fabric of Lao PDR today.

After the Vietnam War, the Soviet Union and Vietnam developed relationships with Lao PDR in order to support communism in Asia. However, after the fall of the Soviet Union in 1991, the Americans and other democratic nations supported Lao PDR to establish market reforms. During that time, the Chinese and the Vietnamese also offered support to Lao PDR. Even Thailand, which itself has only recently emerged from poor country status, is looking at Lao PDR as a potential buyer of Thai products and also a possible producer of cost-effective energy, primarily from the abundance of water power in Lao PDR (ADB, 2006; Binka, 2002; Evans, 2002a; Evans, 1999; IMF, 2004; Stuart-Fox, 1986).

Country development reports detail the aid-dependent nature of Lao PDR and the impact this has on development. In 2003-04 national revenues in Lao PDR were US\$335 million

while expenditures were US\$463 million. The national debt in Lao PDR is approximately 8.4% of the GDP, a situation that causes the Lao government to be in a continuous process of balancing debt payments with assistance. Lao PDR receives approximately US\$400 million annually in assistance, most of which is in the form of grants due to the country's HIPC (Heavily Indebted Poor Country) status. Aid distribution between urban and rural areas is highly unequal, with lowland areas receiving disproportionate amounts of development assistance despite lesser need (Evans, 1999; Pholsena, 2006).

Official statistics, registrations and population surveillance data are unreliable or non-existent in Lao PDR. Most of what is known about populations in Lao PDR is drawn from survey data. While national health indicators are steadily improving, they remain well below international standards and are among the lowest in the region. According to available data, and based on country-wide data, Lao PDR is on track for meeting Millennium Development Goals (MDGs) for primary-school enrollment and child-mortality reduction, although challenges remain for all of the other targets (WHO, 2005a). Given the large discrepancy between urban and rural areas, and supported by the survey data collected in 2000, it is likely that none of the MDGs will be met if regional variations are factored into measurements (Merlin, 2011; Pholsena, 2006; Thome, 2009).

Recently the government of Lao PDR developed a number of policy and strategy documents aimed at accelerating progress toward the MDGs. These documents include a

national nutrition policy (2008), a national food safety policy (2009), a skilled birth attendance development plan (2008), a strategy for maternal and child health (2009), a health information plan (2009-2015), a human resource for health master plan (2009-2020), and a draft of a health financing strategy plan (2011-2015) (WHO, 2005a).

Public Health Care in Lao PDR

In 2005, the public health care system in Lao PDR was comprised of 4 central hospitals, 5 regional hospitals, 13 provincial hospitals, 127 district hospitals, and 746 rural health centres (WHO, 2005a). There were 1,865 licensed pharmacies and 254 private clinics as well as unlicensed providers. Two-thirds of the population has had limited or no access to public health care (Paphassarang, 2002).

The health system in Lao PDR is seriously underfunded (Delang, 2007). It is heavily dependent on donor funding and out-of-pocket payments by patients (Japan, 2006; JICA, 2002). In 2006, per capita expenditure on health was US\$22 (up from US\$11 in 2003) (Dodd, 2009; Patcharanarumol, 2009). Of this the largest share came from out-of-pocket payments submitted directly by users of the system in exchange for services (US\$16.50), followed by donor funds (US\$4.12). The government of Lao PDR contributes US\$1.38 per person, per year to health care services. Health financing in Lao PDR is further complicated by unpredictable commitment from donors. In 2006, for example, donors

committed US\$20.8 million to health care in Lao PDR compared to 2005, when donors committed US\$ 36.7 million, a staggering decrease of more than one-third.

The health system in Lao PDR is decentralized, with most decisions made at the provincial level. The system requires minimal reporting back to central authorities, which causes high levels of inequality between districts. It also creates difficulties in enforcing centralized policies. The Ministry of Finance, for example, has detailed a policy of acceptable user fees at public health care facilities, but the policy is weakly enforced at the district level (Thome, 2009). As a result, the actual user fees paid by villagers vary greatly between districts as well as within districts. Also problematic is that bottom-up mechanisms to gather information from users of the public health care system are non-existent (Thome, 2009). A complete gap in information from health system users makes it impossible for the health system in Lao PDR to respond to the unique needs of communities.

Health care delivery in Lao PDR is highly fragmented. Between 2001 and 2006, the OECD⁴ listed 173 health activities in Lao PDR, 134 of which had a value of less than US\$1 million, indicating that the health care landscape in Lao PDR consists of a myriad of small-scale projects that are operated by different organizations (Dodd, 2009). More than half of funds donated to Lao PDR for health care come from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Other major support comes from Japan and Luxemburg,

⁴ Organization for Economic Co-operation and Development

as well as 12 other bilateral donors and numerous other national agencies (Barennes, 2009).

The public health care system in Lao PDR is also poorly coordinated between government, donors and users of health services. Many of the 173 projects that operate in Lao PDR are focused on improving health infrastructure, which has created major imbalances in the system. Notably, there are 5,000 hospital beds in Lao PDR, more beds per 1,000 people than in any other country in Southeast Asia. Most of these beds are underutilized or not used at all because the majority of the population is too poor to access them, and they face numerous other insurmountable barriers to utilization (Thome, 2009). In Lao PDR, individuals from wealthy households are three times more likely to be admitted to a hospital than are individuals from the poorest households (15.9/1,000 population vs. 42.4/1,000 population) (Thome, 2009). These statistics indicate the imbalanced nature of how health care is accessed in Lao PDR and by whom.

In 2006, the government of Lao PDR recognized high levels of fragmentation within the health system and developed the Vientiane Declaration on Aid Effectiveness, which was signed by 23 countries. The Vientiane Declaration calls for government ownership over policies and strategies, alignment between partner and government initiatives, harmonization and simplification of procedures and programs, improved management for decision-making and mutual accountability.⁵

⁵ <http://www.oecd.org/dataoecd/24/36/39151183.pdf>

Overarching Goals of Health Care in Lao PDR

The overarching goal of the government of Lao PDR is to graduate from least developed country status by 2020 (World Bank, 2005), while the overall vision for public health care in Lao PDR is to “*continually improve [health status] with a strengthened health care system and empowering people [to take] responsibility for their own health, thereby contributing to poverty alleviation.*” (Taylor, 2006 p.24). The program is based on a Healthy Village Model, which is an integrated program that supports access to primary health care, clean water and sanitation (WHO, 2005a)⁶. In addition to primary health care⁷, the Ministry of Health has endorsed basic drug kits⁸ as a primary health intervention strategy (Lao PDR, 2007; Patcharanarumol, 2009; Sengaloundeth, 2003).

Taylor (Taylor, 2006) reports that the Lao government’s current program toward primary health care outlines approaches, principles, components and responsibilities but lacks an action plan to put the program into practice. Sengaloundeth’s (2003) study on the basic

⁶ The Healthy Village Model is an initiative that promotes holistic health in rural areas and enables rural populations to protect and improve their health. Under the Healthy Village Model, health is understood to be influenced by many factors, including environmental conditions, income, individual behaviour, and health services. The characteristics of a healthy village are 1) a clean and safe physical environment 2) an environment where everyone’s basic needs are met 3) social harmony 4) community understanding of local health and environmental issues 5) community participation in identifying local solutions to problems 6) communities that have access to communication 7) accessible and appropriate health services 8) a historical and cultural heritage that is celebrated 9) a diverse economy and 10) sustainable use of available resources (Howard, 2002).

⁷ Primary health care is a World Health Organization concept which has nine components 1) food and nutrition 2) water and sanitation 3) maternal and child health 4) reproductive health 5) immunization 6) first aid/disease control 7) traditional medicine 8) provision of essential drugs 9) health education. (Taylor,2006)

⁸ The basic drug kit is a strategy currently supported by numerous organizations. Basic drug kits are supplied to village health volunteers and include up to ten common drugs, including Chloroquine, Paracetamol, antibiotics and oral rehydration solution.

drug kits found that drug kits on average contained only 3 of the original 10 to 27 medicines and that many of the medicines were expired or unlabelled. The report also found that some of the medicines were sold at up to five times the regulated price, and that Village Health Workers (who administer the drug kits) did not clearly understand the role or function of the kits. Villagers further reported that the drug kits did not contain preferred medicines, such as injectable medicines and brand-name drugs from Thailand.

Health Care Reform in Lao PDR

Challenges to health care reform in Lao PDR are numerous. Inadequate training of health care professionals, low salaries and poor incentive programs for staff are major struggles for improved health system function in Lao PDR. Poor productivity at all levels adds another level of difficulty. Uneven distribution of qualified staff throughout the country also creates challenges.

The government of Lao PDR recognizes the major challenges that face health care reform in Lao PDR. The National Growth and Poverty Eradication Strategy (NGPES) identifies 72 poor districts and 47 priority districts for initial activities aimed at reducing poverty and improving health outcomes in Lao PDR. Twelve health priorities for these districts are outlined, including improved health education and promotion, upgraded health worker capacity, promotion of child and maternal health, immunization, improved water supply

and attention to environmental health, control of communicable and sexually transmitted diseases, development of revolving drug funds, food and drug safety, promotion of traditional medicines, and strengthened sustainability, financing, and quality of service (WHO, 2005a).

Until now, government priority for improving health care delivery in Lao PDR has focused on training high-level health practitioners, such as doctors and nurses. This effort has resulted in improved health worker to population ratios in Vientiane (3.6/1,000) and other lowland areas, but health worker ratios remain very low in rural areas (fewer than one health worker per 1,000 population) (Barennes, 2009). These levels are much lower than the minimum level of 2.4 health workers to 1,000 population set out by the World Health Organization (Merlin, 2011). Low-level staff with minimal training fill the majority of health posts in rural areas, a situation that exacerbates poor health outcomes in rural areas (Bouapao, 2005). There is a lack of targeted programs aimed at ramping up the skills of low-level and local health care providers in rural areas. A major struggle for health care reform in Lao PDR is developing strategies that will attract skilled health workers to rural areas or boost the skills of low-level staff who currently fill rural health posts.

Professional health workers in Lao PDR prefer to concentrate in Vientiane, where opportunities exist to supplement income through private sector practice (Dodd, 2009). In countries everywhere, challenges exist in attracting qualified health care staff to work in

rural areas. In countries where data are available, health workers often refuse to work in rural areas due to poor living conditions, concerns about security, limited opportunities for career advancement and in-service training, infrastructure that is crumbling or inadequate, and a lack of medicines and equipment necessary to work in the field (Merlin, 2011).

Public health care policy research reports that public health care wages in poor countries have decreased in real terms during the past ten years. Small increases to staff salaries in most countries have not kept pace with significantly increased food and fuel prices, along with higher costs of living (UNICEF, 2010a; Vujicic, 2009). In some countries, public health care worker wages are one-quarter what they were ten years ago in real terms. In many countries, health workers are paid wages irregularly, and often these wages keep them at or below the international poverty line of US\$2 per day (UNICEF, 2010a). Low salaries for health care workers affect motivation, work performance, quality of care, staff morale, and they force staff to look for other forms of income (McCoy, 2008; UNICEF, 2010a).

In Lao PDR, public health care sector wages are amongst the lowest in the world and are a major barrier to health care reform (Thome, 2009). In rural areas, salaries are as low as US\$50 per month. Low wages force health care workers in rural areas, who have limited opportunities to establish private practices, to take additional jobs, prescribe extra or unnecessary medication (a portion of which goes to staff incentives), or charge unofficial

user fees for services performed at public health care centres (Bhushan, 2006; Khun, 2008).

The problem is compounded by limited opportunities to raise salaries for health workers. In 2007, the government of Lao PDR awarded a 20% increase to all civil servants, making another raise in the near future unlikely. Equally unlikely is the prospect that the government will consider raising the salaries of health workers in isolation from other civil service employees, all of whom are underpaid. The Lao government already allocates half of its limited health budget to salaries, and squeezing more from it is unrealistic (Barennes, 2009).

Donors who are unwilling to pay salaries further complicate the problem. Traditionally, donor assistance in poor countries has focused on capital and training investments, rather than staff salaries, which are regarded as the responsibility of recipient governments (Thome, 2009). Salaries paid by donor agencies are considered unsustainable because governments will not be able to continue to pay high wages when projects end (McCoy, 2008). Rather than pay salaries, donors prefer to boost low government incomes through incentives such as per diems and travel costs, which dry up once the project winds down (McCoy, 2008; Vujicic, 2009). In Lao PDR, donor policies regarding staff incentives are unregulated. Some agencies pay attractive incentives to high-level staff, which further deteriorates the system by privileging certain staff with generous benefits. This

unregulated system creates resistance to change within the health system from staff who benefit from the current structure (Dodd, 2009; Soeters, 2003).

Recent investigations into global health policy conclude that health care reform in poor countries requires long-term commitment from donor agencies to pay living wages to staff (McCoy, 2008; Merlin, 2011; Vujicic, 2009). These studies argue that core health care reforms, all of which are exemplified in the situation in Lao PDR, will not be overcome in the absence of a major overhaul to the way health care is funded, and who pays for it. Other studies conclude that poor progress toward the MDG is in part a reflection of resistance from donor agencies to pay living wages to front-line health care staff (Campbell, 2010).

In Cambodia, health care reform in some districts has become a model for positive change in the region. Soeters (2003) reports that health care reform in Cambodia required zero tolerance policies that prohibited health workers from charging unofficial fees or operating private practices. As well, third party auditors regularly reviewed health accounts using strict standards. Reform in Cambodia was also precipitated by policies that increased base salaries for health workers to living wages through performance-based incentives. This resulted in improved quality of care and increased uptake of health services by poor people. Health workers in Cambodia were expected to correctly diagnose and treat patients, and offer timely services and respectful care. They were also to ensure a reliable supply of drugs. Soeters (2003) found that health workers valued

their government jobs, which they considered to be lifelong safety nets, and could be pushed to accept policies that they did not initially support. Once health workers discovered that their salaries increased from legitimate sources, and that they could increase their income further from higher patient loads due to improved quality of service, health workers were more likely to accept policy changes.

User Fees

Between 1975 and 1990, health services in Lao PDR were provided free to the entire population. By 1990, however, the health system in Lao PDR was seriously under-functioning with poorly paid staff, drug shortages, poor quality of care and outdated or non-existent infrastructure. To avoid the collapse of the health system, user fees at all levels of health delivery were implemented in 1996 (Thome, 2009).

User fees in Lao PDR are paid up front at the point of service, which means that villagers must have cash in hand if they want to access health services from a public health care facility. Officially, user fees are very low. At village health centres, user fees are the lowest of those at all health facilities. These fees rise incrementally as public health care becomes more sophisticated and farther away from villages. Data from this project reveal, for example, that a typical visit to the Phatang Health Centre for an uncomplicated outpatient consultation, including prescription medicines, typically cost US\$5 or less.

While the costs are low, even nominal user fees can be prohibitive for poor people. Villagers who participated in this study reported that they sometimes did not have any cash to pay for health services from a public health care facility. Other informants reported that they wanted to spend as little money as possible, so they preferred to seek help from a cheaper health provider, most notably the private pharmacy, where consultation was free and medicines were sold in affordable quantities.

User fees are an important source of revenue for health facilities in Lao PDR. A WHO report in 2007 (Thome, 2009) reports that between 48% and 83% of recurrent budgets for hospitals in Lao PDR are raised from user fees, 80% of which derive from the cost of drugs. While user fees create barriers to health care utilization for poor people, they are also enmeshed in the Lao health system, which relies heavily on these revenues for day-to-day operations. It is noteworthy that villagers who participated in this study unanimously reported that they thought it was reasonable for health facilities to charge user fees because they understood that health facilities needed to raise money to cover their costs. Villagers appear to have little or no expectation that their government should or could pay for public health care or even provide subsidies to people who are very poor.

User fees in Lao PDR are charged for patient consultations and also to support the Revolving Drug Fund (RDF). The RDF allows health facilities to charge set fees for drugs plus 25% to cover the costs of restocking, transportation and administration. RDF fees are the only fees collected within public health care facilities that can be used at the

discretion of health facility staff. While the implementation of the RDF was successful because it improved problems with drug supply, the program in its current form provides incentives for over-prescribing and unnecessary prescribing of drugs, which profit the health centre and the staff. The unregulated nature of the program has also resulted in drugs that are marked up 40% or more from set costs (Thome, 2009). Evidence of this was noted in this study. One family took their child to various health centres regularly during the six months that I collected data. The child suffered from repeated ear infections, fevers and a chest cough. On every occasion the family returned with a prescription of antibiotics, a total of seven prescriptions in six months of data collection. Other observations indicated that most villagers who visited a health centre returned with several drugs, one of which was almost always antibiotics, including a family whose child had chicken pox, a woman who gave birth, and a teenage boy who had acne.

Decisions about exemption from user fees are made at the facility level, based on local appraisals of who is poor enough. The result is many localized interpretations of “poor,” and high levels of inequality between districts. In some cases major disparities exist within districts and even within villages. For example, in Somsavat village, which is just 15 kilometres north of Phatang village, only five households were registered as poor enough to qualify for exemption from user fees, even though Somsavat village as a whole was much poorer than Phatang village, and most households qualified as “poor” according to the NPGES guidelines. In Phatang village, no household was registered as

qualified for exemption even though a few households were landless and lived in woven bamboo houses.

In reality, few exemptions are made in Lao PDR, despite a centralized policy outlining exemption criteria and evidence that indicates that projects were carried out to identify and register some households as exempt. The Phatang Health Centre, for example, had a list of families who were identified as exempt from user fees, but this project was only able to locate one family in three villages that had an exemption card. Notably, this family was unaware of the reason for the card, and they did not believe that they would be entitled to free health care. Similar to evidence reported in the literature, respondents reported that monks, civil servants, military personnel, teachers and the deserving destitute are sometimes given a 50% discount on user fees, but that no one, not even the very poor, is ever fully exempted from user fees in Lao PDR.

Two health insurance schemes operate in Lao PDR, one for the civil service sector and the other a community-based health insurance program. Combined, these programs reach less than 3% of the population and do not yet offer good protection against user fees for the Lao population (Thome, 2009).

Health Center Utilization in Lao PDR

Health centre utilization in Lao PDR is low despite high rates of illness and disability (CIA, 2006). The Phatang Health Centre, for example, where data for this project was partially collected, serves approximately 8,500 people but typically receives fewer than 10 patients per day (Lao PDR, 2006a). On average, public health care centres in Lao PDR serve regions of approximately 7,000 people, but only about 1,000 of these people have good access to them (WHO, 2007).

Reasons noted for poor utilization of health services in Lao PDR include poor quality of care, user fees, distance to the health centre, poor supply of drugs, language barriers, long wait times and health centre staff who are rude to poor patients or patients who are from ethnic minorities (ADB, 2005; Gordon, 2006; IMF, 2004; Japan, 2006; Jönsson, 2007; Khun, 2007; Nonaka, 2009; Paphassarang, 2002; Perks, 2006; Taylor, 2006; Vang Chu, 2006; WHO, 2005a). Other reports cite superstitious beliefs, cultural aversion toward Western medicine and lack of knowledge about health as additional reasons why poor rural people do not utilize health centres (Bertrand, 2002; Japan, 2006; JICA, 2002; Kanashiro, 2004; Lao PDR, 2006b; Nonaka, 2009; Taylor, 2006; World Bank, 2004).

While overall utilization of public health care in Lao PDR is low, data suggest that the rate of multiple health centre utilization for a single illness episode is high (Segall, 2002). Nonaka (2009) found that 41% of Lao patients who sought care for an episode of malaria

from a public health care centre visited the health centre twice for the same malaria episode, and 10.6% visited a health centre three times or more times for a single episode of malaria. These data indicate high levels of intervention failure at public health care centres (Segall, 2002).

Paphassarang's (2002) study of health utilization in Lao PDR reports that informants decided which health care provider to consult based on perceptions about the quality of care offered and how this care might respond to the individual needs of the patient and his or her family. Similarly, findings from Cambodia (Khun, 2007) found that women chose not to use the local health centre because they thought the centre was only capable of treating mild illnesses. In Cambodia, for example, women who suspected that their child might have dengue fever knew that the local health centre did not have facilities to administer blood tests that could accurately diagnose the disease (Khun, 2007). These women either persisted with home treatments, purchased small quantities of medicines that they could afford from a local pharmacy, or bypassed the local health centre altogether and sought care from secondary or tertiary level health facilities.

Poor utilization rates of health facilities in Lao PDR are further compounded by reports that poor and rural Lao villagers find health facility procedures to be complicated, intrusive and sometimes rude to poor patients (Paphassarang, 2002). In some instances, Paphassarang (2002) reports that villagers were told to go home and die if they could not afford the cost of treatment offered at a public health care facility. This is an experience

that greatly offends villagers. Other studies report that poor patients felt that procedures to obtain fee reduction from public health care facilities were degrading to poor people (Nonaka, 2009; Soeters, 2003).

Braveman (1998) distinguishes between theoretical and real access to health care in low-income countries. He points out that there are many barriers to health care utilization beyond the obvious financial, geographical and linguistic ones. Braveman (1998) refers to barriers such as *“lack of awareness of the need for a given service ... how to obtain it [and] fear ... of seeking care”* (p. 79) as powerful access-to-care influences. Similarly, Paphassarang (2002) studied utilization and equity of health services in Lao PDR and concludes that access to health care in Lao PDR remains theoretical. Paphassarang refers to “disadvantaged consumers” who face many access barriers, including problems navigating complicated institutional procedures. Additionally, Meesen et al. (2006) found that poor patients in Cambodia required social workers to help them overcome barriers such as stigma, social exclusion and procedures necessary to obtain exclusion from formal fees.

A UNDP (2010) report on progress toward the MDGs in Lao PDR suggests that poor participation in health programs in some communities has resulted in slow progress toward the MDGs. Low participation rates such as these are indicative of a growing awareness that the health concerns identified by international agencies might not be the same concerns prioritized by people who actually live in poverty. In Malawi, for example, a

child might experience up to 12 episodes of malaria before his/her third birthday. In Malawi, malaria is considered normal, and families assess the degree of the problem at the onset of the disease, based on the assumption that malaria is normal, likely to be mild or self-limiting, and will probably be relieved by local herbs, simple medicines bought from a pharmacy, or medicines that are left over from previous episodes (CBC, October 21, 2010). The behaviour of families who live with malaria as a normal part of their lives is directly contrasted with massive world efforts that consider malaria a major health threat and encourage people to utilize public health care for every episode (Khun, 2007)

Similarly, Shirayama et al. (2006) found that Lao villagers reported the risk of malaria as low or very low despite high rates of malaria infection recorded by health information systems in the area. This perception about the risk of malaria infection likely contributes to poor outcomes and utilization of targeted malaria programs in the area. Put simply, villagers might not be worried about malaria. Further, these authors suggest that high utilization of bed nets by informants (92% usage) might not necessarily be an attempt to reduce rates of malaria infection, but an attempt to keep all sorts of pesky bugs away in the night.

Responding to Illness and Disability

Kleinman (1980) identifies three interconnected health sectors: the home⁹ sector, the traditional¹⁰ sector and the public¹¹ sector. In all cultures, the home sector, which includes lay knowledge about illness and home-based remedies, manages 60-90% of illness episodes. These results are in line with other studies from Tanzania, Philippines and India that found that the first response to an illness episode is nearly universally to deal with the problem within the home (Khun, 2007). The large contribution of the home sector to the health of families and communities points to the tremendous importance of local health knowledge and access to simple remedies at the local level.

The traditional sector, which includes herbal doctors, faith healers, shamans or midwives, is the second health sector described by Kleinman (1980). Traditional healers, due to their proximity and shared culture with local people, are well placed to identify and explain, in culturally relevant terms, the social, psychological, spiritual or moral dimension of an illness.

⁹ In Kleinman's work he refers to this sector as the "popular" sector. For reasons of clarity and consistency, the term was changed to the "home" sector for the purpose of this thesis, although the meaning remains the same.

¹⁰ In Kleinman's work he refers to this sector as the "folk" sector. For reasons of clarity and consistency, the term was changed to the "traditional" sector for the purpose of this thesis, although the meaning remains the same.

¹¹ In Kleinman's work he refers to this sector as the "professional" sector. For reasons of clarity and consistency, the term was changed to the "public" sector for the purpose of this thesis, although the meaning remains the same.

In most countries, the public health care sector is the legal and publically organized sector through which formal healing is practised, and where Western medicines and treatments are delivered. In developing countries the public health care sector constitutes a very small percentage of actual health care, while the building up of this sector accounts for a large percentage of public resources spent on public health care (Gordon, 2006; Helman, 2007; Taylor, 2006; WHO, 2006a).

In Lao PDR, as in many other countries, Western medicines are distributed through both public and private health care practices. While the government of Lao PDR controls public health care facilities, private health care in Lao PDR is largely unregulated. Private health care in Lao PDR takes the form of private pharmacies, both licensed and unlicensed, and private health care practitioners, many of whom are also employed in the public health care sector (WHO, 2005a).

In rural Lao PDR, illness episodes are almost always dealt with by home treatments at the onset of the problem, followed by purchasing medicine from a private pharmacy if the problem does not improve (Bouapao, 2005; Caballero-Anthony, 2004). One study in Lao PDR found that 40% of people suffering from symptoms associated with malaria completely home-managed their illness without any outside help whatsoever (Nonaka, 2009). In most cases, only when home treatments and pharmacy medicines fail, do villagers seek help from a public health care facility or a traditional healer (Delang, 2007).

In Cambodia, similar health-seeking trajectories were identified amongst poor villagers (Soeters, 2003).

Khun (2008) reports on the outcomes of different health-seeking actions in Cambodia. Several informants in this study spoke about losing multiple children to dengue fever, despite similar symptoms at the onset of each illness episode. These women chose similar treatment trajectories for multiple children, namely home treatment, despite previous failed treatments, because they lacked feasible alternate options, even if they understood that their child was dangerously ill. Women who could not afford to take their child to a health centre resorted to prayer when the illness progressed and seemed beyond home cures. Other women who did take their child for treatment at a higher level health facility described the experience as tantamount to a “house fire” or a “sinking boat,” due to the high costs and calamitous debts acquired as a result of the hospitalization.

Available data suggest that once villagers begin their search for a solution to an escalating health problem, they often end up switching from one sector to another and sometimes back again. For example, Nonaka (2009) found that approximately three-quarters of Lao villagers who consulted a public health care practitioner switched to the private or traditional sector and vice versa if the problem was not solved in the first instance. Often villagers will transition back and forth between sectors and between different modalities within sectors in their search for a solution. These findings are reported elsewhere. Studies in Tanzania, Mali and Burkina Faso also discovered patients who transition

between public and private sectors and sometimes back again (Nonaka, 2009). Khun (2007) describes this bouncing and detouring as a search that is unplanned and contingent upon availability of resources, geography, access, practical restraints, cultural processes and moral reasoning.

Private Pharmacies

Since 1986, the number of licensed private pharmacies in Lao PDR has swelled from 32 to approximately 1,900 in 2005 (Delang, 2007; Thome, 2009) as a result of policy reforms that allowed private pharmacies to operate. As many as 6,900 unlicensed private drug dispensers also operate from villages throughout Lao PDR. The unregulated nature of drug distribution in Lao PDR results in the production of fake and cheaper substandard drugs that appeal to drug dispensers who want to provide the cheapest product possible for their poor customers and still make a profit. Given the low level of education among drug dispensers in Lao PDR, it is likely that many unlicensed drug dispensers are unaware that their products are substandard or that their practices might be harmful.

Compared to 740 rural health centres, the nearly 7,000 licensed and unlicensed private drug dispensers operating in Lao PDR outnumber rural health centres 9:1 and are a formidable force of health care delivery in Lao PDR. Unlike public health care facilities, private pharmacies are nearly always easily accessible to villagers. In Phatang village, for example, the private pharmacy was located in the centre of the village, and was very

accessible to villagers. Even though the Phatang Health Centre was also accessible to villagers, it still required that villagers walk past the edge of the village, a distance of one kilometre or less for most villagers. Villagers regularly reported that the pharmacy was more convenient to them because it was quicker to get to.

In Lao PDR, villagers report that they prefer to get medicines and medical advice from private pharmacies because the pharmacy is located near their home, the medicines are for sale in small, affordable quantities, the care offered is kind, respectful and timely, and the perceived quality of drugs is good (Mayxay, 2007; Paphassarang, 2002; Soeters, 2003).

The importance and widespread use of private pharmacies in rural areas of Lao PDR is not well recognized by government or donor agencies working toward improved health outcomes in Lao PDR (Delang, 2007; Nonaka, 2009). Syhakhang (2004), for example, reports that 70% of mothers in Lao PDR bypassed the health centre and bought medicines for their ill children directly from a private pharmacy. Syhakhang's (2004) results are supported by Nonaka's (2009) study that examined health seeking for early-episode malaria in Africa, where use of private pharmacies is also widespread. This study reported high utilization rates of private pharmacies in poor and rural areas (Nonaka, 2009).

Available data from Lao PDR report shockingly poor levels of health care delivered from private pharmacies, despite public perceptions that the quality of care is very good (Murakami, 2001; Stenson, 1998; Syhakhang, 2004). In 2004, Syhakhang (2004)

examined the quality of private pharmacies in Lao PDR and found that only one drug seller out of 59 knew what constitutes a good drug, and that only two could state the correct temperature for drug storage. In this study, 58% of drug sellers reported buying drugs from unauthorized dealers, while only 44% were aware of correct drug labelling. Stenson (1998) substantiates these findings. In Lao PDR, Stenson found that 46% (366) of drugs sampled from private pharmacies were substandard. Mayxay (2007) also interviewed pharmacy owners and village health volunteers about malaria treatment in Lao PDR and found that only 14% could identify more than two criteria for severe malaria and that 65% gave an incorrect dose. A further 70% of drug sellers did not know the side effects of malaria medications, and 27% prescribed combinations of anti-malarial medicine because they thought that one medicine was not strong enough. These studies suggest an urgent need for improved training and enhanced recognition of private pharmacists as important community health providers in Lao PDR.

CULTURE, ILLNESS AND DISABILITY

Culture is a set of guidelines that direct people in their view of the world. In most modern societies, culture is characterized as a fluid process of constant change and adaptation (Eckermann, 2008; Helman, 2007). Culture creates a shared perception that makes it possible for human groups to live together and pass on ways-of-being. Cultures also have within them many subcultures, such as young, old, sick, healthy, upper-class and lower-class. Every culture has elaborate processes that move people from one social category to

another social category (Whyte, 1988). Many of these processes beyond the awareness of cultural members (Hall, 1984).

Modern cultures act as resources and constraints on how individuals construct experience (Kirmayer, 2007). While the experience of illness or disability is shaped through cultural explanatory models, individuals who live within cultural groups have different levels of buy-in and exposure to experiences that shape understanding. Diverse experiences account for a wide spectrum of responses to illness within any cultural group (Helman, 2007). Personal experiences, combined with cultural ways-of-being, influence how humans understand bodily processes, how they narrate suffering, and the models used to guide healing practices.

Beliefs and practices relating to ill health are central features to all cultures (Joralemon, 2006; Lock, 1997; Morris, 1997; Whyte, 1988). These beliefs have important implications for the types of treatments people seek for a health problem. Often traditional cultures ascribe the etiology of an illness or disability to supernatural causes or beliefs about the origins of a problem (Bhushan, 2006; Eckermann, 2006; Groce, 1996; Helman, 2007; Kleinman, 1978a). For example, Tran et al. (2007) found that epilepsy in Lao PDR is understood to have supernatural origins, to be life-threatening and to be caused by consuming pig. The term for epilepsy in Lao PDR is *sak pa moo*, interpreted to mean, “mad pig disease.” The problem is understood to be contagious and transmitted by contact with saliva. It can also be a punishment for poor behaviour. Similarly, Faidman (1997)

captures the tension between Western and Lao beliefs around epilepsy when she recounts her work with a Lao family in America. The family exasperated American doctors who wanted to treat the child with strong neurological medications, which would control the disease within her body. The Lao family understood their daughter's epilepsy as a problem with her spirit gone astray, and had very different ideas about how to treat the problem.

Cultural knowledge about illness and disability is transmitted through personal experiences and the images and stories of others' experience (Hyden, 2008; Kirmayer, 2007). In all cultures, oral histories of illness and disability are long and established. They are often reinforced through elaborate rituals, healing practices and historical documents. Cultures that ascribe the cause of an illness or disability to supernatural forces, evil spirits or floundering souls will often search for a cure by appealing to forces outside the body. Even when confronted with persuasive alternative evidence, such as scientific proof, long-established cultural beliefs and practices around health and illness and disability are difficult to refute (Helman, 2007). For example, in Lao PDR, Shirayama et al. (2006) found that 95% of respondents reported attending at least one malaria education program, with some villagers reporting attending as many as six. Of these respondents, only 51.7% mentioned mosquitoes as the cause of malaria. Frequently cited causes of malaria included poor sanitation, unclean water or food, as well as evil spirits. Twenty percent of respondents had no idea what caused malaria. Low malaria knowledge despite high rates of attendance at malaria education programs, answers that appear to confuse malaria

education programs with other health education programs, and respondents who reported supernatural causes all indicate that malaria education programs in Lao PDR are challenged to spread their message. While villagers may be physically present at malaria education programs, the messages clearly do not resonate in memorable ways.

Medical systems in any country are an expression of culture. Payer (1989), for example, reports that American doctors hold an aggressive “can do” approach to illness, a trait that correlates to the frontier spirit of America. As a result, American doctors perform more surgeries, prescribe higher doses of medicine, and run more diagnostic tests than do doctors from other developed countries, such as France, Germany or the United Kingdom. The way an illness or disability is diagnosed, the treatments that are offered for it, the length of treatment regimes, and how health problems are discussed are all expressions of cultural systems of medicine (Helman, 2007; Kleinman, 1978b).

In Lao PDR, culture and health are inextricably linked. Eckermann (2006) suggests that health and illness in modern Lao PDR are influenced by Buddhist and animist beliefs as well as Western practices. Like everywhere in the world, Lao PDR is melding old beliefs with new knowledge, a process that is in continuous flux as communities witness and talk about emerging healing practices. Traditionally, Buddhist and animist beliefs have offered Lao villagers a theory of life that answered difficult questions about mortality, merit, suffering and love, while other traditional practices identified the primary force in life as the soul in the body (Evans, 2002b). The coexistence of entrenched cultural knowledge

alongside Western-style medicine is creating new ways of understanding illness and disability in Lao PDR.

Cultural Apprehension Toward Western Medicine

Low utilization of public health care in Southeast Asia is frequently attributed to cultural apprehension toward Western medicine (Holtz, 2008; Jacobsen, 2008; Skolnik, 2008). Eckermann (2006) cautions about the tendency to uncritically overstate the significance of the “culture boundedness” of health and illness, a propensity that diverts attention away from real and perceived barriers to health care utilization. Anecdotal data collected by High (2007) supports these observations. From her conversations with Lao villagers, High (2007) asked about their willingness to utilize public health care such as hospitals. She reports that none of the villagers expressed what might be called a cultural aversion to public health care. Nonaka et al. (2009) further reports that public and traditional healing practices are not dichotomized practices in Lao PDR and that Lao villagers recognize and value public health care.

Eckermann (2006) also examined public health care centre utilization in Lao PDR and found that barriers such as rough terrain and distance do not fully explain poor utilization of birthing facilities. Eckermann (2006) reports that even villagers who live near to prenatal or birthing facilities demonstrate low utilization rates. In this study women reported that they were apprehensive about using prenatal or birthing facilities because they held fatalistic views about pregnancy and childbirth, they could not leave their fields

for more than a day to give birth, they lacked confidence in the services offered at such centres, and they disapproved of the unwillingness of health centre staff to recognize traditional birthing practices, some of which are considered essential to good outcomes for both the newborn and the mother. While these findings indicate that villagers might be apprehensive about using public health care facilities, the apprehension stems from many compounding influences that are pragmatic and cultural.

Gender and Health

Gender is an important consideration for planning and strengthening health care systems because of the responsibility women hold for family health care and reproduction (Thome, 2009). In Lao PDR, the role of gender is difficult to discuss in absolute terms due to the ethnic diversity of the country. The discussion below offers a summary of gender issues in Lao PDR that reflect a large percentage of the population, including ethnic Lao people, and many other ethnic minority groups. However, diversity exists within the country.

Lao PDR is primarily a matriarchal society. Traditionally, the youngest daughter will inherit her parents' land and house—a custom that recognizes the role of a woman as the caregiver for her mother and father—and will be responsible for managing the funeral ritual upon their death (SIGI, 2010). Upon marriage, a man will normally move to his wife's village, a custom that keeps a woman within the protection of her family.

A review of the land titling process in Lao PDR, since it was implemented in the 1990s, reveals that women's traditional rights as landowners might be changing or compromised due to legalized land titling. The review found that even though men had inherited land only 18% of the time, they were named as the owner of the land 58% of the time. Women were only named as the owner of land 16% of the time, and as co-owners 7%, even though they inherited land 30% of the time. In response to this, the Lao Women's Union has organized seminars to educate women about land allocation in Lao PDR, and the rights of women in the process (UN, 2003).

More than 50% of Lao women are economically productive, in both the formal and informal sector. Women are represented in government positions and they have legal rights to own property, obtain loans and have protection against violence and discrimination. With regards to children, men and women have equal authority (SIGI, 2010). Despite significant legal protection, however, Lao women are still more likely to be poorer than men, their education levels are lower, and domestic violence against women is reported to be common (SIGI, 2010).

Lao women are expected to marry, and many of them marry very young. In 1990, the Family Law set the age of marriage at 18 years, but allows for the age to be lowered to 15 years (SIGI). Seventy-four percent of women between the ages of 15 and 49 years are married (Boupha, 2007). The fertility rate in Lao PDR is 4.07 children per woman, although women with no education have fertility rates 2.5 times higher than those of

women who have completed secondary school. Ten percent of women give birth before the age of 15, and 37% give birth before they are 18 years old (Boupha, 2007).

Mortality rates for women and children are often a good measure of the health status of women. Due to unreliable or unavailable data, the Lao Reproductive Survey (Boupha, 2007) used indirect methods to estimate mortality rates for women and children. The infant mortality rate in Lao PDR is estimated at 63 deaths per 1,000 live births, while the mortality rate for children between 1 and 4 years is 25 deaths per 1,000 children. The total under-five mortality rate is 88 deaths per 1,000 live births. Compared to urban areas, the infant mortality rate in rural areas is twice as high for populations who live near a road, and three times higher for populations who have no road access. In all of Lao PDR, three out of ten births receive antenatal care, and 84% of births occur at home. Again, these numbers vary significantly depending on location. Women in urban areas, for example, are five times more likely to deliver their babies at a health facility than are women from rural areas. UNICEF (2010b) also reports on key health indicators for women. In this report, the adjusted maternal mortality rate is estimated at 660 deaths per 100,000 live births. These health indicators for women and children indicate that much work remains to be done if the MDGs for child and maternal health are to be met¹².

¹² The MDG goal for child mortality is to reduce the rate from 106 deaths per 1,000 children in 1999 to 55 deaths per 1,000 children in 2015. The MDG goal for maternal mortality in Lao PDR is to reduce the rate from 530 deaths per 100,000 live births in 2000 to 185 deaths per 100,000 live births. The latter figure has increased since 2000 due to the current high rate of population growth and the large number of young women of childbearing age (UNICEF, 2010).

While access to health care has important implications for women's health, culture and education also influence the types of health care women seek and for what purposes.

Women who have higher levels of education have fewer pregnancies, they are healthier, and they are better able to contribute economically to their family and reduce family levels of poverty (Ki-moon, 2010). A girl who is educated for at least six years is more likely to seek prenatal and postnatal care for her pregnancies, and her children are more likely to survive. Girls who are educated have higher self-esteem, they are less likely to contract HIV infection, and they are less likely to become sexually exploited. Educated girls are more likely to send their own children to school and spread good health practices to their families and communities (UNICEF, 2010b). Despite knowledge about the importance of women in the development process, women and girls in poor nations receive less education and they have poorer health indicators than men (Ki-moon, 2010).

Women experience many unique barriers to health care. Many traditional societies, for example, do not have a cultural niche that momentarily releases women from their gender identity for medical purposes (Eckermann, 2006; Seymour, 1997; Verma, 2001). Long-established cultural expectations for women in many traditional societies forbid women from interacting with men who are not related to them (Ireson-Doolittle, 2004; Ireson, 1996). Moreover, "intimate" doctor-patient interactions require women to behave in ways that are culturally impossible. The fact that many traditional societies have fewer educated women makes transcending gender issues in health care access by educating more women as health care workers a difficult endeavour.

In Lao PDR, Eckermann and Deodato (2006; , 2008) describe their attempts to overcome cultural barriers to increase utilization of maternity waiting homes in poor districts. To increase the cultural and social appeal of maternity waiting homes, Eckerman and Deodato (2006, 2008) aligned their program with important cultural practices and social skills, such as nutrition and baby care education, contraceptive advice, micro-credit scheme information and handicraft training. To reach these goals, traditional diet restrictions were permitted, sterilized bamboo was used to cut umbilical cords, and women were encouraged to give birth in the traditional position. Attempts were also made to transform cultural practices that were deemed “unsafe” to safer alternatives¹³ (Eckermann, 2008).

Disability in Poor Nations

Developing nations, which have the fewest resources, are home to the majority of disabled individuals. Poverty, malnutrition, prenatal and congenital deficiencies, disease and war are major factors that cause high numbers of disabilities in developing countries. Three out of four people who are disabled live in a developing country where resources to help them are limited or non-existent (Japan, 2002). The World Bank estimates that approximately one in five people in poor nations live with a disabling condition and that half of these disabilities are a direct consequence of poverty (Hartin, 2006). The very

¹³ In this case, the cultural practice of “smoking” baby, whereby the baby rests near a smoking fire, was replaced with heat. In Lao PDR, mothers believe that smoke from a fire will keep evil spirits away from the baby. The authors of this study report that the suggested replacement of smoke with heat was not well accepted by Lao mothers.

limited data available suggest that people who are disabled face increased barriers to health care utilization due to problems with mobility, families who must prioritize health spending to contributing family members, and health systems that are discriminatory to disabled people (Buchner, 1998; Hartin, 2006). The limited data suggest that the situation of disabled people who live in the world's poorest nations is very poorly understood and the health needs of this large population of people are not well incorporated into health care promotion and reform.

Data from this project reveal high levels of disability and chronic illness within the villages sampled. In Phatang village, for example, 15% of households were caring for at least one family member who had a disability or a long-term health problem. Some of these households had as many as three disabled family members. Nearly all of these households were simply living with the problem, as most had long since given up looking for a cure or even relief from the problem. High rates of disability and long-term illness result in poor economic growth in communities, due to large segments of the population who are economically under-productive or unproductive. Disability or long-term illness also results in families who are vulnerable to increased poverty. The connection between long-term illness or disability and poverty is evident in Lao PDR. The quality of life and social consequences of high rates of illness and disability within populations are also apparent, although harder to demonstrate.

THE COST OF HEALTH CARE

This section examines literature related to the cost of health care in poor countries from a global perspective. It reports on important issues that impact how much health care costs in poor countries, who pays for it, and how these costs are administrated. The global perspective presented in this chapter contextualizes data collected in this study.

Global Funding of Health Care

Throughout the world, Western medicine has a major impact on the types of illness that are identified as important, how they are funded, and what is done about them. People who are poor carry a disproportionate amount of the world's burden of disease, yet only 10% (WHO, 2006a) of global health research is devoted to discovering or improving treatments for diseases that primarily affect the poorest people in the world (Bhargave, 2006). Ninety percent of global health research and development seeks cures for 10% of the world's burden of disease, most of which are diseases common to high-income countries, where people are able to pay higher prices for drugs. People with little or no purchasing power rank low on the scale of priority for new drug development or innovative ways to distribute cheaper drugs to impoverished places (MSF, 2001).

A major multinational effort to combat HIV/AIDS, malaria and tuberculosis has resulted in significantly improved capacity and success at treating these three diseases. These

efforts have also, however, caused other diseases, most notably non-communicable diseases, to fall off the radar of global concern (Khun, 2008; Levine, 2007). In poor nations, non-communicable diseases account for similar levels of burden of disease as HIV/AIDS and malaria combined. The large amounts of money allocated to HIV/AIDS, malaria and TB have significantly reduced public funding for research and distribution of cures for non-communicable diseases, some of which are comorbid diseases to HIV/AIDS and tuberculosis (Khun, 2007). Throughout the developing world, including Lao PDR, the top seven neglected non-communicable diseases, including roundworm, whipworm and hookworm, account for high levels of mortality and morbidity, but are still endemic diseases. For just US\$0.50 per person per year, the top seven non-communicable diseases could be treated or prevented, resulting in massively reduced morbidity and mortality amongst the world's poor. This figure is juxtaposed to the estimated US\$200 spent per person per year on HIV/AIDS treatment alone (Helman, 2007).

In Lao PDR, half of all the donated funds for health care are earmarked for malaria, tuberculosis and HIV/AIDS projects, while the other half are thinly distributed among many other, and mostly very small, health projects (Barennes, 2009). The 2010 UNDP report on progress in Lao PDR toward the Millennium Development Goals reports that HIV/AIDS remains low in Lao PDR (0.1%), but the risk of an increased rate of infection is high due to high prevalence rates in neighbouring countries; the large number of Lao people who work or transit through these countries; and the low levels of education about the disease amongst the Lao population. The incidence of TB and malaria are high in Lao

PDR, and drug-resistant strains of both diseases are present. The report also notes that non-communicable diseases are a challenge in Lao PDR (UNDP, 2010).

The worldwide focus on malaria, tuberculosis and HIV/AIDS is grounded in data that detail high rates of morbidity and mortality that occur as a result of just these three diseases. HIV/AIDS, TB and malaria are highly contagious diseases that have reached pandemic levels in some places (Bhargave, 2006; Chen, 2004; De Wall, 2004; Holtz, 2008; Store, 2004). While complicated and expensive to treat once a person is infected, these diseases are easily prevented through education and protective measures such as bed nets and condoms (WHO, 2005b). The global agenda to fight the big three diseases, and the significant amount of money funnelled to them, are the result of political and cultural forces that garnered support from large-scale institutions through convincing data and public appeals about the global health threat posed by these diseases. There is a great fear in Western nations that health pandemics in Africa or Asia could become pandemics elsewhere in the world.

Many health advocates argue that the focus on communicable diseases has created a crisis, and even backward spiralling, in the treatment of non-communicable diseases, due to lack of funding and international focus (Helman, 2007; Khun, 2008; Levine, 2007). In Lao PDR, for example, immunization rates have decreased in recent years (Maekawa, 2007). Between 2000 and 2004, immunization rates for measles, mumps and rubella (MMR) decreased from 69% to 60%, and immunization rates for diphtheria, pertussis, and tetanus

(DPT3) decreased from 53% to 45%. During this same period, immunization coverage for polio (OPV4) decreased from 57% to 45%. Maekawa et al. (2007) reports that reduced immunization coverage in Lao PDR is linked to reduced or cancelled funding for vertical immunization programs from international organizations (Maekawa, 2007).

User Fees

User fees for public health care were introduced in many low-income countries in the 1980s and 1990s as part of government plans for economic restructuring (Meessen, 2006; Patcharanarumol, 2009; Segall, 2002). User fees charged to poor people who use public health care are rationalized through arguments that point out that public health care systems require financing and that many people, even poor people, are willing and able to pay at least small amounts of money for health services (Barber, 2004; Gilson, 2005). Funds raised from user fees can improve the quality of service at health centres, increase incomes for health centre staff, and add value to health services (Paphassarang, 2002). The World Bank (Meessen, 2006) concludes that user fees are necessary for impoverished health systems in poor countries where there are limited funding alternatives.

In most countries, user fees are required up front at the point of service (Lagarde, 2008). The 2000 World Health Report (WHR)¹⁴, however, calls for a high degree of separation between paying for and utilizing public health care. User fees collected at the point of service in direct exchange for urgent medical help are thought to cause insurmountable barriers to health care utilization for poor people. The 2000 WHR precipitated discussions about the need to create universal health coverage schemes for poor people who do not have savings on hand to pay for medical emergencies when they arise. McIntyre (2010) anticipates that universal health coverage will be a focus in the upcoming 2010 WHR.

Many reports indicate that even when small user fees are introduced, utilization of health services by poor people dramatically decreases, indicating that user fees create major barriers to health care utilization and create inequities in health systems (Gilson, 2005; Khun, 2008; Soeters, 2003). In Kenya, for example, the uptake of worm prevention treatments decreased from 75% to 19% after user fees were introduced. Other studies show that the sharp decrease in health care utilization after the introduction of user fees is followed by a subsequent growth in service utilization, even by poor people, if the quality of care improves alongside the introduction of the fees (Gilson, 2005; Jacobs, 2004). In Cambodia, Jacobs et al. (2007b) found that when user fees were introduced at public health care facilities, poor people switched to more expensive private health providers, but

¹⁴ <http://www.who.int/whr/2000/en/>

then switched back again when they learned that health care services and facilities had improved as a result of the user fees.

Upfront user fees are problematic for people who do not have savings or the time to sell land, livestock or personal items during an emergency (Khun, 2008). Upfront user fees also force people to access health services from private providers who sometimes offer more sympathetic financing options (pay later, pay in kind), but who may also charge higher fees.

Whether to remove user fees from health services in poor countries, especially at the primary care level is a heated debate. Gilson (2005) refers to user fees at the level of primary care as a regressive form of health financing that causes inappropriate self-treatment and partial drug use and creates barriers to early diagnosis and treatment of health problem, leading to higher rates of mortality and morbidity (Khun, 2008; Paphassarang, 2002). However, countries that have removed user fees from primary level care at public health care facilities, such as Kenya and Uganda, have experienced dramatic increases in health care utilization, followed by reduced quality of service, shortage of drugs and overwhelmed staff (Meessen, 2006). In Uganda, the removal of user fees resulted in a 74% increase of workload for health facility staff who also lost personal wages that were generated by the fees. In Sierra Leone, where user fees were removed in 2010 for pregnant women, new mothers and children under five years, crowds of women and children overwhelmed health facilities. While many people in the crowd

were sick, many others came because they thought that the free health services might be short-lived, and they wanted a chance to have their children checked by a doctor. Within a few overwhelming hours, health facilities in Sierra Leone had run out of drugs and filled every hospital bed (Merlin, 2011).

In many countries, user fees are entrenched in health systems and are not easily removed. Removal of user fees requires a comprehensive plan for how health systems will manage an increased demand for health services, maintain an adequate supply of essential drugs, sustain or improve the quality services, and pay living wages to staff (Khun, 2008; Lagarde, 2008; Soeters, 2003).

McIntyre (2010) suggests that an excessive focus on the need to abolish user fees distracts attention from necessary system-wide reforms. What are required are holistic approaches to health care staffing, leadership, information dissemination, and supplies of drugs. For example, South Africa, Uganda, Senegal, Burundi and Zambia all abolished user fees for primary health services but the focus on removing the user fees neglected to identify system-wide solutions to create other forms of financing and service delivery (Meessen, 2006). While abolishing user fees from health services for poor people resonates well with a rights-based perspective on equality, health systems cannot run without financing. A health system that is “free,” but too impoverished to provide good quality service does not satisfy the basic rights of all people to a healthy life. Meessen (2006) further points out that removal of user fees does not create “free” health services because patients must

still absorb indirect costs such as transportation, food, and lost income. In many cases, poor people cannot afford so-called free public health care due to other indirect costs associated with accessing such health services.

Exemption from User Fees

A common strategy used to try to protect the poorest people from user fees is to develop schemes that exempt them from paying user fees. Under ideal circumstances, exemption programs identify the poorest of the poor, for whom user fees might be a true barrier to public health care uptake. These people are given a special exemption status that entitles them to free health services from public health care facilities.

Many reports identify that exemption programs are generally ineffective (Barber, 2004; Blas, 2002; Jacobs, 2007b; Khun, 2007; Lagarde, 2008; Patcharanarumol, 2009).

Problems with exemption programs are both administrative and social. A major problem with exemption programs is that they often result in lost revenue for health facilities and the staff who work in them (Blas, 2002). In many impoverished countries, user fees supplement poor wages for health facility staff. For this reason, exemption programs create stigma and an unwelcome atmosphere for poor people who require services but do not increase revenues for the staff or the facility. Exemption programs are further criticized for problems related to identifying who is poor enough to be exempt and then ensuring that these people are actually exempted at the point of service (Soeters, 2003).

Exemption programs often struggle to identify criteria for who is poor enough to be exempt from user fees. In countries where financial records do not exist, other means to identify a family's inability to pay for health services are required. Some programs have attempted to define poor by quality of house or family assets (livestock or land). Meessen (2006) reports that such criteria often result in too narrow an identification protocol and also create barriers to families who are not identified as poor enough. This is especially so when a health problem becomes complex and requires hospitalization or intensive care. Other programs have asked communities themselves to take responsibility for identifying their poorest members, a strategy that creates multiple localized definitions of poor and creates huge inequalities between communities (Bouapao, 2005).

Another administrative problem with exemption programs has to do with ensuring that people who are identified as poor actually receive the exemption when they arrive at a health facility. Khun's (2008) study of user fees in Cambodia reports that exemptions were often granted arbitrarily, based on sympathy and knowledge of specific circumstances, but that monks, students, village health volunteers and other village leaders who did not meet exemption criteria for "poor" were also exempted from user fees. Similar findings are reported by Paphassarang (2002), who reports that government and health facility staff in Lao PDR were exempted from health service fees while poor people were required to pay for health services. In Paphassarang's (2002) study, not one exemption was granted to 30 people who entered public hospitals and were eligible for

exemption. The problem is compounded by poor people who are often unaware of their right to health care exemption or of their right to request it when they enter a health facility (Jacobs, 2007b). Health system exemption policies, which are often donor-led, are often not well communicated to the poor people who are the intended beneficiaries of the policy.

In Lao PDR, Patcharanarumol (2009) reports on a disturbing inverse relationship between exemption programs and the people they are intended to protect. In Lao PDR, the poorest people, many of whom are ethnic minorities, report paying the highest admission cost to public hospitals (US\$266.40/admission). These people were also more likely than people who were better off to experience a catastrophic illness episode. Patcharanarumol's (2009) study is supported by other studies conducted elsewhere. Khun (2007) reports that poor households in Africa pay more for health services, are more likely to become further impoverished because of an illness episode, and have higher rates of morbidity and mortality as a result. Van Damme (2004) reports similar observations from Cambodia, where the poorest people pay the highest fees and are charged more to borrow money to pay for health care.

Unofficial User Fees

In many developing countries, official user fees are juxtaposed to “unofficial fees” that health workers charge for services rendered. In Lao PDR, civil servants in all sectors

regularly charge unofficial fees to supplement low salaries. While the charging of unofficial fees for public services in Lao PDR contributes to a very poor country rating by Transparency International, according to the 2009 Corruption Perception Index (158/180), a more sympathetic view of unofficial fees is possible. In Lao PDR, official government salaries for health workers are so low that health care staff must seek other means to increase their income and sustain themselves. In Cambodia, where government wages are similarly low, Soeters (2003) found that health workers considered government wages so unfair that they were completely unwilling to engage in discussions about work ethics, motivation and providing good quality service in the absence of an agreement to increase their official wages.

However, unofficial fees in Lao PDR are sometimes extraordinarily high and clearly much higher than required to boost health workers' wages to a living wage. In Cambodia, Soeters (2003) describes unofficial user fees charged by government health workers as a ruthless drive to profit regardless of consequences to patients. Soeters (2003) further describes health workers who recklessly pursue income-generating activities to the detriment of public health care.

Public Health Care Workers in Private Practice

Another strategy used by public health care workers to supplement poor salaries is to establish private practices, where fees for services are legitimately charged. Soeters

(2003) refers to public health care workers who double as private practitioners as a counterproductive “fuzzy monopoly” where both the private and the public health care sector are dominated by the same people. Any benefits that might arise from a truly competitive environment are negated when the competition is running against itself, and especially when temptations exist to funnel people into the more profitable sector. (Khun, 2007).

Khun (2007) points out that systems supporting the same workers in both the public and private sector indicate that the problem of delivering health services to poor populations has to do with the capacity of the system, not the training of health care staff. Khun’s observation offers an interesting perspective on current health system reform policies that prioritize improved training of health care staff as a key strategy to increase health care utilization in poor places.

Data indicate that private health care utilization is very high in many developing countries. High utilization rates of private health services are reported regardless of level of poverty or geographical location (Barennes, 2009; Delang, 2007; Patcharanarumol, 2009; Soeters, 2003; Syhakhang, 2004). Paphassarang (2002) reports that poor people choose private health care providers because these providers are more flexible, they offer partial or reduced services and fees, and they sometimes offer credit or the option of paying in kind. Khun (2007) also reports that people in Cambodia use private health providers, and especially providers who will come to their home, even when the cost is

higher because of geographical proximity, perceived and experienced higher quality of care, familiarity, and lack of knowledge about services offered at public health care centres. Van Damme (2004) further reports that private practice health care in poor places is also driven by the principles of maximum profit. In Cambodia, Van Damme (2004) ascertained that private health providers who operated businesses in remote areas with little or no access to public health care facilities charged more for their services than did private practitioners who operated close to public health care facilities, and who therefore had competition. Van Damme's findings offer a disturbing observation that the poorest people who have the least access to public health care might pay higher prices for private health services.

Catastrophic Health Costs

The cost of health care can be a catastrophic event for poor families and might result in early diagnosis or preventative treatments being traded off for other immediate family priorities such as food, shelter or schooling (Harving, 2007; Keman, 2004; Khun, 2008; McIntyre, 2010; Van Damme, 2004). For some families, a catastrophic event can be a matter of a few dollars (Noihomme, 2007; Patcharanarumol, 2009; Soeters, 2003). A study on dengue fever in Cambodia conducted in 2003-2004 reports that villagers spent on average US\$49.25 and up to US\$150.00 on a single episode of dengue fever, including direct and indirect costs (transportation, etc.). These reported costs did not include indirect loss of income. In rural Cambodia, where the average monthly income is

US\$13.50, these reported costs are catastrophic. Similarly, in Lao PDR, Patcharanarumol (2009) reports that one family tried seven different treatment options for a ruptured appendix. This family reports paying US\$463.50 for all seven treatments combined, a cost that was 354% of their monthly income.

The ability of a family to recover from catastrophic health care costs is dependent on the amount of assets (livestock, land) a family has, savings held by the family, and the adults-to-dependents ratio in the family. Families who have more adults of working age than dependent members are more likely to be able to spare adults to accompany a sick family member to a health facility and then earn back lost income as a result of the costs incurred (Patcharanarumol, 2009).

For many poor families, main sources of health care financing include loans, sale of property or assets, selling labor, and delaying treatment (Khun, 2008; Patcharanarumol, 2009; Soeters, 2003). The catastrophic long-term consequences of financing health care are well documented (Khun, 2008; McIntyre, 2002; Patcharanarumol, 2009; Soeters, 2003; Van Damme, 2004). Families who sell their land or livestock, or borrow money to pay for health care, are often plunged deeper into poverty and become vulnerable to higher levels of mortality or morbidity as a result. The chances that a family will not be able to respond to a second illness episode, or will delay treatment that might result in another catastrophic illness event, increase as families recede further into poverty. In Cambodia, Van Damme (2004) reports that 63% of households were in debt after hospital

admission and that after one year only 10% of households had paid back their loans. Sometimes these loans were serviced by astonishingly high monthly interest rates of between two and a half and fifteen percent.

SUMMARY

The challenges to improved provision and utilization of health services in Lao PDR are complex and poorly understood. Reliable data from Lao PDR are lacking, and many areas of Lao PDR are too remote for data to be collected, given the current infrastructure of the country. In one study, for example, official statistics reported 24 births in nine villages, but researchers who conducted door-to-door interviews in the area found 120 infants born during the same period in just seven of those villages (Eckermann, 2008). Clearly, not enough is known about the lived reality of health, illness and disability in Lao PDR, and particularly in rural areas.

The data presented in the following chapters of this thesis offer a village-level look at health care issues in one rural area of Lao PDR. The topics covered in this literature review contextualize the data collected in this study, and presented in this thesis. When villagers narrated their illness and disability experiences for this study, they talked broadly about three issues. First, they talked about how their poverty influences how they seek health care, where they seek health care, and at what stage during an illness episode they seek health care. Second, their narratives were coloured by their culture and how culture

shapes their experience of illness and disability. Third, their narratives were surrounded by a sense of bewilderment, as if the process of recovering from an illness episode were incomprehensible, especially if the treatments were sought from Western-style public health care facilities.

A review of the literature surrounding the three issues identified indicates that poor Lao villagers are not alone in their quest to find health in a complicated system. Regional data collected for this review, along with data from other poor nations, indicate that poverty, culture and bewilderment are common themes in the struggle to establish and operate Western-style health systems in poor places around the globe. What is less clear, however, is how these broad themes manifest at the village level and how local solutions might be discovered.

This literature review grounds the study to follow. By piecing together what is already reported, a base for what is yet to be learned is created. The chapters to follow are the beginning of new learning about the lived experience of illness and disability in a village context in rural Lao PDR.

CHAPTER THREE: METHOD

The chapter begins with a discussion of ethnographic method. An understanding of recent changes as to how ethnography is carried out and how this fits with the history of ethnographic methodology creates the groundwork for how ethnographic method was utilized in this study. Current dogma on the theoretical and practical application of ethnography in the field is also discussed. The chapter then moves to a narrative description of how this project emerged, the process of starting the project, and changes that were made along the way. These sections tell the story of how I moved to Phatang village, with my children and an interpreter, and collected illness and disability narratives from poor villagers. Through this story, the ethnographic methods used to guide the project, as well as how data were collected and then subjected to multiple comprehensive data analysis strategies are discussed. Ethics related to the project are discussed as a crosscutting theme throughout the chapter, and then elaborated on fully near its end. The chapter also includes a discussion about the limitations of the study.

ETHNOGRAPHIC METHOD

Current ethnography traces its roots to the early twentieth century when Polish-born Bronislaw Malinowski spent four years living amongst the people of the Trobriand

Islands, New Guinea¹⁵(Malinowski, 1984(1922)). Malinowski was the first to articulate a methodology for ethnographic fieldwork, and in particular, participant observations (Hammerlsey, 1999). Malinowski went on to influence many students who followed his path and carried on the tradition he set for ethnographic practice (Kaberry, 2002).

Background of Ethnographic Practice

Ethnography began as a research method used by anthropologists to document shared beliefs, folk knowledge, behaviours, practices and artifacts of a group of people (Goetz, 1984; Gubrium, 1999). The result of an ethnographic project is a description of a cultural scene (Spradley, 1972). Early ethnography nearly always studied indigenous or native people. An important aspect of early ethnography was the study of kinship and how this produced culture. From its beginnings to the present day, fieldwork has been an important component of ethnography. For early ethnographers, fieldwork usually involved travelling to distant and usually non-Western locations to study cultures that were unknown to the Western world. Fieldwork was nearly always a long-term endeavour, with anthropologists spending at least one year, and often more, collecting data in the field. Participant observations were and continue to be a key activity that ethnographers engage in while they are in the field. Participant observation is the process of living closely with a group of people in their natural environment so as to gain

¹⁵ Earlier forms of ethnography can be traced to the early 1800s, but it was Malinowski who first articulated a methodology. Malinowski is known as the father of ethnography (Kaberry, 2002).

familiarity with their cultural ways-of-being. Interviews and surveys are other tools frequently used by ethnographers to collect data in the field (Atkinson, 2007; Denzin, 1997; Denzin, 2005; Hammersley, 1995; Marshall, 2006; Shaffir, 1999; Spradley, 1979, , 1972).

Questioning Early Ethnographic Practice

Starting in the 1960s, ethnography came into question. Critics blamed ethnographic practice for helping to create the “native” and extending Western influence and power. Ethnographic accounts were denounced for producing so-called objective reports of “other” dark-skinned people that dichotomized the human experience as justifiably imbalanced. Ethnography became a synonym for colonial power and truth that fuelled racist strategies to control uncivilized and deviant natives (Christians, 2007; Geertz, 1963, , 1973).

In 1973 Clifford Geertz published his seminal book, *The Interpretation of Culture*, in which he argues that the search for an all-encompassing definition of culture is misleading (Geertz, 1973). For Geertz, culture is a web of significance in which humans are suspended amidst symbols that give meaning to their lives. The question that punctuates the essence of culture, according to Geertz, is not what people *do* but what they *mean*. Geertz questioned the method of ethnographic practice that claimed to accurately and meaningfully represent others. He was the first in a line of other critics

who would note that ethnographers could never be passive and objective observers who record absolute truths about others. He further began the discussion, which continues to this day, that ethnographic reality is disturbingly indistinguishable from the written version of it (Clifford, 1986c; Manson, 1997; Marshall, 2006). Geertz further developed the notion of “thick descriptions,” which is the practice of explaining with thick detail the subtleties of human behaviour.

Geertz’s writing about ethnographic method reflected other seminal works in philosophy that were also emerging at that time. In the 1960s Jacques Derrida developed his strategy of deconstruction that centred on text as an unequivocal mode of interpretation (Turner, 1989). Derrida also challenged the Western tendency to interpret phenomena through binary oppositions such as true/false, civilized/uncivilized, and so on. Derrida’s deconstruction challenged notions that ethnographers could enter the field and emerge with transcendental truth and objectivity (Silverman, 1989). After deconstruction, ethnographers lost the privilege to tell the “truth” or make unequivocal claims about others (Gergen, 1999). To the field of ethnography, Derrida’s work posed serious questions that would in time reshape ethnographic practice. Questions such as, “What is truth and whose truth is true?” and “What is civilized and who says so?” became tough questions that ethnographers would need to reconcile.

Derrida’s work on speech and writing was also important to the practice of ethnography. Derrida looked at seminal thinkers such as Plato, Rousseau, and Levi-Strauss and

deduced that all thinking ultimately reduces to written texts, which are celebrated as if they *are* speech (Derrida, 1997, , 2001). From this, ethnographers learned that writing could never be a pure conduit of meaning because meaning is never entirely captured by the written word. Text that claimed to capture others, with the intent that readers could know the truth, were revealed as always partial interpretations (Clifford, 1986a, , 1986b, , 1986c).

In the 1960s, Michel Foucault also emerged as a decisive thinker whose work influenced ethnography. Foucault was interested in systems of discourses that create knowledge. According to Foucault, discourse controls what can be spoken about, where and how it can be spoken, and who may speak it (Rainbow, 1984). For Foucault, discourse is socially reflective, it stifles independent thought, and it is power creating (Gubrium, 2000, , 1989). From the perspective of ethnography, power operates through discourse. Ethnographers who venture into the field invariably recreate power discourses through processes that dismiss other discourse as irrelevant (Gergen, 1999; Gubrium, 1989). Foucault's system of discourse shed light on the ethnographic privilege to scrutinize others, a practice that ultimately only recreated power imbalances.

The Crisis of Representation

Between 1986 and 1990, ethnography experienced what has become known as a “crisis of representation” (Denzin, 2005). During this time the positivist, realist and romantic

qualities of twentieth-century ethnography came under fire. The book, *Writing Culture* (Clifford, 1986c) is widely acknowledged for precipitating the crisis of representation. In this book, ethnography was criticized for continuing a rhetoric of “savage” ethnography that attempted to textualize and simplify exotic cultures before they became lost forever. *Writing Culture* called for ethnography to free itself from the grip of unmediated meanings and scientific inquiry. It also heralded in a “new ethnography” that no longer claimed to represent truth, and acknowledged partiality as an overdue and necessary factor in the study of human diversity. *Writing Culture* also confronted authority in ethnographic texts by dispensing with discursive practices that spoke unequivocally about others, as if the author is positioned above and behind her subjects (Pratt, 1986). The impact of *Writing Culture* caused ethnographers everywhere to begin to question their ways of knowing.

The crisis of representation created a crisis of confidence in ethnography. During the first part of the twentieth century, ethnography claimed that it could record social phenomena with scientific rigor (Hammersley, 2000). Ethnographic realism assumed that data, if collected correctly, could represent reality and uncover hidden truths (Stroller, 1999). The crisis of representation called into question the ability of ethnography to represent anything at all. Ethnography became politically charged because of its collaboration with colonial power and creating marginalized “others” (Hillier, 2007). At the same time, researchers could no longer afford the time or the cost of staying in the field for years at a time to collect data (Hillier, 2007). Moreover, a pervasive pursuit for “scientific truth”

surfaced as a powerful world view that valued rigour, validity and reliability as essential to any knowledge claim. By the 1980s some believed that ethnography might vanish altogether (Stroller, 1999).

New Forms of Ethnography

What emerged from the crisis of representation, however, is a new form of ethnography. There was, and continues to be, a growing awareness that scientific method has great power to answer certain types of questions, but limited ability to bring coherence to complex social, economic and political problems. In an increasingly globalized world, there is a tremendous need to understand the lived experience of complex problems (Lincoln, 2007; Stroller, 1999). Ethnography, along with other qualitative research methods, has the potential to contribute significantly to unravelling the social context of multilayered, complex problems. The debate over the legitimacy of qualitative research methods, including ethnography, has abated (Culyba, 2004). Currently, there is an increasing receptiveness to all forms of qualitative inquiry across a widening field of disciplines. While ethnography is still a hallmark of anthropology, it is practised and widely taught across university campuses.

The new ethnographic practice recognizes that the discourses of ethnography can no longer claim to capture lived experiences (Denzin, 2005). The current-day ethnographer is recognized as a historically and biographically situated participant who is prejudiced by

her class, age, language, gender and cultural circumstances (Hammersley, 1995; Warren, 1988). The new ethnographer also recognizes the impossible task of rendering experience as text, and embraces the necessarily partial representation of human experience (Clifford, 1986c; Gubrium, 1999; Warren, 1988). Like other research practices that use words to describe, ethnography has had to reflect critically on how language creates meaning. In his analysis of interpretive inquiry, Max van Manen (2002) describes writing as always a solitary experience “[w]here language ironically seems to rob us of the ability to say anything worth saying or saying what we want to say” (p. 3). Van Manen further points out that “No interpretation is ever complete, no explication of meaning is ever final, [and] no insight is beyond challenge” (p. 7). More and more ethnographic inquiry is understood to *be* text and the ethnographer is called upon to hone her skills as a writer (Hammersley, 1995). One response to the text-as-representation quandary is a call for ethnographers to offer alternative forms of expression, such as poetry, drama, co-constructed and creative writing (Bochner, 2007; Denzin, 1997; Ellis, 2007b).

New forms of ethnography differ substantially from older genres of ethnographic practice. New ethnography is attentive to power and politics, and intends to move people to action. The ethnographer who entered the field simply to know is a bygone phenomenon replaced by an ethic that delineates the ethnographer as one who is behooved to collaborate with research because the topic resonates within her, and holds the potential to create a more equitable world (Hammersley, 2000; Hillier, 2007).

Ethnography has also branched into different subfields. Feminist ethnography, for example is concerned with the plight of oppressed people (Hayano, 2001; Stacey, 2001), while autoethnography turns the ethnographic gaze inward to record a story of self (Ellis, 2001, , 2007a, , 2007b, , 2008; Hayano, 2001). Medical ethnography is another subfield of ethnography, and is of particular interest to this study. Medical ethnography is concerned with the social, political and economically created human experience of suffering (Helman, 2007; Joralemon, 2006; Kleinman, 1995; Kleinman, 1978a, , 1980, , 1986, , 1988a, , 1991, , 1998, , 1985; Kleinman, 1997a; Kleinman, 1978b; Kleinman, 1988b, , 1988c; Young, 1982).

No matter the subfield, ethnography is always a process of representing the social world through narratives. Moreover, the crux of ethnography is often about telling credible and authentic stories (Fetterman, 2010). How we write these stories, however, determines what we represent (Davies, 2004). Denzin (1997) refers to “messy texts” that are committed to cultural criticism and reflectivity. Messy texts announce their political agenda and are aware of the realities they invoke. Moreover, messy texts, “...*fold the teller’s story into a multivoiced history*” (p. 224). Reflectivity and polyvocality are now important strategies that ethnographers employ when they “write up” their data.

Ethnographers always draw on their own experiences when they engage in data collection and the subsequent writing up of that data. These experiences necessarily become part of the ethnographic narrative. Barthes (1986) argues that we are always present in our texts and challenges us to write ourselves into our texts. Objectivity, according to Barthes, is

tantamount to pretending that there is no such thing as an author. Davies (2004) informs us that the ethnographer is both the *gazer* and the *gazed at* during the ethnographic process. We always gaze at ourselves to make sense of what seems incomprehensible. Ethnographers do not need to look harder to comprehend the field; rather, they need to reflect on what they see, and how their seeing is framed (Lather, 1993).

Who is this Ethnographer?

Recently, a debate has emerged in ethnography about who is qualified to conduct ethnography and where. Rising education levels have created an increasingly professional cadre of researchers who have the skills to conduct ethnographic inquiry within their own cultures. Indeed, even in North America, ethnographers are turning more and more to ethnographic questions that are closer to home. Ethnography remains tainted by the image of the all-knowing white ethnographer who set off to distant lands to record so-called truths about the backward people “over there.” Recently, “native” ethnographers,¹⁶ who are familiar with the culture and language of the group they study, were granted the status of “authentic” researchers. These researchers, it is argued, are qualified to offer a “true” representation of their culture (Smith, 2007). Accordingly to this principle, they have a better understanding of the group they represent and are the

¹⁶ “Native” ethnographers are any ethnographers who are closely aligned with the cultural group that they intend to study. For example, an Italian citizen who was born and raised in Italy, and could align with the language and culture of Italy, would be a “native” ethnographer if he or she conducted an ethnographic study with an Italian cultural group.

only people capable of appreciating the true character of their cultural group (Atkinson, 2007; Smith, 2007).

Smith (2007) refers to the notion of native ethnographers as essentialist and challenges the assumption that so-called “authentic” researchers are not outsiders. Cultures, if understood as complex phenomena, are characterized by a multilayered social system and guided by complex rules of engagement. Definitions of insiders and outsiders that are based solely on race have failed to reflect meaningfully on what encompasses culture. In their work as qualitative researchers in aboriginal communities, Hillier (2007) further challenges the native-as-better dictum for assuming that all aboriginal people are alike, and that cultural variation is non-existent in aboriginal communities. Likewise, the assumption that any representation of a cultural group created by an “insider” can truthfully represent that culture is a perilous supposition that moves dangerously close to simplistic interpretations of cultures that characterized earlier eras of ethnography.

Hammersley (1995) proposes that an inside view might not be a necessary condition for ethnographic research. Outsiders, he suggests, might be better placed to study novel settings due to their objectivity and emotional distance from the topic. As well, the empty slate that an outsider brings to the field might be better suited to absorb unexpected or challenging findings. Even language differences, which are always problematic for ethnographers who are not versed in the local language, are impossible to ignore if the

researcher must acquire a new language, and the subtleties that go along with it (Van Manen, 1990; Van Manen, 2002).

New Ethnography in the Field

Like the world in which ethnographers immerse themselves, ethnographic practice itself is often chaotic and unplanned (Fetterman, 2010). While every ethnographer enters the field with an agenda for what she hopes to accomplish, unforeseeable circumstances often require a sudden change in agenda. The current-day ethnographer must be adaptable to change, creative, willing to learn from adversity, and able to turn challenge into serendipitous opportunity. Hammersley (1995) further suggests that an ethnographer in unfamiliar settings must embrace her role as an “acceptable incompetent.” Listening, asking questions, watching, making blunders and formulating connections are all part of the process of appreciating how social structures operate. While ethnographers have certainly always had to adjust their plans according to unplanned contingencies that emerge during fieldwork, new ethnographic rhetoric embraces the evolving nature of ethnographic fieldwork as necessary and even welcome. Strict adherence to predetermined plans conjured outside of the field will not capture the essence of the questions sought if the plan becomes irrelevant or impossible to follow once the realities of the field are discovered. Ethnographers no longer need to pretend that they can anticipate everything about the field.

Operating in the field also requires that the ethnographer simultaneously balance her dual roles of researcher alongside village friend, guest and neighbour. Atkinson (2007) proposes that ethnographers endeavour to maintain a “marginal” position in the field. A marginal position allows the researcher to be a participant observer while also being wary about becoming over-immersed in the field. Often, managing relations in the field is difficult, as it requires an ethnographer to simultaneously live in two worlds that have very different boundaries. This quandary is made further problematic by a new research paradigm that demands ethical integrity from all researchers. Ethnographers can hardly expect honesty and frankness from participants if they themselves are not honest and frank about their place in the field.

Global realities have also changed how ethnographers conduct fieldwork. Ethnographic fieldwork is now often necessarily shorter than earlier forms of ethnographic inquiry. To begin, funders are unlikely to pay for multiple years of fieldwork. Moreover, current-day questions asked by ethnographers are often based on pressing social problems that require innovative solutions in the near term. The world cannot wait years to discover how to manage homelessness, poverty and violence, for example, in an increasingly globalized world. In this same globalized world, researchers are unlikely to have the flexibility to remain in the field for extended periods of time. The new politically, economically and socially focused ethnographic practice that intends to inform policy and reduce inequalities understands that the turnaround from ethnographic data collection to shared

knowledge must occur in a time frame during which the data will remain relevant and useful.

Using Ethnographic Method to Research Illness and Disability in Rural Lao PDR

This project was guided by and embraced new forms of ethnographic pedagogy. Data were collected largely from participant observations along with other ethnographic data collection tools, including interviews, discussion groups and observations. Altogether, I spent nine months in Lao PDR, and six of those months were spent living in the field. Data collection was messy, sometimes unplanned, and more than once I had to quickly adjust my research agenda because something occurred that changed everything. The experience touched me in ways I could never have anticipated.

The story that emerged from the data collected in Lao PDR, and laid out on the pages of this thesis, is necessarily partial. Within it, I include a multilayered text, but the story, admittedly, is mostly my story. All of the stories were filtered through my eyes, and they came to rest on this paper through my hand. I struggled to reduce lived experience to text, and in this process I engaged in multiple reflective processes. As a result, much of this thesis is written in the first person. I am indeed a storyteller.

But the story that I tell is important. It results from a long and rigorous process of data analysis and data reduction. Careful attention was paid to integrity, honesty and ethics.

At every step, I was mindful that my story is also a story that belongs to villagers. I tell my story so that their story can be heard. In every way, I have tried to honour my informants' rich and complex lives as I wove them into this text. I tell this story because I think and hope it has political potential. It is a story that imagines and advocates change.

I approached this topic as an outsider, and more often than I want to admit, I fittingly embraced Hammersley's (1995) role as an "acceptable incompetent." I used to say that I was like a bull in a china shop when I lived in Phatang village. The villagers helped me find my grace there. On mornings when all the women were required to go to the *wat* (temple) to offer alms to the monks, the village women would rouse me from my bed at what I thought was the crack of dawn, although they considered it the middle of the morning. They would patiently dress me, adjusting my scarf over my left shoulder, and hand me a silver bowl filled with rice, candies and other essentials. At the *wat*, they showed me how to sit, where to put my hands, when to bow, and how to line up and offer my alms. Afterward, with my legs tingling from sitting on my knees, we would return to the village, they happy to have shown me something that was important to them, and I happy just for the gift of being there.

The remainder of this chapter offers a detailed narrative of how the ethnographic method for this project evolved. Background information on how I found myself asking questions about illness and disability in a poor village in Lao PDR is offered. Data

collection methods and sites are discussed, along with the process that I engaged in to analyze the data. Ethics and the limitations of the study are also discussed. My ethnographic approach is highlighted throughout the discussion.

I chose to continue this chapter in narrative form because, as humans, we understand each other best when we share the stories of our lives. Ethnographic process always involves two tasks. First, the ethnographer collects data, and second, the ethnographer discovers ways to represent that data. Often this representation is in the form of text. The narrative that follows is my story about my first task of collecting the data. The chapters to follow are my representation of that data.

BEGINNING THE RESEARCH PROJECT

In 2005, I approached the Interdisciplinary Graduate Program at the University of Calgary because I wanted to continue interdisciplinary research related to illness and disability in low-income countries. This interest arose from my master's thesis, for which I conducted an ethnographic project that studied social and cultural interpretations of deafness in Swaziland. From this experience, I learned that disability is poorly understood in research, and that complex issues around how individuals, families and communities cope with and understand disability are often based on anecdotal data, or not reported at all in the academic literature. In Swaziland, for example, I learned that people who are deaf are cared for and valued by their families, they mostly marry hearing

spouses, they have children, and they participate in culturally important rituals that are necessary to gain personhood in Swazi society. These findings are in sharp contrast to other findings that identify disabled persons in developing countries as neglected and outcast from their families and communities.

My supervisory committee represents Community Rehabilitation and Disability studies, Health and International Development. Through my work with the Faculty of Medicine, I became involved with the Lao Human Resources for Community Health Program (LHRCHP). The LHRCHP is working to increase health capacity in Lao PDR by training medical students to work in rural areas. Students in this program are recruited from rural areas and sponsored through their medical training to prepare them to return to their homes and fill desperately needed rural health posts.

Motivation for this project derives from data that reports on poor utilization rates of public health care in Lao PDR juxtaposed to low health indicators, particularly in rural areas. The goal of the LHRCHP is to train doctors to work in rural Lao PDR, and it was indicated to me that village-level data on health seeking, illness and disability would help the program achieve these goals. From the outset, the goal of this project was to collect data that would identify reasons for poor health centre utilization and ways in which rural health centres might become more relevant to villagers. Ethnographic research method was identified as a research tool that could elicit narratives on the lived experience of

suffering, which could usefully inform future health care reform practice and policy in Lao PDR.

Investigating Lao PDR

In 2006, I travelled to Lao PDR in order to meet key stakeholders, identify a research site, gain permission, and finalize my research questions. Initially, my research questions for this project focused on understanding how mental health is understood in rural areas of Lao PDR. During this investigative trip, the focus was broadened to: *“When poor Lao villagers discover themselves to be ill or disabled, what types of treatments do they seek and why?”* This change in plan, which resulted from gaining a better appreciation of the project at hand, was the first to emerge. Others would follow.

During this trip, Phatang village was selected as the research site because it was close to a newly built village health centre that was due to accept students from the LHRCHP starting in January 2007. Also during this trip, I gained permission from the village leader to conduct this project and I also organized a house to rent. An interpreter, who agreed to accompany me to Phatang village between January and June 2007, was also identified and hired. As well, preliminary ethnographic data, in the form of interviews, were collected from non-governmental organizations (NGOs) working in the field of disability in Vientiane.

Phatang village is remote (located approximately three hours north of Vientiane) and near other villages where data could also be collected. From a practical point of view, the village was close to a paved road, and many of the houses in the village had electricity and a toilet, which was essential since I intended to bring two of my children with me to the village.

Arriving in Lao PDR

I returned to Lao PDR with my family in January 2007 to begin the research project. Together with my interpreter, we travelled to Phatang village. Once in the village, we purchased basic furniture along with a stove and a fridge. We also wired a few extra lights in our sleeping loft, created an area that would become my office, built shelves for clothing and books, laid plastic flooring on the lower level of the house, and connected a hose that would bring water to our house. The house was in excellent condition when we arrived. It was spotlessly clean and had clearly been prepared for our arrival.

The house that I rented was in the centre of the village, which made for wonderful immersion into village life. While I had lived in Africa several times previously, and once with a small child, I had never lived in the middle of a village. All of my other living arrangements were located on the outskirts of villages. In Swaziland, for example, I first lived at a school for deaf children with Swazi teachers. On the second occasion in Swaziland, we lived in a Catholic mission, in a classroom that we converted into a house,

which was close to surrounding poor villages. In Phatang village, however, in order to arrive at my house, it was necessary to turn off the main road and plunge into the heart of the village. Once off the main road, it was necessary to travel down the steep and muddy lane past the temple until nearly at the river's edge. On the right side in the centre of the village was my house.

Three weeks after we arrived in Lao PDR, my husband and my eldest child, who was 12 years old at the time, returned to Canada. It was at this moment that I learned how painful it is for a mother to part with her child. While we did come to love Phatang village, I never lost the sense that there was something partial about my existence there.

Research lines of inquiry for this project focused on perceptions of illness and disability in Lao PDR; the etiology of health problems; health-seeking behaviours; costs of treatment from public, private and traditional services, including indirect costs such as transportation; and perceptions about the efficacy of treatment. These lines of inquiry are closely related to the types of questions that derive from medical ethnographic practice, which is discussed in the literature review. Village maps that were drawn by villagers near the end of data collection, detailed field notes, and analysis of other relevant material supplemented the data. A thorough review of Lao national documents (e.g., census material), including a full examination of the library at the *École Française d'Extrême-*

Orient¹⁷ in Vientiane, was conducted. Due to high levels of suspicion and fear amongst villagers and other informants, interviews were not electronically recorded. This was another change in plan. I had originally planned to video record as many interactions as I could, and I had purchased a compact video camera for that purpose.¹⁸ Instead, handwritten field notes were recorded in a 2-inch by 3-inch logbook during interviews and other exchanges. These were expanded into lengthy illness and disability narratives or interview notes within hours of interactions.

A Time of Change

Our first few weeks in Phatang were a time of substantive change. This change challenged my ethnographic abilities to quickly rebound upon discovering that major changes had impacted the project. After we set up house, I was waiting for the intern students to arrive at the health centre as planned. When they did not arrive, I inquired after their whereabouts. I was informed that the government had decided that their skills

¹⁷ The École Française d'Extrême-Orient library holds the most comprehensive collection of Lao documents, books and manuscripts available, many of which are unavailable anywhere else. The collection includes documents written in English, French and Lao language.

¹⁸ Perhaps I should have anticipated this. In Swaziland, where I collected ethnographic data in 1995, I had similar problems with collecting video data, although for different reasons. There, my informants were enamoured with the video camera and would vie to be in front of it. For this reason, I was able to get some video data. In Lao PDR, my informants were intimidated by the video camera and did not want to say anything at all in front of it. Altogether I have about 15 minutes of video data related to this project. There is a whole subfield of ethnography called "video ethnography," which I studied at the University of British Columbia. While my attempts at video ethnography did not surface in Swaziland, I had hoped I would get better results in Lao PDR.

would be better utilized in another village called Namuang, located 28 kilometres away.

No one from the LHRCHP was aware of this change.

This change required major adjustment and, for a time, left me wondering whether I might still be able to continue the project at all. The interns were intended to be my connection to Phatang village. I imagined seeking answers to my research questions by following the interns around and learning from their experiences. I was also told that the student interns would have basic English language skills, and I was counting on them to ease my feelings of isolation in the village, where only my interpreter, my children, and I spoke English. Without the interns, my interpreter became my primary language connection to the village, especially in the early stages of the project.

While I was trying to recover my research, it was the villagers who helped me land on my feet. The villagers had prepared for us and they wanted us to stay. The lady who rented the house to us, I later learned, went to a spirit healer and sacrificed a chicken on our behalf. She asked him to align the spirits so that we might stay and bring good luck to her and her family. Shortly after we arrived, I discovered small altars set up around the house, although at the time I did not realize their significance. Other villagers greeted us and asked if we would stay. The village leader reiterated his commitment to host us in Phatang village. The staff at the village health centre, in an act of amazing generosity, offered us access to their health centre and said they would gladly participate in the project. Throughout data collection, staff at the village health centre remained true to

their word. They willingly allowed us to visit their health centre whenever possible; they talked candidly about their experiences; they let us sit in on all of their activities; and they invited us to remote villages where they conducted mobile health services. The support from the staff at the village health centre was invaluable to the success of this project.

For a time I considered relocating to Namuang village, where the interns were placed. We visited Namuang village and the student interns generously offered us a small space in their already cramped housing, if we wanted to move there. However, it was not possible. Namuang village is located 12 kilometres off the main road down a dirt road that passes over three rivers. Two of these rivers did not have a bridge, but they could be crossed during the dry season on a motorcycle. In the rainy season the road was impassable. The village had no safe water supply or electricity. The reality was that I could not move to this village with my children.

Ultimately, the relocation of the interns was serendipitous and strengthened the ethnographic process of the project. First, the interns at Namuang gave us a connection to a distant research site, and we regularly collected data from this village until the rains started. Second, and perhaps more important, being without the interns forced us to embrace and be embraced by the village. Soon after our arrival in the village, several villagers emerged as key informants who were eager to talk about their experiences, and they were also keen to tour us around the village and introduce us to other villagers who might usefully inform the project.

Working without the interns also enabled data to be collected from both the village and the health centre. In the absence of the student interns, a lot of time was spent talking to villagers and recording their illness and disability narratives. From this, a snowball research strategy emerged whereby we would talk to one villager and his or her story would lead us to another villager and so on.

Data for this project were collected without the presence of an official government escort¹⁹. At the time I did not realize the significance of this. To my knowledge, no foreigner has been permitted to collect data in Lao PDR, or even visit a rural village, without a government-appointed escort since the Lao Communist Government took power in 1975. Possibly, the interns were intended to be our escorts, but when their location was changed I inadvertently found myself collecting data in a village without government scrutiny.

Motherhood in Phatang Village

My children were tremendous ambassadors to Phatang village. While my children experienced significant culture shock early on during our time in the village, they soon became very comfortable. They made friends and through these friends I made friends

¹⁹ At least no official government escort that I was aware of. Several people have informed me that it is unlikely that I would be allowed to stay in a village without an escort. These people suggest that perhaps someone whom I was not aware of was watching me.

with the families around us. It did not take long for the villagers who lived near us to put aside their apprehensions and curiosity about us and realize that we had many similarities because of the children. Together the villagers and I engaged in the task of rearing children, mine and theirs, feeding them and keeping them safe. Because I was a single parent in Phatang village (and admittedly not that efficient at the labour-intensive job of managing children without modern conveniences), I could not have survived (or accomplished much work) were it not for my neighbours, who embraced my children and pitched in to help me care for them. This reciprocal form of parenting transformed me from primarily a researcher to primarily a mom who was also conducting research.

From the start, I knew that having my children with me in the village was a boost to the ethnographic goals of this project. I have a history with it. When I conducted ethnographic research in Swaziland in 1995, my husband and our first child, who was two years old at the time, accompanied me. While Swazi villagers never understood my role as a researcher, and they were amused by my husband's role as the "house dad," they managed to overlook everything because they loved our son. My blond, fair-skinned child was carried everywhere by the local youth, whose parents had instructed them to look after him. He ran barefoot, and bare-bottomed, like the other African toddlers, and before we left he jabbered away in SiSwati. Motherhood made me more recognizable to villagers. It was the same in Phatang village, although perhaps less natural for my older children (ages six and eight at the time), who were acutely aware of being plunged into a completely foreign place with a different language. I took my two youngest children with

me because it was the most logical thing to do for our family, but I was also aware that having them with me would ultimately help us immerse in the village.

DATA COLLECTION IN RURAL LAO PDR

Methods used to gather data included participant observations; semi-structured interviews; focus group discussions; direct observation of health centre staff and semi-structured interviews with these same staff; and formal interviews with key informants working in health care delivery in Lao PDR. Significant amounts of data collected by this project derive from villagers who visited me at my house. Often these villagers wanted advice for their health problem, and in the process they shared with me their illness or disability narrative. Disability and illness narratives are powerful tools that allow for reflection and reproduction of core values regarding illness and disability as experienced through lived experience. These values often support social and economic structures within societies (Joralemon, 2006). Knowledge about them can support health care reforms that are sensible to local people. Additional data were collected through outings with health centre staff to remote villages for health promotion activities, such as mobile immunization clinics. Additional interviews were conducted with individuals working in disability-related organizations in Lao PDR, including the School for Deaf Children; the School for Blind Children; Handicap International; hospital staff working in the prosthetic department at the Rehabilitation Hospital in Vientiane; individuals working with Community-Based Rehabilitation (CBR) in Lao PDR, a facility in Vientiane that

makes wheelchairs; and also individuals who work on mental health projects and social work projects in Lao PDR. Formal interviews were also conducted with professionals who work at the psychiatric unit at Mahosot Hospital, academics who study Lao PDR, pharmacy staff, village leaders and school staff.

Data Collection Sites

Data for this project were collected over six months between January and June 2007.

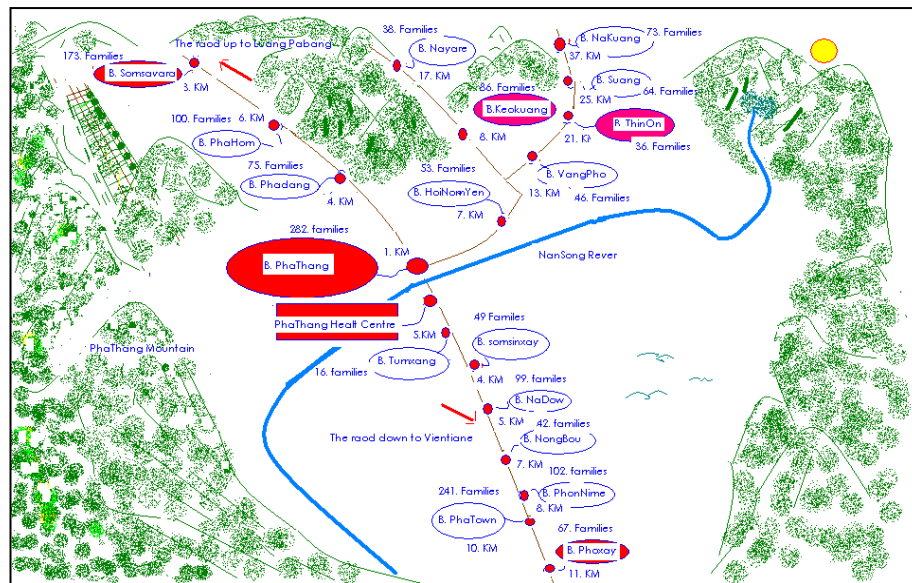
Data primarily derives from Phatang village, which has a population of approximately 1,000 people (300 households) and a health centre within easy walking distance. Other data were collected from Somsavat village, Namuang village, Phonxay village, and Somsinxay village. Data were also collected from the town of Vang Vieng and from key informant interviews in Vientiane city. Other informants for this project came from Keokuang village and Thin-On village, although I did not travel to these villages.

Interviews with key informants working on projects in Vientiane were also conducted.

Figure 1 illustrates a community map that was drawn by villagers for this project and identifies villages where data for this project were collected²⁰. Detailed information about data collection sites is located in Appendix A.

²⁰ On several occasions during data collection, I asked my interpreter if he could draw two maps for me. I wanted a map of the village and also a map of our data collection sites. On each occasion, I gave him tools to complete the project. In the first instance, I gave him a big piece of poster paper, pens and other drawing tools to complete the project. Another time, I gave him more paper and fancier drawing tools. Each time the project was clearly regarded unenthusiastically, and little was accomplished. Near the end of our time in the village, I downloaded a computer program that could draw circles, lines and so on onto my computer. The computer program was a hit. My interpreter was enthralled by the task and he took it on eagerly.

Figure 1: Participatory Map of Research Locations



Interpretation

Interpretation within ethnographic inquiry always poses challenges, and the degree to which these are discussed within any study varies. Often they are not discussed at all, in a pervasive attempt to appear as if the researcher is the all-knowing and only collector of data (Twinn, 1996). In this section, I would like to discuss openly some of the challenges of interpretation that were encountered during this study, how we tried to navigate them, and how they might influence the data.

Soon, he had swarms of villagers peering over his shoulder at my small computer screen, each pointing and arguing about where what should go and so on. The process went on for weeks until everyone agreed that the maps were suitable. The two maps included in this thesis are a result of those efforts. I had nothing to do with the drawing of these maps.

Interviews with villagers were exclusively in Lao language, which were interpreted for me. Interviews that took place outside the village were conducted in Lao language or English, depending on who was being interviewed. The same interpreter, Phonexay, accompanied all phases of this project. The limitations of interpretation were navigated somewhat by the lengthy duration of this project, when repetitive themes and saturation emerged during later stages of data collection. The long term of data collection also allowed Phonexay and me to develop a pattern of working together and deepen our understanding of how to work best within boundaries of interpretation.

Throughout data collection, Phonexay and I worked together to improve interpretation. Because trained interpreters are difficult or impossible to come across in Lao PDR, much of the interpreter training occurred on the job. Activities that were used to enhance interpretation skills included “practice interpretation,” where we used children’s books to bring awareness about the need to include details in interpretation. Regular post-interview debriefing sessions were also planned to discuss how the interpretation went that day. We also experimented with seated/standing positions that best facilitated interpretation.

Phonexay was a graduate of the Lao American College and had excellent spoken and written English language skills. He was also a gifted teacher, and this gift did not go unnoticed in the village. Within weeks of our arrival, villagers convinced him to teach

English. Every evening, seven nights a week, Phonexay offered free English lessons, which he conducted out of our neighbour's house. The classes were very popular. After a few nights, the class was split into two one-hour sessions because of the large number of students. While our days were filled with data collection, our nights were filled with young villagers eager for the opportunity to learn English. These language lessons were an important activity that helped us integrate into Phatang village. In rural Lao PDR, many villagers consider learning English important to escaping village poverty. Many nights during lessons, students would spill into my house, hoping for the chance to practise their English skills with a native speaker. It was a wonderful opportunity. While they learned English from me, I learned Lao from them.

Phonexay had previously been a Buddhist monk, and this had an impact on the research. Monks, even former monks, in Lao PDR are revered, and villagers everywhere had an immediate respect for him. Phonexay's experience as a monk was beneficial because people trusted his generous and caring nature, but it also caused villagers who participated in this study to be wary about talking to a former monk about certain topics, most notably animist practices. Realizing that Phonexay would not immediately integrate with Phatang villagers was a challenge that I had not anticipated. However, the long-term nature of the project allowed for villagers to get to know us, and they eventually become more comfortable talking about these topics. While it is not known the extent to which this problem was controlled for by length of data collection, significant amounts of data

related to spirit healing, animist practices and traditional medicines were collected, and these data were easier to collect as time passed.

Another challenge had to do with gender. Because Phonexay is male, it might have made it difficult for some women to discuss female problems with me through Phonexay. Again, it is not possible to know how much gender influenced data collection, or if gender became less significant as villagers became more familiar with us. My own gender probably also influenced the type of data we collected, and from whom. More data were collected from women than from men, although it is difficult to determine the reason. Women are often responsible for family health, which might have caused female villagers to be identified as the best spokespersons on the issue. It might also have been that women were more comfortable talking to me.

Interpretation for this project was often characterized by imbalance. Often the conversation between Phonexay and the informant was much larger than what was interpreted for me. This situation was very frustrating for me, and it often came up in debriefing sessions. Sometimes, however, if I interrupted the conversation to ask for interpretation, Phonexay would explain to me that he was seeking clarification, and that he would interpret for me shortly. While the rhetoric around interpretation suggests that “good interpretation” offers a word-for-word account of the entire conversation, my experiences with interpretation in Phatang village make me wonder, especially given the circumstances, if imbalance is inevitable, and possibly necessary in some circumstances.

Over time, interpretation in this project regained better balance, and I became more accepting and understanding of the challenges inherent within it for both Phonexay and myself.

During the latter parts of data collection, my Lao language skills increased sufficiently so that I could usually follow the conversation between Phonexay and the informant, at least to a degree. Being able to follow the conversation made it possible for me to gauge the translation better, and was sometimes insightful. On one occasion, for example, we went to interview an old man who was blind. There were many people in the room, including a young woman who was married to the man. The woman had a toddler with a large swollen tummy. As we sat down and engaged in greetings, Phonexay scolded the woman. He said, *“That one there! Her stomach is full of worms! Why did you not take her to the clinic?”* The woman replied, *“I did, but the medicines are no good.”*²¹ While the interaction was useful data, I would have preferred to discover it in a gentler way. In the end, the old man told us about his journey of becoming blind, which was not influenced by the reprimand directed at the woman.

While Phonexay always accompanied me to scheduled data collection events (interviews, etc.), my Lao language skills increased to the level that I was able to function independently for day-to-day purposes within the village. I was also able to communicate with informants about their stories to some degree. Sometimes during an interview, I

²¹ These quotes are my memory of what was said, not word-for-word quotes.

would speak for myself and ask questions of an informant. If an informant arrived at my house while Phonexay was away, or if I came across an informant while walking in the village, I was able to communicate for myself. Once I even managed to talk to villagers on the phone, which is very difficult for someone who is learning a language. I was away for the day, collecting data with LHRCHP Canadian colleagues, when I got caught in a rainstorm and was unable to get home. I phoned a villager and managed to tell her about my problem and ask her to look after my children until I could return.

Capturing Stories

Phonexay interpreted stories for me. These stories became both a data capturing and a data analysis strategy. Many times Phonexay's "larger" conversation was a result of his trying to understand the story so that he could relate it to me. Sometimes Phonexay was unfamiliar with medical terms, or the names of internal organs, and his conversations were an attempt to become clear about what was being said. I am confident that the stories collected represent the stories as Phonexay understood them.

Many times the stories were collected over weeks, even months, as events transpired in the lives of informants. This following of stories allowed for data to be collected through interpretation, but also through observation and interaction. This triangulation of data collection enhanced ethnographic data collection methods because I was not dependent

solely on interpreted conversations to capture the lived experiences I was intending to document. Much of the data collected derives from my own observations, as well as my participation within the stories. I watched the stories unfold, I influenced how they transpired, I felt them, and I was able to ask questions about them from multiple stakeholders. Often I was able to ask the same question several times, and to different stakeholders at different times, and this helped to clarify answers. Being able to seek clarity over time and from multiple viewpoints was useful, especially in circumstances where stories had seemed unbelievable.

Because of the nature of interpretation in this project, none of the data collected were transcribed. From early on in data collection, I recognized that I was collecting stories, and that these were my stories about a village in Lao PDR. During interviews I scribbled notes into my tiny logbook and at night I expanded those scribbles into stories. All of the stories are written from my perspective. They include descriptions of the environment, smells, colours, sounds and non-verbal behaviour. They are written using literary elements and discursive writing strategies that evoke emotion. Altogether, I wrote 62 stories, ranging in length from 4 to 20 pages, as a result of this project.

Otherness in a Village

I anticipated my “otherness” in Phatang village and had devised strategies that would make it possible for a female Canadian researcher to collect valuable data on illness and

disability in a rural Lao village. I never intended to deny the influence that being foreign would have on data collection, only to plan for it. Living in the centre of the village was one plan that I hoped would help me integrate into village life. Certainly, just living close to villagers for an extended amount of time helped build friendships and trust. Another strategy, which I happened to have available to me, was my children. A third strategy, which I did not anticipate, was the asset I brought to the village. In the early days of data collection, I discovered that villagers were very concerned about their health. Phatang villagers were eager to have a foreigner, who they thought had important knowledge about health and healing, live amongst them. I became a protected asset in Phatang village because villagers came to see me as someone who could help them access and understand health care services and information.

However, I did not anticipate that Phonexay would also be a foreigner in Phatang village. Because he is a Lao person who grew up in a poor village, I assumed that Phatang villagers would automatically embrace him. This finding is closely aligned to data that discusses insiders and outsiders in ethnographic data collection, and asserts that even people of the same race or ethnic group can be foreigners within their own cultural group (Hammersley, 1995; Willis, 2007). What I discovered is that Lao society is organized around the nuclear family. Outside the family, weak ties exist within villages, but outsiders are viewed suspiciously. While my presence as an outsider in the village was regarded with curiosity, Phonexay's status as an outsider brought a potential threat to the village. In Lao PDR, one can never be sure who might be working for the government,

and if there might be repercussions for saying the wrong thing to someone who is tied to the government. Clearly, I was not connected to the government, but villagers were not so sure about Phonexay. He had to earn respect and trust from villagers. Fortunately, he is talented at personal relationships. The English language classes he taught went a long way toward earning villagers' trust. His gentle and kind spirit also quickly won villagers over, as did his ability to make friends.

Like any long-term research project of this nature, data collected for this project increased in authenticity as time progressed and villagers began to trust that their stories were safe with us. For example, at the onset of data collection, nearly every villager we spoke to reported that they always went to the health centre when they became ill. Similarly, women told us that they delivered *all* of their babies at the health centre. As time went by, and villagers understood that these “foreigners” in their village were not reporting their stories back to government officials, we began to hear stories about giving birth at home, we were invited to traditional ceremonies intended to heal, and we were invited to talk with families who harboured the most “shameful” types of illness and disability.

Being a Canadian woman who did not speak Lao before entering the village, and who initially learned about Lao culture from books clearly brought limitations to the research. I learned as I went along, and some things I never fully understood. However, being a foreigner also had benefits. I had no agenda other than to record narratives, and from these learn how health centres in Lao PDR might become more useful to villagers. Over

time, villagers embraced this agenda and willingly told their stories. Villagers, I discovered, understand that foreigners operate important sectors of the Lao system, and especially the social system. Poor villagers who participated in this study were eager to have their stories sent to foreigners who have the power to help. On two different occasions, in two different villages, I listened to informants who said that if foreigners want to help, then they should come to the village and offer the help directly. Without offering the help first-hand, villagers insisted, the help would never get to them. My foreign status, and disconnect from government, made it possible for villagers to talk openly in ways that are not normally possible.

It was easier to gain trust from Phatang villagers because this is where we spent most of our time. Our reputation, however, quickly spread to distant villages. Often distant villagers knew about us before we arrived in their village. While our reputation was useful for data collection, this same reputation was also problematic. Over time, news spread that a foreign woman with health knowledge was living in Phatang village. Partway through data collection, I started receiving villagers at my house who had travelled from distant villages in the hopes that I might help them with their health problem. Once, these villagers walked over mountains to reach me, and another time villagers pooled their resources and arrived as a group in the back of a truck. These constant requests for help from villagers tested my ability to remain “neutral” in a place where many people are in great need of help.

Giving Back to a Village

I soon realized that a major problem with my research method was that I intended to collect narratives, but I did not have plans for how I might reimburse villagers for their stories. Mostly, villagers did not share their stories with me only because they wanted to tell them. For the most part, villagers told their stories because they wanted help. Early on in data collection, I discovered myself in an ethical conundrum because I had so little to give back.

The English language classes were one way of giving back. I also gave back in other small ways. I took pictures of every villager who informed this project, and then went to great lengths to print these pictures and personally deliver them to informants, even if these informants lived far away. These pictures were always well received. One elderly lady was very pleased with her picture because she expected to die soon and was glad to have a picture for her funeral. I also gave small gifts when it was appropriate. If an interview indicated that a villager might benefit from something small that I could purchase, then I tried to purchase it for the villager.

I was also conscious about supporting local shops in the village. I bought whatever food I could from the village as well as other things like phone cards and bottled water. I also purchased supplies and assembled newborn baby care packages that were given to poor families who delivered a baby at the health centre. When I left, I donated my bed nets

and mattresses to the Phatang Health Centre²² and many of my other things were given to villagers.

The giving back that I struggled with the most, however, was my medical knowledge. It was here that I had a hard time drawing a line between researcher and village friend.

While I have no formal medical training, only motherhood and a few basic first aid courses, my layperson's knowledge of medicine was invaluable in Phatang village. More than anything, villagers wanted me to help them understand their health problem and find a solution for it.

Partly because of my children, I arrived in Phatang village with a small suitcase filled with basic medicines and first aid supplies. All of these products were over-the-counter products that can be purchased at any pharmacy in Canada. I thought these products would be useful to my children or me, but I also packed a few extra things because I suspected they might come in handy. Once, in Africa, my host family's baby woke in the night with a high fever. The infant screamed all night long and the family paced the house, clearly worried that he would die. Since that time I take baby and children's medicines with me whenever I travel to a poor place, even if I am just a tourist. They almost always come in handy.

²² It didn't take long, however, for me to learn that these things had disappeared from the health centre. I have no idea where they ended up.

In Phatang village my suitcase of supplies became problematic. Villagers were very aware that I had a stash of medicines and that I knew how to use them. They wanted a share of them. Throughout data collection, I struggled to manage nearly constant requests for help from villagers. I worried that helping too much would taint the data. My entire time in the village can be characterized as a struggle between my resolve to conduct research, and my personal ethics that many times made it impossible for me to sit idle while people suffered needlessly.

In the end, I helped a lot of people. While I struggled with this helping from a research point of view, I decided that I could not refuse to help people if it were in my power to do so, and if they wanted the help. In my attempt to maintain my boundaries, I directed many people to the local health clinic and sometimes I accompanied them there. Many other people, however, had advanced and complicated problems that were beyond the scope of the health centre. Often these people had already engaged in a long search for a solution to their health problem, usually unsuccessfully. If I thought I could help, then I did. I accompanied people to the hospital, I made phone calls to gather resources or information, and I arranged for prescription medicines to be delivered from Vientiane. While I did this, I recorded their stories. I paid for most of this, although the cost was usually nominal by Western standards. If I was at the health centre and people arrived with no food or complicated problems that were beyond their ability to pay, then I arranged for food and I paid for the treatment. While I knew that I could not solve all of the problems in Lao PDR, I decided that I would try to help with the problems that I

found along my journey. In this way my ethnographic method became action-orientated to a degree. As much as possible, I tried to incorporate sustainability into my helping, as I was fully aware that I would leave and villagers would need to be able to help themselves.

I did not realize the power of my data until I returned to Canada. In Lao PDR, I worried that I had compromised the study because I could not observe suffering without helping. In Canada, I realized that the close-up experiences that I documented as a result of helping gave me a window into the complexities of the problem in Lao PDR that I would not otherwise have had. In Lao PDR, I participated with people who were searching for a solution to their health problem. I often did not know exactly where the solution might be found, but I usually had an idea of where to look. Together, villagers and I experienced the health system in Lao PDR and learned how this system operates for people who are rural and poor.

Not all of the data I collected in Lao PDR results from helping. Often I did sit and listen to stories. Sometimes these stories were about things that had happened in the past, and sometimes there was nothing that could be done to help. In these cases I just listened. Sometimes I had no idea how to help, and sometimes villagers were not seeking help. Often I sat on the veranda of the health centre and just watched what happened that day. At the health centre I was always only an observer. I respected the roles of the health centre staff as the experts in their field, and only ever asked questions about their work.

Indeed, illness and disability are such a worry in Phatang village that it is possible to just live in the village and collect large amounts of data about how villagers cope with illness and disability during their day-to-day lives. Data collected for this study are a mixture of observations, interviews and my own lived experiences of accompanying poor and rural people through the health system in Lao PDR.

ANALYSIS OF DATA

Data collected were subjected to multiple qualitative data analysis processes, which took place between September 2007 and December 2009. Data were analyzed with attention to shared themes, commonalities and diversity across interactions with villagers and in relation to other data gathered. NVivo qualitative analysis software was used to manage and discover themes within the data. The data were also analyzed through a *Writing for Change* strategy that was developed by the International Development Resource Centre (IDRC). Analytic notes and narrative writing strategies, which were then subjected to further theme-based analysis, were also used to draw out poignant thematic results from collected data.

Data from this project consists of 62 personal stories about health and disability, 250 pages of field notes plus journal entries and analytic memos. Two participatory maps²³ were developed from this project and incorporated into the analysis. Other data include

²³ Discussed earlier

two handwritten logbooks, and a file containing a copy of every email message sent to and received from my supervisors, family and friends while I was in Lao PDR. Many of these email messages give lengthy, detailed and candid accounts of our experiences in Phatang village.

In keeping with ethnographic process, data analysis began as a reflective writing process. This was the first step of turning lived experience into text. When I returned to Canada I found that I was very close to the data, and that I needed time to reflect on what I had experienced and learned in Lao PDR. For this reason, much of my early writing emerged before I immersed myself in the data. At that time, I wrote about how it felt to live amongst people who suffer high rates of illness and disability. I also wrote about the ethics of ethnography and power in research. Much of what I wrote was a personal process of coming to terms with the data. This writing led me to understand the power of the data, and that my ultimate giving back to my informants would be to tell their stories, as they had asked me to do.

When I immersed myself in the data, I began by reading and rereading. The data were then uploaded into NVivo qualitative analysis software (v.2) where they were subjected to a comprehensive categorical analysis. From this analysis basic categories and thematic units of data emerged. The NVivo process also made it possible to easily retrieve chunks of related data. All of the categories and themes that emerged from the NVivo analysis were printed and posted on the walls of my office for further analysis and reflection.

Over time these posters of data became cluttered with sticky notes that expanded on content, and arrows that began the process of identifying the complex, interconnected nature of the data.

Using the NVivo analysis as a base, the main ideas of the data were further refined through a *Writing for Change* process. This process pushed the data into a single succinct statement that epitomized the main message drawn from the data. From this main message, six key statements were developed. Important points drawn from the data further supported the six key statements. The main message was, “In rural Lao PDR there are many barriers that inhibit people from accessing Western health care services.” The six key statements were 1) A complicated health care system is difficult for rural people to navigate (systems); 2) Rural people often do not understand the types of treatments that they can get at a health centre (knowledge and information); 3) Health care facilities are often very far away from where rural people live (distance); 4) The cost of health care often makes health care inaccessible for poor and rural people (cost); 5) Rural people often believe in other forms of health care that are also effective (cultural norms and beliefs); and 6) Many people in rural Lao PDR have had experiences that cause them to fear and distrust the health care system (fear and distrust). Together this process formed the initial outline for this thesis. The process also identified the main audience for this thesis, what I wanted the document to do, and what kind of information my audience required. Eventually, the six key statements were reduced to the three topics

that are discussed in this thesis: paying for health care (chapter 4); seeking health care (chapter 5); and bewildered by health (chapter 6).

In September 2009, with my initial outline in hand, I began writing. My first attempts at writing at this level, however, indicated that I was still too close to the data. I was still writing stories that I was too close to. What I realized at this time was that I was writing my own story. These stories formed the second round of writing that was accomplished for this project. In particular, I wrote two stories that embodied my experiences in Phatang village. One story tells about a family who walked across the mountains to ask if I could help their son, who had a terminal illness. They did not know how terribly ill he was, but I did. It is a story about my journey with them. The second story recounts the day my daughter's friend fell and hit her head on my cement steps. It is a story about the lived tension between my dual roles as researcher and woman, mother and friend, in a Lao village. Like my earlier writing, these stories are narrative and discursive. They expose how I came to love a village.

While this second round of writing did not produce thesis material, the stories functioned as an opportunity for another round of data analysis. After the stories were written, I pulled them apart. On 16-inch by 33-inch paper, I drew columns into which I divided the stories. One column was for the *main story*, another column was *my story* and the last column was for *other information*. During this process, I literally pulled myself, and all of the other extenuating information, out of the story. What I was left with was the

essence of what I needed to write about. This last data analysis strategy streamlined the data to the point where I knew exactly what I needed to write and how it needed to be written. Taken together, the processes that were used to analysis data for this study built upon each other to create layers of analysis that ultimately brought out the essence of the topic.

ETHICS

All of the required formal ethics approvals were sought and granted for this project. Ethics approval was obtained from the University of Calgary and also from the National University of Lao PDR as an addendum to the LHRCHP. Other permission was also granted from the Medical Department at the National University of Lao PDR. In September 2006, four months prior to the commencement of data collection, the Phatang village leader was contacted in a face-to-face meeting, and he granted permission for us to live in Phatang village and collect data between January and June 2007. The village leader also organized housing for us. Early on in the research phase, when the research strategy changed due to the interns not arriving at the Phatang Health Centre, the ethics review committee at the University of Calgary was contacted and permission was granted to continue with the research. Also, near the beginning of the project, I registered my children and myself as living in Phatang village with the Vang Vieng police station, where we were given verbal permission to reside in the village and collect data. All of

the names used in this document were changed to protect the identity of informants, except for my interpreter Phonexay who asked that I use his real name.

Much of the preceding discussion in this methods chapter describes the ethical dilemmas this project encountered. For the most part, I was unprepared for the ethical dilemmas I would face in Phatang village. I often found myself necessarily reacting in ways that I hoped would honour both my role as a researcher and also my role as a village guest and friend. Even though I had had previous experiences living near poor people, my complete immersion in the village, along with my research questions that clearly touched an urgent issue for villagers, created an ethical situation that I had not anticipated.

When I left the village, the data that I held created a huge ethical dilemma for me. While I knew the data was important, I worried about how it was gathered. For nearly one year, I was unable to look at the data because I knew that many people in Phatang village, and elsewhere in Lao PDR, continued to suffer, and yet I had left with their stories. Even though I tried, I was unable to help many people. Ironically, the main worry that I fretted about while I was in the village reversed itself in Canada. In the village, I worried that I had helped too much. At home, I worried that I had not helped enough. I was concerned that I would gain from observing suffering. When I finally started to read the data, however, I remembered the villagers who had asked me to share their stories with the world. It was this realization, which was my political purpose, that gave me the power and, in my mind, the ethical clearance to write.

LIMITATIONS OF THE STUDY

The inductive (ethnographic) method used to gather data for this project limits the ability of this project to generalize results to other groups or areas. Data collected in this study represent stories collected in Phatang village and surrounding areas. The results cannot be generalized to other areas in Lao PDR or Southeast Asia. Phatang village has several distinguishing features that make it different from other rural villages in Lao PDR. Firstly, most villagers in Phatang village are ethnic Lao, which means that data from this project cannot represent the experience of people who are from ethnic minority groups. Although data were collected from a number of villagers who were ethnic minorities, the majority of the data collected came from Phatang village where most of the villagers are ethnic Lao people. There was no systematic plan to identify an informant's ethnic group or to analyze data derived from these people according to ethnicity. Secondly, Phatang villagers had good access to a health centre and reasonable access (half an hour by tuk tuk) to a district hospital. Many rural villages are much more remote than Phatang village and the experiences there are likely different. Thirdly, absolute poverty is not as pervasive in Phatang village as it is in many other rural villages in Lao PDR. This project did not attempt to identify "degree of poverty" in any way. This difference again makes it impossible to generalize data from this project to other areas in Lao PDR based on level of poverty. Likewise, data from this project cannot be generalized to other areas in Southeast Asia. This project only ever intended to tell the story of the villagers who informed the data.

My status as a Canadian-born female researcher also brought a limitation to the study. Lao language and culture are something that I learned about from books and experiences, and my grasp of these was and is partial. This study was primarily conducted through an interpreter who, despite being Lao himself, also had to contend with being “foreign” in Phatang village. It is not known how much our foreign status influenced the data. As with any study, my gender and background certainly influenced how the data were collected and what types of data were collected, even if I did make attempts to control for them.

The results discussed in this thesis result from my analysis of the data. Qualitative research is always the interpretation of the person who “writes up” the data, although sound analysis can help to minimize this limitation. It is for this reason that I claim the stories in this thesis as mostly mine. When I started the task of writing this thesis, I realized that the most truthful approach I could take was to write my story about listening to, participating in, and watching the stories of others.

SUMMARY

This chapter discusses the first stage of the ethnographic process undertaken to conduct this project, which was the collection of data. Data collected for this study evolved from a reflective, critically aware, politically and socially engaged, and discursive ethnographic

tradition that has emerged in the last half century. The evolving ethnographic tradition outlined at the beginning of this chapter is woven into the narrative that describes the processes of collecting data in Phatang village. The chapters to follow represent the second stage of the ethnographic process undertaken for this project. These chapters embody the themes that emerged from analyzing the data, and the stories that resulted. They are my shared stories of illness and disability in Phatang village.

CHAPTER FOUR: PAYING FOR HEALTH

This is the first of three chapters outlining the findings of this study. In this chapter, the links between poverty and health care utilization are examined, with a specific focus on how the cost of health services influences the types of treatments poor villagers seek for health problems. The chapter begins by offering a picture of the economic situation of Phatang village juxtaposed to other villages where data were collected. The chapter offers a detailed analysis of what villagers reported paying for various health services followed by a discussion about what influences the cost of health care in Lao PDR.

POVERTY AND HEALTH IN RURAL LAO PDR

An important observation gleaned from this project is the link expressed by many villagers between poor health and poverty. Villagers who participated in this study understood that they suffer from high rates of illness and disability because they are poor. They also understood that this situation is a grave injustice, and that a solution to their pain and suffering might exist elsewhere in the world. When data collection began, it did not take long for villagers to determine that someone with health knowledge had arrived in their village. Data collection for this project was both impeded and enhanced by the large number of villagers who sought my help for their health problem. People who came

looking for help told their incredible stories, which added greatly to the data collection, but they also came because they wanted financial assistance in accessing a solution to their health problem.

Poverty must be understood within the local context in which it is experienced. In Phatang village, for example, most households have a rice paddy and many also have a river garden. Chickens and cows wander freely around the village, and some families keep other livestock corralled. Most houses in Phatang are permanent structures constructed from wood and cement and are built raised above ground, as is the traditional Lao custom. Many households have built, or are building, cement walls and floors around the bottom level of the house, a process that often takes many years and is completed as money is available.

Some households in Phatang village earn a small income. There are several restaurants in the village, numerous shops selling basic supplies, two *tuk tuk* drivers²⁴, a licensed pharmacy, numerous traditional practitioners, a petrol pump, a seamstress, a mechanic, an ice seller and a local *Lao Lao* (whisky) seller, to name a few. Numerous households have a weaving loom for making fabric and handicrafts. On any given day, a motorcycle selling ice cream, sweet breads, meat or fish might pass through the village. Every second day a truck comes to the village, selling filtered water to villagers who can afford it. Villagers often walk through the village selling their garden produce or sweet fruits

²⁴ A tuk tuk is a motorcycle with benches with a roof built onto the back where passengers can sit.

harvested from their crops. Sometimes non-villagers walk through the village selling healing remedies.

Compared to other villages in Lao PDR, Phatang village has a robust economy and is not classified as “poor” according to the Lao National Growth and Poverty Eradication Strategy (NGPES) guidelines. Phatang villagers mostly have enough to eat, and many eat a variety of healthy foods each day. Most Phatang villagers have decent houses to live in. Some villagers even enjoy small luxuries. Children might be given small sums of money to buy sweets from a local shop, and adults might enjoy a bottle of Beer Lao on a special occasion. Once during data collection, a boxing competition came to Phatang village. Villagers who could afford it paid to see the boxing while others enjoyed the tents, games and special-occasion food that came as part of the festival. The close proximity of the village to a health centre and a secondary school further increases the overall prosperity of the village.

Prosperity in Phatang village, however, is small-scale. Many household items are sold in single-use packets that are affordable, telephone cards are sold in denominations of US\$1 or less, and small candies can be purchased for less than ten cents. The day-to-day life for most villagers is comfortable in the absence of a catastrophic event.

The tipping point for Phatang villagers into catastrophe occurs with even small changes in a family’s income or expenses. While villagers can sustain themselves by eating from

their crops, and some save small sums of money over time to build a house or invest in livestock, these hard-won gains are quickly unravelled in the event of a catastrophic event. Often the catastrophic event is an illness that renders a normally productive adult unable to work and requires costly treatment from a hospital. Data from this project suggest that the prospect of potential illness is a major worry for villagers who are aware that their comfortable life is precariously positioned.

Phatang villagers mostly have no savings except for the wood and cement in their house, their land or their livestock. Villagers can, and often do, sell these assets to pay for health care, a process that often plunges them further into poverty and from which it takes years to recover. Some never recover, especially if the illness episode requires them to sell their land, and causes a family to become vulnerable to hunger.

The relative prosperity of Phatang village is juxtaposed with other villages that do fit the NGPES criteria for “poor” and were included in data collection for this project. In very poor villages, even minor illness episodes are beyond the capacity of most villagers, who often do not have any assets to liquidate in the case of a catastrophic event. These people are at the mercy of fate and their low level of health care utilization is in large part a reflection of their poverty.

HOW MUCH DOES IT COST?

Every time villagers spoke about their illness or disability experience, they told about how much seeking a solution to their health problem cost. Usually cost was one of the first things villagers spoke about. When data collection for this project began and villagers told their health-seeking stories, I was shocked to hear the costs that villagers reported paying for health care. I even considered that villagers had embellished their stories with unbelievable costs. After months of listening to stories, patterns of health care costs became evident, and I became convinced that villagers were telling genuine stories²⁵.

Tables 1-5 offer a breakdown of costs that villagers reported paying for various kinds of health care²⁶. Individual tables clearly demonstrate cost trends while a cross-analysis of the tables reveals patterns of costs based on where villagers sought health services. The tables also offer a comparison of the fees villagers reported paying for health services from public, private and traditional providers. In this section each table is discussed individually and also in relation to the other tables.

²⁵ Interestingly, High (2007) also reports on villagers who claim to have paid extraordinarily high costs for health services obtained from public hospitals in Lao PDR. High finds the costs so astonishing that she concludes that villagers must have exaggerated the costs.

²⁶ Costs reported by villagers are documented in both US\$ and Kip. Often villagers will quote Kip when they report on relatively minor costs. Almost always they report higher health care costs in US\$.

For the purpose of the remainder of this thesis, health services in Lao PDR are discussed as primary, secondary or tertiary on the basis of financial accessibility and level of competence and sophistication of care as perceived by villagers. Primary health services are provided by village health centres and some district hospitals, which offer basic medicines and treatments to help with common village illnesses and accidents. Primary health facilities have staff with at least minimal qualifications, although most are not trained doctors. Primary health facilities might have one or two beds where patients can stay overnight and are the least expensive public health care option available to Lao villagers.

Secondary health services are provided by some district hospitals, provincial hospitals and some central hospitals in Lao PDR. Secondary health care centers in Lao PDR can perform some surgeries; some have X-ray and ultrasound equipment; many can perform a Caesarean section; and some can administer blood transfusions. Secondary hospitals have a higher percentage of high-level staff and more beds for patients. Secondary hospitals are more expensive than primary health care facilities, and they can provide health care services for extended periods of time.

Tertiary hospitals are also discussed in this thesis. Tertiary hospitals are very high-level institutions that can provide health care to patients with complex problems. They have highly qualified staff and they are prohibitively expensive for villagers. There are three tertiary hospitals located in Lao PDR (Mahosot, Mittaphab and Settathirat) although

villagers who participated in this study mostly spoke about receiving tertiary level care from hospitals located in Thailand and other middle- or high-income countries.

The reason for distinguishing between primary, secondary and tertiary health care in Lao PDR in this manner derives from how villagers who participated in this study spoke about public health care options in Lao PDR. During data collection, villagers distinguished between the village health centre (primary), which provided more affordable but not-so-good care, hospitals (secondary) that provided better care and were more expensive, and high-level hospitals in Vientiane or outside of Lao PDR (tertiary) that provided outstanding care but were prohibitively expensive. Some villagers distinguished between hospitals in Vientiane that were considered very good, and other hospitals in Vientiane and elsewhere in the country that were considered less good.

The Village Health Centre

A trend illustrated by Tables 1, 2, 3 and 4 is that public health care in Lao PDR is most affordable at the village health centre, followed by a dramatic increase in costs for health services obtained from secondary and tertiary hospitals. While some of the very poorest villagers struggle to pay user fees charged by village health centres, many villagers can manage these fees, although just barely. Cost becomes a major barrier to health seeking when the village health centre was unable to solve a health problem, and villagers sought treatment from secondary or tertiary facilities, private health care providers, or traditional

healers. In some instances, villagers spent all of their money looking for a solution to a health problem from primary public health care, such as the village health centre, only to discover that their problem required secondary or tertiary services. Villagers sometimes also discovered that the treatment they received at a primary public health care facility was ineffective.

Table 1: Reported Costs of Treatment at Phatang Clinic (Primary Health Care)²⁷

Health Problem	Reported Cost
Treatment for child with impetigo	10,000 Kip / US\$1.00
Medicines for man with chronic neck stiffness	5,000 Kip / US\$0.50
Overnight treatment for child with malaria	50,000 Kip / US\$5.00
Consultation and medicines for child with diarrhea and vomiting	15,000 Kip / US\$1.50
Consultation and medicine for child with burned feet	24,000 Kip / US\$2.40
Overnight treatment for man with high fever, vomiting and diarrhea	44,000 Kip / US\$4.40

While the village health centre has good capacity to administer preventative or primary level health services, the capacity of the village health centre to deal effectively with complex or advanced health problems is limited. Data from this project indicate that while some wealthier Phatang villagers utilized the village health centre for early-stage health problems, the majority of villagers held off utilizing the village health centre until it was clear that the problem would not resolve on its own or by other home remedies.

Poorer Phatang villagers who participated in this study and those in distant villages never

²⁷ In 2007, 10,000 Kip was equivalent to US\$1. The 2007 exchange rate is used in all the tables outlining costs in this thesis.

sought help for an early-stage health problem from a public health care centre and only participated in preventative health care (e.g., immunizations) when mobile health teams came to their communities. While the village health centre offers valuable services to village people, a visit to the village health centre is often not a good investment of scarce family assets because by the time villagers decide to seek help for a health problem, it often requires treatments, medicines or knowledge that are beyond what is available at the village health centre.

Poor Lao villagers who participated in this study did not have any disposable income to spend on ineffective treatments to a health problem; however, this is the experience of nearly every villager interviewed for this project who suffered from a major health problem. Often villagers exhaust their resources seeking help from just one health facility and then have to return to their village to earn, borrow or liquidate more funds so that they can try something else. Often villagers embark on multiple health-seeking forays, a process which takes months or years, during which time the problem worsens and leaves the villager either destitute or living with the consequences of the health problem.

Secondary Hospitals in Lao PDR

As illustrated by Tables 2 and 3, the cost of health care escalates significantly when villagers who participated in this study sought help for a health problem from secondary or tertiary hospitals. While the cost of the village health centre is somewhat accessible to

many Lao villagers, a visit to a secondary or tertiary hospital is usually a catastrophic event for poor, or even not-so-poor villagers. Villagers who participated in this study only ever sought help from a hospital under dire circumstances. Given that 71% of the population in Lao PDR lives on less than US\$2 per day and 23% live on less than US\$1 per day, the reported cost of health services provided by hospitals in Lao PDR and elsewhere are astonishing (Patcharanarumol, 2009). What is more astonishing is that villagers sometimes manage to pay these costs.

**Table 2: Reported Cost of Treatment at Hospitals in Lao PDR
(Secondary Health Care)**

Health Problem	Reported Cost
Quoted cost for treatment of abdominal pain	6 million Kip / US\$600
Quoted cost of spleen removal surgery for child	2 million Kip / US\$200
Actual cost for spleen removal surgery for child when paid for by researcher	600,000 Kip / US\$60
Treatment for baby with swollen leg – 6 weeks in hospital	600,000 Kip / US\$60*
Treatment for child with stomach ache and diarrhea	3 million Kip / US\$300
Cost of hospital stay for old man who suffered a stroke	3 million Kip / US\$300 per month
Treatment for child with stomach problem – 1 week in hospital	3 million Kip / US\$300*
Consultation for child with developmental delay	500,000 Kip / US\$50
Treatment for child with fever, diarrhea and vomiting	4 million Kip / US\$400*
Ultrasound for a pregnant woman when paid for by researcher	20,000 Kip / US\$2
Consultation for child with bloated stomach	50,000 Kip / US\$5
Hysterectomy	2 million Kip / US\$200
Amputation of leg	8 million Kip / US\$800
Crutches for man with amputated leg	60,000 Kip / US\$6
Artificial leg	Free
Mastectomy and other treatments for breast cancer. Provided by a visiting doctor from Taiwan	Free
Cleft lip repair in Vientiane 13 years ago	Free

*Family reports that they received the treatment for ½ price because they are poor.

The Private Pharmacy

An important health care option for Lao villagers is the private pharmacy. Most villages in Lao PDR, including very poor villages, have access to a private pharmacy that dispenses basic and sometimes potent drugs. The village pharmacy is often the most affordable Western-style health-seeking option available to villagers. Importantly, the location is nearly always closer to where villagers live and often significantly so. The village pharmacy also functions within the market of the village, selling products that are in high demand, and in quantities that villagers can afford. Villagers can either seek the advice of the pharmacy owner for medicines that might help their health problem, or they can request specific drugs, in specific quantities, if they know what they want and depending on how much money they have to spend. In Phatang village the licensed private pharmacy would sometimes sell different variations of the same drug. These drugs were sold for different amounts of money, depending on where the drugs were produced. Drugs produced in Lao PDR were usually cheapest.

Table 3: Reported Cost of Drugs Obtained from a Private Pharmacy

Health Problem	Reported Cost
Drugs for man admitted to psychiatric ward of hospital	110,000 Kip / US\$11 per week when paid for by the researcher
Medicines for severe abdominal pain. Family chose this instead of a 6-million Kip treatment from a hospital	1 million Kip / US\$100
Medicines for villager who has a mental health problem. (Diazepam; Flanaxol). Must be purchased in Vientiane	100,000 Kip / US\$10 per month
Medicine to treat child with diarrhea	25,000 Kip / US\$2.50
Medicines for woman with stomach pains. Family chose this medicine instead of surgery	46,000 Kip / US\$ 4.60
Eye medicine and cotton swabs to apply it	8,000 Kip / US\$0.80

Medicine called Stemina, which is a popular village treatment administered intravenously for general malaise and lack of appetite	50,000 Kip / US\$5.00
Manual breast pump	35,000 Kip / US\$3.50

While the village pharmacy sells medicines for early-stage health problems, villagers can also find medicines for advanced and complex problems there. Several villagers who participated in this study reported seeking help for a serious health problem from a hospital in Lao PDR only to discover that the treatment offered there was far beyond what their family could afford. These families resorted to the village pharmacy, where they reportedly purchased the same or similar drugs at a significantly reduced cost.

Phatang villagers who participated in this study reported that they like to get help for their health problems from the village pharmacy. The pharmacy is convenient for them, the prices are affordable, and the owner has a long family history in the village. While many villagers who participated in this study stated that the medicines for sale at the village pharmacy are good quality, a number suggested that it is necessary to be cautious about purchasing medicines from the village pharmacy because sometimes the medicines are not good or expired. A few villagers said that they like to take the village midwife with them when they buy medicines from the pharmacy because she has knowledge about medicines and is able to tell if they are good or expired.

Of all the health-seeking options available in Phatang village, the village pharmacy has perhaps succeeded best at providing health services for people who have early-stage

health problems. While this project discovered very few villagers who utilized public health care to prevent future health problems (free immunization clinics, for example), many villagers did seek help for a health problem at the onset or near to the onset of the problem from the village pharmacy. While private pharmacies in Lao PDR, as in other impoverished countries, are highly criticized for dispensing poor quality or even fake medicines, for utilizing staff who have little or no qualifications, for administering truncated sequences of medicines, or for prescribing entirely wrong medicines, no data exist for how often villagers utilize private pharmacies, for what purposes and what the appreciative outcomes of these actions are. Despite major procedural flaws and possibly even dangerous practices, data for this project suggest that private pharmacies in Lao PDR might be functioning as front-line health care providers that offer essential early-stage health interventions and meaningfully reduce morbidity and mortality in villages.

Out of Country Health Services

By far the most expensive form of health care reported by villagers who participated in this study was health services received from tertiary hospitals, primarily hospitals in Thailand. Villagers in this study universally agreed that hospitals in Thailand offer the best health care available in the area. According to villagers, hospitals in Thailand are well stocked, they have knowledgeable staff, and they are clean and

friendly to villagers who can afford them. A surprisingly large number of villagers who participated in this study received treatment for a complex

Table 4: Reported Costs of Medical Care Obtained Outside of Lao PDR (Tertiary Health Care)

Health Problem	Reported Cost
Abdominal surgery in Thailand	US\$500
Tracheotomy in Thailand	US\$2,000
Anticipated cost to reverse above tracheotomy in Thailand	US\$500
Medicines and treatment for a blind man in Thailand who developed an eye infection	US\$300
Bowel surgery performed in Thailand	US\$800
Cost of heart surgery for 2-year-old child with a heart defect. Surgery to be performed in USA	Free, including transportation to USA. The child travels without a family member.

health problem from a hospital in Thailand, always at an exorbitant price. In every instance, villagers had help paying for the treatment from a wealthy relative, often a relative living and working overseas. While health services provided by hospitals in Thailand are highly regarded by Lao villagers who participated in this study, this type of health care is utterly unavailable to villagers who do not have support from wealthy relatives. In nearly every case, villagers in this study reported paying extraordinarily high costs for health services received at tertiary health facilities.

Traditional Medicines

Table 5 illustrates the costs villagers who participated in this study reported paying for traditional medicines and healers in Lao PDR. While many traditional medicines and healers function within the economy of the village, data gathered from this project

indicate that Lao villagers nearly always pay for traditional medicines and healers, and that the costs associated with these types of treatments are sometimes significant. Sometimes these treatments are more expensive than treatments that would be available at public health care facilities. Notably, traditional medicine people who live within the village and prepare traditional medicines or ceremonies for fellow villagers usually charge very small sums of money for their services and sometimes accept payment in

Table 5: Reported Costs of Various Traditional Medicines and Healers

Health Problem	Reported Cost
Spirit Caller for child with Down Syndrome	100,000 Kip / US\$10 500,000 Kip / US\$50*
Traditional medicines for child with Down Syndrome	100,000 Kip / US\$10 plus a chicken
Cream purchased from a walking medicine seller to make a woman's skin pale	40,000 Kip / US\$4
Medicines from a walking medicine seller to help a woman become pregnant	400,000 Kip / US\$40
Midwife	30,000 kip / US\$3 plus a sin**
Spirit Calling ceremony for child who is not growing well	50,000 Kip / US\$5 plus animal for sacrifice
Ceremony to heal a girl who suffered a debilitating seizure provided by a walking medicine seller from Cambodia	1.5 million kip / US\$150
Ceremony to protect a home from evil spirits	100,000 KIP / US\$10 plus 3 chickens

*Two children (15 years; 3 years) in Phatang village had Down Syndrome. These are costs quoted for each child at different times.

**Traditional Lao skirt.

kind. However, “walking medicine sellers,”²⁸ are reported to sell poor villagers medicines they claim will resolve a variety of health problem, often at an astonishingly high price. Clearly, walking medicine sellers have discovered that many Lao villagers are desperately looking for a solution to their health problems and will buy anything, even at a high price, as long as the seller comes to the village and convinces villagers of the usefulness of the product.

WHAT IS INCLUDED IN THE COST?

When villagers who participated in this project reported paying for health services, they told about the cost they recalled spending to receive treatment for a health problem. Rarely were villagers able to, or asked to, break down health spending costs into detailed categories, with the exception of transportation costs. Health spending costs reported by this project are an amalgamation of numerous costs that villagers recalled paying, and had calculated into their memories as *the cost of an illness*, which may include user fees, medicines and treatments received from multiple health centres, including traditional medicines and practices, transportation costs for themselves and probably multiple other family members, and possibly interest paid on loans incurred as a result of the illness.

²⁸ Walking medicine sellers are, according to Lao villagers, people who come from Thailand, Vietnam, Cambodia or China and walk through rural villages in Lao PDR selling cures to common and complex problems.

However, the long-term data collection strategy utilized was able to shed light on multiple factors that influence how much villagers report paying for treating a health problem from various health facilities in Lao PDR. As well, because I helped numerous villagers access health services for the treatment of simple and complex health problems, I was also able to experience from close observation what poor villagers experience when they are faced with the cost of health services in Lao PDR.

This section offers a discussion of the factors that contribute to the cumulative cost of health care in Lao PDR. The discussion is highlighted with narratives drawn from data collected. Through this discussion the complexity of paying for health care in rural Lao PDR is illustrated.

How Will I get There? The Cost of Transportation

The cost of transportation to and from health facilities in Lao PDR is a major barrier for poor villagers. While some villagers might be able to afford the official fees required by public health care facilities in Lao PDR, many are unable to afford the transportation to get there. Fuel is very expensive for Lao villagers. Poor Lao villagers, many of whom live on less than US\$2 per day, pay world-market prices for the gasoline used to transport them from their village to a health centre.

Table 6 illustrates transportation costs reported by villagers who participated in this study. The cost of transportation to a health centre is often many times more than the cost of the treatment from a public health care centre, especially if the treatment is sought from a village health centre (See Table 1). The cost of transportation is a major consideration for villagers who require health services and must decide what course of action is most practical for their family. The cost of getting to a health centre caused many villagers who participated in this study to choose to take medicines from a private drug dispenser or other locally available options, even if the cost of such options was more than the would-be user fees charged by the public health care facility.

Table 6: Reported Costs of Transportation to a Health Centre

Health Problem	Reported Cost
Ambulance to Vientiane for girl who swallowed poison	700,000 Kip / US\$70
<i>Tuk tuk</i> to take a woman in labour from Somsavat village to Vang Vein hospital	150,000 Kip / US\$15
Public transportation one-way to Vientiane from Phatang village	60,000 Kip / US\$6
Transportation by <i>tuk tuk</i> (private) one-way to Marie Theresa Hospital from Phatang village (approx 100 km)	150,00 Kip / US\$15
Public <i>tuk tuk</i> transportation one-way to Vang Vieng Hospital from Phatang village	16,000 Kip / US\$1.60
Amount paid by a family to a person passing by a serious motorcycle accident who took a man to hospital	100,000 Kip / US\$10
Private <i>tuk tuk</i> to take a man with serious mental health disorder from Phatang to psychiatric hospital in Vientiane	200,000Kip / US\$20*
Transportation one-way from Keokuang village to Phatang village vlinic	3 hours' walking

*Service was provided as a courtesy by a fellow villager who owns a *tuk tuk*.

While the cost of transportation to a health facility is a major barrier for poor villagers who participated in this study, the problem of securing transportation to a health facility exacerbates the problem. Many villages in Lao PDR are geographically cut off from main roads and are completely inaccessible by motorized vehicle for weeks at a time during the rainy season. As well, securing transportation at night is a problem for rural villagers. Low-cost motorcycles, which are the main form of transportation in Lao PDR, have dull headlights, and the roads connecting rural villages to larger centres with health facilities are treacherous and often mud-filled or riddled with potholes. Many people who contributed to this study reported having an aversion to travelling at night due to fears of rebels who live in remote forested areas of Lao PDR and are reported to sometimes attack villages and roads in the night. In addition, transportation drivers might refuse to take a sick person to a health facility in their vehicle if it is believed that the sick person might die along the way and release a malevolent spirit onto the driver, who might suffer untold negative consequences for years to come.

An example of the complicated nature of garnering transportation to a health centre happened late one night in Phatang village. We had already gone to bed when a woman knocked at our door. I came down from our sleeping loft to discover the woman holding her teenage daughter, who was doubled over from pain. I led the woman and her daughter into our house and gave the girl a mat to lie on. The mother reported that her daughter had suddenly begun having severe cramps in her lower right abdomen a few hours earlier. The woman said she just came from the village health centre, but the health

centre staff did not know what to do about the problem, and they sent her away. The woman came to our house out of desperation. She hoped that I would know what the problem was, and that I might have some medicine to help. I looked at the girl, but I did not know what to do either. I suggested the woman take her daughter immediately to a district hospital 18 kilometres away, and I offered her the use of my motorcycle and money to pay for the treatment. The woman refused to go. She said that she did not know how to drive a motorcycle and that she could not ask anyone to help her because it was too dangerous. I also knew that I could not make the trip at night, even if I knew how to drive the motorcycle, as it would be very dangerous for me too. In the end the woman returned to her home with her daughter to wait out the night.

On another day, a man, named Yai and his wife came to see me at my house. A few weeks earlier Yai had nearly died in a terrible motorcycle accident. At my house Yai showed me his shaved head and his face crisscrossed with stitches. He and his wife were concerned about the stitches because some of them had become red and painful. They said that they had gone to the clinic but that they were unhappy with the treatment they received. As I showed Yai and his wife how to clean the stitches and apply antibiotic ointment that I had brought from Canada, they told me their story. After the motorcycle accident, Yai lay on the road, bleeding and seriously injured. Several motorists passed by, but all of them refused to take him to the hospital because it seemed clear that he would die. None of them wanted a dead man and his wandering spirit in their vehicle. One passing motorist, however, took pity on the dying man and took him to the hospital.

After taking Yai to the hospital, the motorist went to the Yai's family and demanded a payment of US\$10 for his services and the risk he took. As Yai and his wife told me this story, they shook their heads at the outrageous charge, but they still agreed that the passing motorist had taken a significant risk for a stranger.

Can it Wait a Little Longer? Delayed Health Seeking in Lao PDR

Delayed health seeking is major contributor to the high cost of health care in Lao PDR. There are many reasons why villagers who participated in this study delayed seeking help for a health problem from a public health facility at the onset or near the onset of a health problem. While cost is a central factor that causes villagers to delay seeking early-stage help for a health problem, other issues such as hope, lack of awareness and confusion exacerbate the problem.

Lao villagers who participated in this study often delayed seeking help for an early-stage health problem because they hoped that the problem might get better on its own. The best-case scenario for any health problem is that the problem will resolve on its own with minimal cost and energy expended by the family or individual. If families do not have to spend even a small amount of money; if they do not have to take the time to accompany a person who is not yet very sick to the hospital; if they do not have to submit themselves to a foreign clinic that they do not understand well; or if they can avoid the offensive treatment poor people are sometimes subjected to at public health care facilities in Lao

PDR, then they would rather stay at home, sleep and see if the problem resolves on its own. Throughout data collection for this project, many villagers reported that their first response to an illness episode is to go to sleep for a few days to see if the problem might resolve.

As well, poor Lao villagers who participated in this study often did not seek help for a health problem from a public health care facility because they were unaware that the problem might be solved at the health facility or because the cultural history of their village held different traditions for how certain health problems are solved. Data collection for this project found many villagers, including a boy who was tongue-tied, a girl who suffered epileptic episodes, people with broken bones, people with mental health disorders, and a deaf child, who never sought help for their problem from a public health care facility and were surprised to hear that help for their problem might be available there.

Regardless, delayed health seeking sometimes results in a health problem that might have been easily and inexpensively resolved in the early stages but over time erupts into a major health problem that becomes prohibitively expensive and requires specialized services from health facilities that are far away. The resulting complicated and expensive treatment regimen is often difficult or impossible for poor villagers to navigate and results in high rates of morbidity and mortality. In Phatang, many villagers simply live with their health problems because they are unable to access help for the problem from a

public health care facility, either due to cost, cultural or knowledge barriers, or because of complex systems that are insurmountable for poor villagers.

A tragic example of the consequences of delayed health seeking is a man named Saitong, who was cutting corn in his field when his knife hit his leg and cut it badly. Saitong hoped that if he went home and rested, his leg might heal on its own. After a few days, his leg did not heal and was very painful, so he consulted the local bone healer, who is well known to be very successful at treating broken or hurt bones. The traditional healer tried all of his medicines, but Saitong's leg only became more painful. After some time, Saitong went to the village health centre, where he was given some medicines for his painful leg. He took the medicines but they did not work. The problem became so bad that Saitong gathered what money he had and borrowed some money from his neighbours so that he could travel to Vientiane, where he sought help for his problem. At the hospital, doctors told Saitong that his leg was badly infected and that it needed to be amputated. The doctors also told him that the surgery would cost US\$800, and that if he did not raise the money he would die. Saitong went back to his village, sold his land and borrowed more money from his neighbours. Once he had the money, he returned to the hospital in Vientiane, where his leg was amputated. Saitong is currently a landless peasant who hobbles around on crutches that he bought from a local non-governmental organization (NGO) for US\$6. His wife sells handicrafts and her labour so that they can survive. They have two sons, one of whom lives with them, and they struggle to send him to school. The other child was sent to live with relatives who could better support

him. Saitong also has a prosthetic leg that was provided free to him by an NGO, but the prosthetic is uncomfortable, and he cannot afford to return to Vientiane to have it properly fitted. Later, while I was collecting other data for this project in Vientiane, I was informed that amputations are provided free of charge in Lao PDR by a specialized NGO.

The outcome for Saitong might have been different had a number of circumstances transpired differently. Had he known that a serious cut from a dirty knife has the potential to cause severe infection, the outcome might have been different. Had he lived in a place where the culturally accepted way to deal with a serious cut is to go to a health centre and have the wound cleaned, possibly get stitches and perhaps some kind of antibiotic, the outcome might also have been different. Had the doctors at the village health centre had the training to recognize that the magnitude of Saitong's infection was beyond the curative abilities of their medicines and referred him to appropriate treatment sooner, the outcome might have been different. Finally, had Saitong lived someplace where the health system was less complex and where it would be impossible for a poor man to be told to raise US\$800 or choose to die, the outcome might also have been different.

What about the Farm? The Indirect Costs of Health Care in Lao PDR

The indirect costs of health care are important barriers to health in Lao PDR. Indirect costs are also difficult to substantiate in monetary terms, and perhaps especially so in a

subsistence economy. However, the micro and subsistence economy in which most poor Lao villagers exist makes the indirect cost of health care in Lao PDR a hidden catastrophe. While it is possible to track user fees, transportation costs and the direct out-of-pocket expenses villagers report paying for health services, the indirect cost of health services creates barriers equivalent to or even greater than direct costs, but is difficult to demonstrate. In Lao PDR, the indirect cost of health care can result in a family that misses planting or harvesting a crop and faces possible hunger; or a family that must rely on children to carry out subsistence activities while the breadwinner is away; or a family that must deal with the loss of essential income because the earner loses a job or has to take time away from paid employment. The ripple effect of the indirect costs of health care is increased morbidity and mortality in families that become weakened by hunger, children who are uneducated and more susceptible to illness, and families who have even less income to spend on health care for other family members who might also become ill.

The indirect cost of health care includes lost wages, lost productivity or opportunities that result in immediate or future loss of income or resources. These indirect costs might include time away from the household for multiple family members, and the resulting lost household labour. In Lao PDR, at least one family member, and often two or more, always accompanies a sick person to a hospital or clinic. The combined indirect costs of sending healthy family members to accompany a sick family member, for days or weeks at a time, and compensating for their absence is an important factor that families consider

when they decide whether they can afford to send a sick family member to a health facility.

Data from this project indicate that the ability of families to absorb the indirect costs of health care ebbs and flows with the seasons of rice planting and harvesting, and how much labour the family requires at any given time to ensure the immediate and future survival of all family members. As well, families calculate the net cost of an illness, including indirect costs, against immediate and future gains and losses that might result from seeking a cure to the illness. If the person who becomes ill is a non-productive family member, such as a child, the family might not be willing to absorb as many costs that could compromise the entire family, as they would if the sick person were a key breadwinner that the entire family depends on for survival. Other indirect costs have to do with the composition of the family, and whether there are enough productive adults available to send some to the hospital while still leaving others at home to care for dependent family members and carry on with subsistence livelihood.

Other indirect costs are the unusual costs families absorb while they stay at a distant hospital for extended periods of time. Families who travelled to a hospital as part of this study, travelled loaded with supplies to support their stay. They brought sleeping mats, blankets, cooking pots, clothing, soap, and as much rice as they could. If a family required more food, or if they wanted to supplement their rice with a bit of fish or chicken, then these things, which families would normally gather from their farms,

needed to be purchased at the market. Families also needed to purchase fuel for cooking while they stayed at a hospital. In some cases, these indirect costs are the tipping point for families that make a trip to a health facility impossible.

The costs villagers who participated in this study reported paying for health services do not include indirect costs. While villagers did not calculate a dollar amount for indirect costs associated with receiving treatment from a public health care facility, many villagers spoke about the indirect cost of health care and the barrier these costs create for them.

Unofficial Fees

In Lao PDR unofficial fees charged for health services create major barriers to health care for poor villagers. While villagers who participated in this study reported the cumulative cost they paid for health services, the exact breakdown of how much of those costs were unofficial fees is difficult to determine. No villager who informed this project indicated that he or she knew the cost of unofficial fees paid for health services, or the official cost of the health services received.

Unofficial fees are fees charged by health workers or by health care facilities for services rendered. The omnipresent practice of public health care sector workers in Lao PDR

charging fees over and above official costs for health services is well documented in the literature. In Lao PDR, unofficial fees for public health care services are illegal, yet the practice is pervasive (Khun, 2008; Soeters, 2003; Van Damme, 2004). Moreover, unofficial fees for all kinds of services in Lao PDR are a way of life, and poor villagers are not impervious to them. During data collection for this project, villagers spoke about paying unofficial fees to public officials for multiple purposes, including, for example, permission to continue farming upland fields, to enter university, to cover traffic tickets, to get out of jail, to obtain a visa, or to improve a failing grade at school.

As indicated by Table 2, poor villagers who participated in this study often paid extraordinary unofficial fees for health services, and this was especially true when they accessed health services from secondary and tertiary health care facilities. What is notable is that several villagers reported receiving a quote for health services from a public health care facility, but these fees dropped significantly when I accompanied the villager to the hospital and paid for the services myself. Ironically, even though I was far more able to absorb extraordinary fees for health services, I was only ever charged official fees²⁹ for health services. In some cases, the health care provider offered the service at no cost. My experience with accompanying poor villagers to various public health care facilities throughout Lao PDR is that official fees for public health care in Lao PDR are typically very low. User fees can range from a few dollars for a consultation and

²⁹ An assumption that I make, and which is reinforced by the receipts I received, is that the costs that I paid are the official cost of health services in Lao PDR, and that I was not granted any further reduction in costs.

medicines from the village health centre up to about US\$60 for a complex surgery and multiple other procedures from a secondary hospital. These costs are in sharp contrast with the very high costs poor villagers reported paying for public health care.

To illustrate, a family came to our house one day to ask if I might help their seven-year-old child, named Koa, who was growing poorly and had a large, distended stomach. The family had recently taken the child to a district hospital, where they were told to return in two weeks with US\$200, which would pay for surgery to help the child. The family is very poor, living far into the mountains in a remote village. Because they could not afford the fees requested by the hospital, they walked to Phatang village because they had heard that a foreign woman who lived there might help them. After consulting with colleagues, I was told that Koa should be taken to a pediatrician at one of the provincial hospitals in Lao PDR. Koa was taken to the provincial hospital, where he was diagnosed with a rare genetic blood disorder called thalassemia, which causes blood to be unable to carry oxygen to vital organs in the body. Without regular blood transfusions and another procedure called iron-chelating therapy, to remove excess iron in the blood that results from regular blood transfusions, children with thalassemia die.

Koa developed an enlarged spleen as a result of his condition. At the hospital he underwent surgery to remove his spleen. He was also given a blood transfusion.

Altogether, I paid approximately US\$60 for all of the hospital bills related to treatments

for Koa. Notably, I also paid approximately another US\$100 to transport the family to and from the hospital, and also to pay for food during their stay.

While the surgery might make the child more comfortable for a time, it will not save his life. When data for this project were collected in 2007, blood transfusions were only available at provincial and central hospitals in Lao PDR, and they were expensive (approximately US\$25 per blood transfusion). Logistically, this family could never manage to travel to a main hospital even once a month for a blood transfusion. The cost for blood transfusions, and also for transportation to and from the hospital, is unimaginatively expensive for this family. In any case, chelation therapy is unavailable in Lao PDR. The only children in Lao PDR with thalasemia who survive are the very fortunate ones whose families can afford to take them to Thailand for treatment. It is unclear what health services the family would have received had they paid US\$200 to the health workers at the district hospital.

Exemptions From User Fees for the Very Poor

The villages where data for this project were collected were part of a foreign-managed and funded health development project that aimed to improve capacity at health centres and also improve equality in access to health services. In order to improve equality, the health development project issued every household in the district a health card that identified each family as belonging to a health centre. Most families were issued yellow

health cards, while some families were identified as very poor and were to be issued pink health cards that would identify them as eligible for free health services from district public health care facilities. Eligibility for pink health cards—and thus free health services—was determined through a village committee that made eligibility decisions based on local circumstances.

During data collection for this project, an attempt was made to find families who had been issued pink health cards, and ask them about their use of health services. I wondered if families who had access to free health services had higher rates of health care utilization. In three villages, only one family had a pink health card (11 were reported to have been issued), and this family did not understand, or believe, that the health card would entitle them to free health care. The family was very poor and had never used the health centre. All of the other pink health cards were issued, but it is unclear to whom. Interviews with families who were listed as eligible for pink health cards revealed that these families were never told they were eligible for free health services. Remarkably, all of the families thought it was impossible that they could be eligible for free health care, and most thought it was irrelevant because they could not afford transportation and other costs related to getting to the health centre. Many families seemed uninterested in the services offered by health centers or hospitals and how these services might help their family.

Other interviews conducted for this project revealed that respondents thought that some people might be eligible for reduced (no one mentioned free) health services, but these people were not necessarily the very poor. Government officials, police officers, military personnel, health workers and monks were all mentioned as people who would receive reduced fees for health services at public health care facilities. Poor people might be eligible for reduced fees for health services (informants often mentioned that certain villagers might get a 50% discount) but only if they were legitimately poor, not poor due to laziness or addictions to drugs or alcohol. A number of poor villagers who participated in this study reported receiving reduced fees for health services when they presented a poverty certificate signed by their village leader to staff at a health facility. Sadly, the costs for public health care reported by poor villagers, who said they were charged half the cost of the treatment, were still extraordinarily high, and clearly much higher than the official cost of the health service they received. No villager who participated in this study was aware of the pink card equity project operated by the health development project that was managing health services in the district. Villagers agreed unanimously that free health service for poor people in Lao PDR is impossible.

The Cost of Health Care for the Vulnerable

Data from this project indicate that very poor, ethnic minority, or disabled villagers in Lao PDR might pay higher fees for health services than Lao people who are wealthier or have a higher social status. This finding is in line with Paphassarang's (2002) study that

reports that exemptions from user fees in Lao PDR are arbitrary, with government officials and hospital staff exempted from fees for health services from public health care facilities and people who are very poor paying high fees for health services. Observations garnered from this project reveal that people who are very poor, belong to an ethnic minority, or are disabled are poorly tolerated at all levels of the public health care system. Data from this project indicate that no exemptions exist within the system to help very vulnerable populations access health services, and that these people are sometimes unwelcome in public health care facilities. Multiple reports from data collected for this project reveal that numerous public health care facilities in Lao PDR withheld necessary health services to very poor or ethnic minority villagers. The unwillingness of health facilities to offer health services to these people appears to be systemic across the entire health system, despite programs that aim to provide equitable access to vulnerable populations³⁰. Very poor villagers, ethnic minorities, or people who were disabled reported paying unreasonable amounts of money for health care given to them at public health care facilities. Many times public health care services were withheld from these people, even if the withholding of such services could result in preventable death or disability.

Somsavat village, where data for this project were collected, is comprised of villagers relocated from three remote mountainous villages. Most of the villagers in Somsavat

³⁰ For example, the health care equity program that attempted to provide free public health care to poor villagers by issuing pink health care cards to poor families. This program is discussed elsewhere in this thesis.

village are ethnic minorities, and many are landless. While many families were relocated as long ago as 20 years, poverty in Somsavat village is ubiquitous. During data collection at this village, one woman spoke about her 12-year-old son who became very ill from drinking water from the river. The woman is a single mother, and she reports that she cried and cried because she did not know what she could do for her son. Out of desperation she took her son to a public hospital, where she was given a “reduced fee” due to her poverty.³¹ The boy stayed in the hospital for one week. The mother paid US\$400³² for treatment for her son, who recovered well. The woman reports that the cost she paid was half price. When asked how she could afford such a high cost, the woman reported that she was very lucky because her older daughter had recently married, so she had money from the wedding. She also borrowed money from relatives.

As data for this project progressed, numerous people suffering from mental illness were identified as informants. In every case, families who cared for a person with a mental illness reported that they could never take their family member to a public health care facility, not even the village health centre, because public health care facilities would not provide services to people who are “crazy”. One family in Phatang village reported that if their “crazy” family member gets a cold, they must go to the village pharmacy and get medicines for him. Another family reported that their daughter, who suffered for many

³¹ In order to be given the reduced fee, she was required to provide a “poverty certificate” from her village leader and also request approval from hospital staff.

³² It is not clear how much of this amount was for user fees, medicines, transportation or other costs. What is clear is that the costs are many times beyond any reasonable amount for using a public health care facility in Lao PDR.

years from “wandering around the village” was identified as having a problem with her mind by a group of interns who were previously stationed at the village health centre. This family was grateful to these interns who told them about medicines³³ they could purchase from Vientiane that would help their daughter. The family travels to Vientiane once a month, where they purchase medicines from a private pharmacy. They report that the medicines help their daughter a lot. The daughter is not followed by a medical professional and the medicines cost US\$10 per month. It is very difficult for the family to manage this ongoing cost.

A Word about Unofficial Fees

Taken from a human rights standpoint, unofficial fees charged to poor villagers are unethical. However, even poor villagers in Lao PDR understand that the health professionals who work in public health care facilities could never live off the wages paid to them by the government, and that users of health services must compensate by paying fees over and above official fees. In 2007, doctors in Lao PDR were paid approximately US\$50 per month, roughly 15% of what a rural family would need to survive per month³⁴. In Lao PDR, unofficial user fees are not corruption *per se* but rather a survival strategy employed by nearly every public servant in the country. That health

³³ During this interview, the family showed me the medicines, which were hung in a plastic bag on the wall of the house in full reach of the children playing around the house. The medicines were Fluanxol, which is an anti-psychotic drug, and Diazepam, which is a sedation medication.

³⁴ Based on estimates and informal data collected from this project.

professionals in Lao PDR desire a comfortable life and feel entitled to compensation for their skills and knowledge is not surprising. Everywhere in the world health professionals are acknowledged through their pay cheques. The corruption about rampant user fees is not the fees themselves, but the arbitrary manner in which they are applied, the completely unregulated nature of these fees, and the inequality they create.

To illustrate, a young woman in Phatang village was pregnant with her second child. Every time I saw this woman I asked when the baby was due, and every time she told me that the child was due in August 2007. I found this unbelievable because by May 2007, she seemed huge with the pregnancy. I asked her many questions about whether she had been to the health centre to have the pregnancy checked, and if the baby moved and so on. Finally, I asked if she would like to go for an ultrasound to check if she was having twins. She gratefully took me up on the offer. I accompanied her to the hospital, where I gave her 5,000 Kip (US\$5) to pay for the ultrasound, which was more money than the official cost of test. While I was sitting in the waiting area, a nurse came to get me and asked if I would like to come and see the ultrasound result. I agreed and went into the room with the woman and the doctor. After the test, the woman paid the doctor and he diligently gave her back the change. When he returned the change to her, she looked at me and asked if she could give him the rest of the money. She clearly wanted to thank him for administering the test and assuring her that her baby was fine. When she gave him the remainder of the money she clasped her hands, bowed to the doctor and offered him a heartfelt thank-you.

No Credit Here

Lack of credit is a major problem for villagers who would like to access public health care in Lao PDR, but who do not have quick access to money—either large or small amounts. In Lao PDR, public health care facilities require that users pay up front for public health care, which poses major problems for poor, or even not-so-poor families who do not have accumulated savings to draw from quickly. Because an illness episode usually emerges unexpectedly, with little or no time to liquidate assets or arrange for credit, poor families who urgently need public health care are often caught off guard and unable to pay upfront fees.

Numerous villagers who participated in this study stated that they prefer to use private pharmacies or traditional healers for illness episodes because these services extend credit to poor families, they offer reduced or even free services in some instances, and they offer partial services based on what families can afford. Sometimes these health services also accept in-kind payments. In Lao PDR, the cost of health services, and how this influences utilization rates for public, traditional and private health care, is a complex problem that is made even more complex by the pool of intended users who do not have savings, yet also do not have access to credit. Data from this project indicate that poor utilization rates of public health care in Lao PDR is at least partially a reflection of families who are excluded from this kind of health care because they cannot pay all of the required fees up front and in cash without any time to arrange it.

While lack of credit is certainly a barrier to public health care utilization for poor Lao villagers, it is not clear whether improved credit is the solution. While poor people might make better use of public health care facilities if they had options to increase their debt, it is not clear what the consequences of this debt would be. Micro-credit schemes elsewhere have demonstrated that poor villagers can absorb small amounts of debt if it is used to increase economic productivity. However, micro-credit schemes that would help villagers pay for a one-time health problem, often at costs that are much higher than typical micro-credit loans, and would at best return a person to previous economic productivity, might not be a viable health-financing option for poor villagers.

SUMMARY

Data from this project indicate that the economic barrier to health care in Lao PDR is the *cumulative cost* of finding a solution to a health problem. The catastrophic cost of health care derives from the combined cost of transportation, delayed health seeking, lack of knowledge about where to find a solution to a health problem, unofficial fees, indirect costs, upfront payment policies, unknown costs or fear of what a service might cost, and the exorbitant costs of having to travel out of country to solve a health problem. When a poor villager is faced with a health problem, the economic barrier to seeking help cannot be explained in simple causal terms. The economic barrier to health seeking and

health care utilization in Lao PDR is a complex problem requiring a nuanced and multifaceted understanding of the problem.

The impoverished health system in Lao PDR has necessarily generated alternative funding strategies, most notably unofficial fees, to ensure the survival of the system and the people who work within it. The completely unregulated nature of this unofficial system creates major inequalities in health care access for the poorest people in the country. Data from this project indicate that people who are very poor or vulnerable, including people who belong to ethnic minorities or are disabled, are poorly tolerated at all levels of the public health care system. These people are sometimes required to pay more for public health care than are people from more valued social classes. Moreover, these people often spend large sums of money searching for a solution to a health problem from multiple health care providers, and from both the private and public sectors. This searching and detouring, which can go on for months or years, often results in catastrophic consequences for families who become further impoverished as a result of health seeking.

The cost of health care is a major worry for poor villagers. Poor people who participated in this study did not have cash in hand to pay up front for services rendered, and they had no way of knowing how much money they might need if they sought help for an illness episode from a public health care facility. The more complex the health problem, and especially if the problem required services from a secondary or tertiary health care

facility, the more fearful villagers became about the potential cost of public health care. While available cash is the immediate problem that poor villagers face when they confront the health system in Lao PDR, the root problem stems from public health care policy that relies on poor people to sustain the health system.

The cost of health care often pushes people to seek a solution for their illness from health care providers that are cheaper, more easily accessible, accept delayed payment or payment in kind, or offer partial sequences of medicine. Alternative health care options are often more predictable and therefore less daunting for poor villagers, who could easily tip into catastrophic poverty if the cost of a health care service becomes unmanageable. The economic motivations that cause poor villagers to search for solutions for illness episodes from alternative health care providers need to be understood through the complex landscape that villagers face when they pay for *all the costs* associated with health care utilization.

In this study, the private pharmacy was a particularly well-regarded health-seeking option that poor villagers commonly used when they first confronted an illness episode. The impact that the village pharmacy has on health outcomes and health seeking amongst poor people is highly under-recognized in health care reform in Lao PDR. Despite widely acknowledged concerns about the quality and safety of health care delivered by private pharmacies, little is known about the impact these pharmacies have on village health or how these pharmacies might be bolstered to better serve villagers. What is clear

from this study, however, is that the village pharmacy has acquired a significant niche of the health care delivery sector in Lao PDR.

Hope is where this chapter leaves off. Through all the searching and seeking, despite repeated failed or partial results, villagers who participated in this study always hoped that a solution to their health problem might be discovered. No matter how poor, hungry, undereducated, desperate or ill people are, they always possess the power of hope.

Chapter five moves the discussion of health care utilization in Lao PDR beyond the issue of cost, to the lived experience of searching for a solution to a health problem. In Lao PDR, searching for a solution to a health problem is a complex process that is highly influenced by cultural ways-of-being. Culture influences the types of health care choices villagers make, for what types of illness or disability, and at what point during an episode. Culture also frames how villagers narrate their illness and disability experiences, and the types of hope they take from different forms of health seeking.

CHAPTER FIVE: SEARCHING FOR HEALTH

THE CULTURAL CONTEXT OF ILLNESS AND DISABILITY IN LAO PDR

This chapter discusses villagers' experiences of searching for health. In Lao PDR, the types of treatments villagers seek for a health problem, when they seek it, and where are influenced by the cultural context of the village. Like every culture in the world, Lao villagers have established customs through which pain and suffering are understood and narrated. This chapter begins by outlining the cultural context in which illness and disability were understood by the villagers who participated in this study and how these perceptions influenced the types of treatments villagers sought for health problems. The illness and disability narratives that emerged from health seeking are also discussed. The chapter ends with a discussion of how hope influenced the searching and narrating of illness experiences. The chapter draws from narratives offered by villagers who informed this project.

INTRODUCTION

The village of Phatang is the lived reality of the theories of development. Books that describe, ponder, theorize or try to solve the problems of poverty, high maternal mortality, stunted children or glaring global inequalities are talking about places like

Phatang village. Phatang village is the three-dimensional form that lifts off the page when the problems of the poorest people in the world are discussed.

Phatang village is also an exemplar of global health innovation. A new health centre constructed at the edge of the village is the product of the latest knowledge and practice thought to best address glaring health inequalities in the world. A morning spent sitting on the veranda of this health centre might bear witness to any number of issues often discussed within the corridors of some of the largest and most powerful health institutions. The Phatang Health Centre is the place where population health unfolds, where a small but important number of tiny babies take their first breath of village air, and where strategies for treating diarrhea and malaria, deliberated in distant offices, are carried out.

The village of Phatang is also implicated in the cultural clash between Western medicine and traditional village health and illness practices. At one end of the spectrum is Western medicine with all its cultural ways-of-being. At the other end is a village that embodies hundreds of years of established cultural practice. Between these two is the Phatang Health Centre, the meeting place of cultures. Into the health centre walk Lao villagers, who are both Buddhist and animist, and from the health centre they receive treatments and medicines that are developed from beliefs that fundamentally clash with the ways villagers understand health and illness.

Amazingly, this clash of cultures is quiet, possibly even harmonious. A visit to the village health centre would not reveal crowds of angry villagers resisting indoctrination of a foreign philosophy. While the clash is very real, it is also theoretical. In the village, the cultural disconnect between the health centre and the village is like a foiled science experiment that discovers the immiscibility of oil and water, the stubborn determination of one substance to simply lie on top of the other. The health centre in Phatang village does not exist in tension with the village. Rather, it exists beside it, and villagers take from it what makes sense to them. They also take the things that they perceive might help them.

More so, the Phatang Health Centre is a positive development in the village. Villagers in Phatang are better off because they live within close walking distance of this health centre, even if the centre dispenses medicines and treatments that function by strange means, and even if the health centre is underutilized from a statistical point of view. Phatang villagers are by far the most likely users of the Phatang Health Centre, with health centre utilization inversely correlated to the distance villagers from elsewhere must travel to get there. If a health centre were built at the edge of every little village in Lao PDR, utilization in the country as a whole would increase, as would overall health, despite cultural disconnect, simply because villagers would have easy access to it.

Lao villagers are not so culturally bound that they would rather live with pain and suffering than submit themselves to a foreign health paradigm. Poor utilization of health

services in Lao PDR is not the result of villagers who purposely stay away from health centres because they disagree in principle with the philosophical underpinnings that guide the Western-style medicines offered there. Resistance to Western medicine is not a luxury available to Lao villagers. In their desperate search to be healthy, Lao villagers take what they can get.

CULTURE, ILLNESS AND DISABILITY IN LAO PDR

Like many traditional cultures, Lao people understand the circumstances of their day-to-day lives to be highly influenced by forces external to their bodies. External forces are partly about how much luck a person has, or whether the person has acquired enough merit. External forces are also about spirits, both benevolent and rogue, that are understood to influence a person's life trajectory. Similarly, while good or bad behaviour is understood as something individuals can control, the way a person behaves can provoke outcomes that are beyond an individual's control.

Luck and Merit

In all areas of their lives, Lao villagers are cognizant of the importance of protecting good luck and acquiring merit. A Lao villager, for example, who harvests a bumper crop that was planted with new seeds might attribute the crop to the seeds, but he will also

understand that good luck is what brought the seeds his way and made them sprout in the first place. Attributing life's events to luck removes personal blame from events that are understood to be beyond an individual's control. While all cultures allow for luck to at least partly explain undesirable life experiences, the degree to which societies tolerate luck as an explanation for adverse events varies.

Western culture has a strong history of holding individuals accountable for creating success in their lives. Westerners value the courageous pioneers who overcame harsh conditions, tamed unwieldy land and built a good life through determination and effort. Many Westerners make a direct link between democracy, scientific development and strong economies and the hard work and personal sacrifices made by the ancestors of Western livelihood.

While Westerners value individual determination, health is an area in which even Westerners allow for luck to explain why some people in some circumstances are healthy, while others are not. Westerners understand that genes inside the body determine a person's potential for health, and that individuals are unavoidably bonded to the genes they inherit at birth. Bad-luck genes, however, do not get Westerners completely off the hook. In Western culture, a person born with a predisposition to an illness or disability is expected to do things (exercise, not smoke, eat healthy foods) that might circumvent the uprising of wayward genes.

Lao villagers allow for luck to explain significant portions of their lives. In Lao PDR, hard work and determination do not necessarily pay off with a gainful life. Lao villagers have worked hard, yet still suffered for hundreds of years. In Lao PDR, the ability to escape village poverty and live a healthy life has more to do with luck than with earning an honest day of pay. Lao villagers understand that they are poor and sick in a world that is filled with abundance, and that these circumstances are beyond their control. In Lao PDR, a good strategy to escape crushing poverty is to look for a lucky break. For example, in June 2007, 40 students graduated from the Phatang Secondary School. The only students from this graduating class who had any hope of continuing with their schooling or of garnering a job beyond subsistence farming were those lucky enough to have connections outside of Phatang village. In rural Lao villages, school achievement does not determine who will receive post-secondary training. It is connections and good luck that matter.

When Lao villagers encounter consecutive health or personal problems, they understand that bad luck might have caused these problems. In Lao PDR, a good way to resolve a problem with bad luck is to increase personal merit. An important way to increase personal merit is to spend time at a *wat*³⁵. In Lao culture it is common for families to send young boys to live at a *wat*, as it is understood that a young man and his family will benefit from the increased merit he acquires by living there. Other ways to tap into the benefits of increased merit include making donations to a *wat* or offering alms (donations

³⁵ Temple

of food or money) to monks who walk the streets at dawn with open baskets to collect what people have to offer. Although young girls do not usually live at a *wat*, women can acquire merit by sending their sons to a *wat* and by offering alms³⁶. Women can also seek advice from monks when they need it (Evans, 1999).

The importance of luck runs through Lao society regardless of economic or social status. While Lao villagers understand that they need luck to lift them out of village poverty and the resulting poor health, wealthy Lao people understand that it is luck that put them in their good position in the first place. In Lao PDR, luck is relative. Lao people, including highly educated doctors, lawyers and successful business people, who might already be considered lucky by Lao standards, are just as likely to seek merit as a resolution to their bad-luck health problem as are poor villagers.

Spirits

Lao people also understand that achieving good health is closely related to living harmoniously with the spirits that Lao people believe inhabit natural objects and humans. A good crop requires good seeds and hard work to maintain seedlings, but sacrifices to local spirits, especially at planting and harvesting times, are essential to the harvest. Lao people also understand that good health results when the 32 spirits (known as *khwan*), which are guardians over different parts of the body and mind, are kept in equilibrium. In

³⁶ Offering alms is primarily a woman's activity in Lao PDR and the main way that women can gain merit.

Lao PDR, people believe that poor health often results from spirits that are not in balance, are “wandering,” or are provoked. Many Lao ceremonies, in particular the *bacci* ceremony, which calls spirits back to a troubled person and makes sacrifices to appease these spirits, aim to restore a person’s good health.

In Phatang village, every person who suffered a major health problem had multiple spirit-calling ceremonies performed on his or her behalf in hopes that appeasing, rebalancing or returning spirits to the suffering person might solve the problem. Often these ceremonies were performed at great expense to the family and sometimes in tandem with other health practices. In many cases traditional spirit-calling practices were more costly to families than the would-be costs of public health care. After many years and many attempts to return spiritual balance to a suffering person, families in Phatang village sometimes reported “giving up” on a sick family member, whom they determined to be beyond hope and no longer worthy of valuable family resources.

An example of this comes from a 25-year-old woman who, her family reports, was eating chicken one day when she fell down. Her spirit escaped from her body and left her “half-dead.” She was 12 years old at the time. The incident caused the right side of her body to become paralyzed. After the accident, the family sold some jewellery and paid a healer from Cambodia US\$150 to conduct a ceremony that would call their daughter’s spirit back to her body. The treatment did not work. On another occasion, the family took their daughter to a specialized monk in Vientiane, who studies traditional medicines and also

tried, unsuccessfully, to return the girl to good health. On the day I met this family, 13 years after the accident, the family reported that they had given up trying to heal their daughter and resigned themselves to the fact that she would live the rest of her life with a missing spirit. After the incident, the girl withdrew from school, and her family reports that it is not possible for her to marry. When asked, the family said that they had never looked for treatment for their daughter from a public health care centre.

Another example comes from a baby who was born at the Phatang Health Centre. On the day this child was born, the grandmother, who was to attend the birth, had gone to work on the farm when the young mother went into labour. Not knowing what to do, and alone with an impending birth, the young mother and father sought help from the village health centre. A few hours later, the health centre staff delivered a healthy baby girl. A few days later, I visited the family. When I arrived at their house, I found the mother sleeping on a raised wooden bed with hot coals spread out under it on tin trays. The baby was tightly wrapped in a pink blanket, a hat on her head, sleeping peacefully under a mosquito net. Under the baby's head and tucked under a white pillow was a long knife, its sharp, rusty steel blade tucked protectively under the pillow, and the worn wooden handle poking out. In the room, which was already hot from the midday heat, a small fire cast smoke over and all around the sleeping baby and mother. The hot coals under the bed were to keep the mother warm, replace heat lost during childbirth, and protect her from postpartum hemorrhage. The smoke was to protect the mother and baby from harmful spirits, and the knife was intended to scare off any would-be spirit robbers that might try

to harm the baby. The mosquito net was to protect the baby from malaria. Both the mother and baby were to remain in this room for one month, after which a *bacci* ceremony would be held to acknowledge the arrival of the baby, and also name her.

SEEKING HEALTH

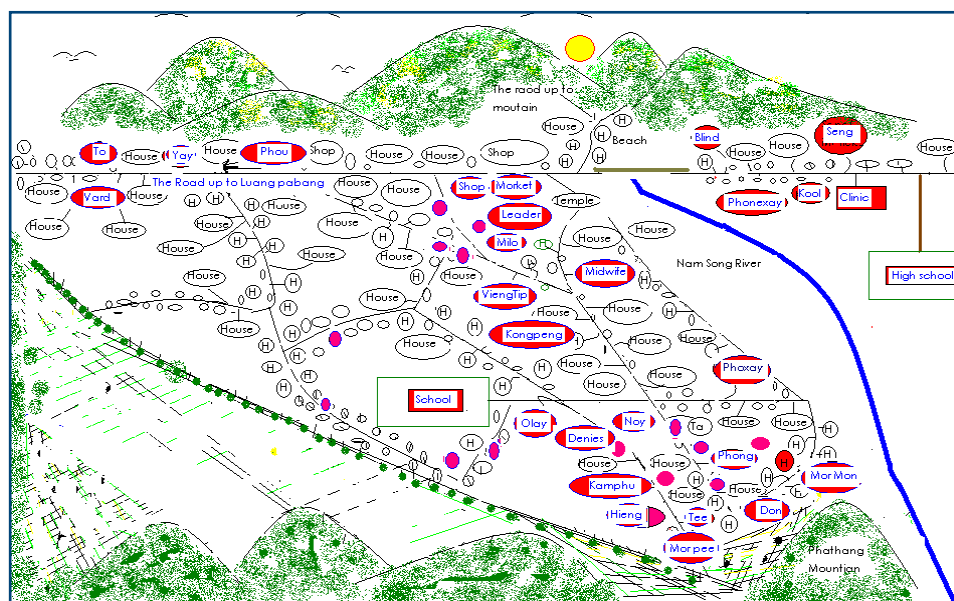
The types of treatments villagers who participated in this study sought, and the order they sought them out, depend on a number of entwined factors that were both cultural and practical. Villagers who participated in this study made decisions about how to manage an illness or disability depending on how they understood the problem, what they thought caused it, and how they thought it might be solved. Decisions villagers made were also influenced by stories that circulated around the village about the problem, what other villagers have done to solve similar problems, and where the problem had previously met with satisfactory outcomes. Villagers also weighed their choices for addressing a health problem based on ease of access; whether the option was within walking distance, how much time it would take, and how many family members would need to be spared to accompany the ill person. Priorities also come into play when families made choices about how to deal with a health problem. Families prioritized at the individual level by deciding who in the family would get treatment for a health problem and where the treatment would come from. Families also prioritized at a cultural level by choosing to address health problems through treatments that made sense to them. Hope was also a factor that impacted the types of treatments villagers sought when they become ill or

disabled. Often the efficacy of a treatment is less important than the good feelings—and especially the feelings of hope—that an ill person and his family receive from pursuing certain kinds of treatments.

Everywhere and Everything

Data for this project suggest that Lao villagers who participated in this study look *everywhere* and will do *anything* within their means to find a resolution to their health problem. If the health centre is within their means, either physically or financially, they will try it. A participatory map (Figure 2) developed for this project reveals startling numbers of villagers who suffer from chronic illness or disability. Of the 300 households in Phatang village, this project found 43 with chronically ill or disabled family members. Some of these households had multiple family members to care for. Many of these people suffered from problems that were either preventable or treatable, and most had not yet discovered a resolution to their problem. Many of these people told about their attempts to manage or cure their illness or disability as a long and complicated journey through multiple health systems. This journey frequently involved seeking help from public, private and traditional healers, often simultaneously, and always at great expense relative to available resources.

Figure 2: Participatory Map of Phatang Village



Note 2: Red indicates households that have members with a chronic illness or disability

While villagers might be willing to go anywhere or try anything to find a solution to their health problem, most villagers were limited by what was practical for their family. Even a distance of five kilometres creates a barrier to villagers whose only mode of transportation is their feet and occasionally a bicycle. For most poor and rural villagers in Lao PDR, the decision to hire a vehicle to take a family member to a clinic or hospital is a major decision that requires significant family resources. Such decisions are usually only taken in moments of desperation.

The close proximity of the Phatang Health Centre to Phatang village benefits nearby villagers, who have the option to visit the health centre, at minimal expense and effort, for

small problems before these problems erupt into large, complex and very expensive problems. Villagers who live far away do not have this luxury. Distant villagers who participated in this project often put off seeking help, or did not seek help at all, from a public health care centre until the problem became very complex. When distant villagers who participated in this study arrived at the Phatang Health Centre, their problems were often advanced and difficult for health centre staff, who had limited training, to successfully diagnose and treat.

While the cultural disconnect between the village and the health centre is difficult to bridge, the problem is exacerbated by the number of patients who return with inadequate or partial treatment to a complex problem. Because many villagers do not return to their village with stories of success about how their health problem was solved by a public health care centre, it is difficult to get village buy-in on the usefulness of the types of medicines and treatments offered at these facilities.

Data from this project indicate that when villagers from Phatang village become ill or disabled, they have at least ten local options available to them for how they might manage a health problem (Table 7).³⁷ While the treatment options listed in Table 7 appear as

³⁷ Interestingly, there is an eleventh health-seeking option available to villagers, although no villager spoke to me about this option. Upon returning to Canada, I had the opportunity to meet with a visiting doctor from Lao PDR. The doctor asked me about the “Village Health Volunteer” (VHV). I was told that every village in Lao PDR has a VHV. Because I had no knowledge about such a person, I contacted Phonexay, my interpreter in Lao PDR, and asked if he could inquire about the VHV for Phatang village, and how it was possible that we had not met this person. Phonexay went to Phatang village to investigate. He discovered that the VHV lives in Nadao village, which is on the way to Phatang village. In 2010 the VHV had held the post for 3 years. She has received training in the treatment and prevention of malaria and

separate activities, the lived village reality is that these options are intertwined, and many villagers who participated in this study engaged in multiple treatment options simultaneously, especially if the health problem was severe or ongoing. In some cases, villagers tried every option at least once, a long process that often left them very poor and still without a satisfactory outcome. In their desperation, villagers who could manage it sometimes traveled to larger health centres, or even to centres outside of Lao PDR, with the hope that they might find a solution to their health problem. While villagers often traveled to visit a Western-style health facility, they also traveled far to consult with private health care providers, including monks, shamans and other types of traditional healers.

One villager, for example, began having pain in her arm so she tried “everything” available near Phatang village, but nothing worked. When her pain became unbearable to the point that she could not move her arm, she went to the hospital in Vientiane, where doctors recommended that she go to Thailand for treatment. In Thailand, doctors told her that she would soon die, and they gave her medicine that made her hair fall out. She stayed in Thailand for seven days, but since she could not afford to continue the treatment, she returned to Lao PDR. In Lao PDR, she reports that she was “very lucky” because a doctor was visiting from Taiwan who knew how to conduct a surgery that

tuberculosis. Villagers could come to her house, or she might visit them at the Phatang Health Centre. She also worked in the hospital in Vang Vieng. She had a revolving drug kit that has medicines donated from overseas organizations. The medicines are good because “they are not produced in Lao PDR and they look very expensive.” No villager who connected with this study reported seeking help for a health problem from the VHV.

could help her. The woman underwent a mastectomy, which was provided free of charge. After the surgery, the Taiwanese doctor gave her a special stone, which she was instructed to tape to the nape of her neck. He told her the stone was traditional Chinese medicine, and that it would help restore her energy and keep the illness away. The Taiwanese doctor also told the woman that she would only live six more months, and that she should prepare her family. At the time of this interview, the woman had lived nine months past her surgery and reported feeling strong. She wore the stone around her neck every day. She was very insulted that doctors predicted that she would die.

Table 7: Health care Options in Phatang Village

Health Care Options in Phatang Village	
1.	Visit the private pharmacy that is located in the village.
2.	Visit the Phatang Health Centre .
3.	Visit the village midwife who, along with delivering babies, provides basic health information and will administer injections and IV drugs. She also grows some medicinal herbs in her garden.
4.	Visit a retired doctor who runs a private practice out of his home and also sells an assortment of Western and traditional medicines.
5.	Visit the moh mung (bone healer) who lives in Ban Somsinxay, one village away.
6.	Visit the mo chum who makes traditional medicines.
7.	Ask the moh phi , or spirit healer, to make an offering to the spirits for you.
8.	Spend some time (days or weeks) with the village monks , who can help people gain more merit, which may in turn help their bad-luck-related health problem.
9.	Buy medicines from any number of medicine peddlers who regularly walk through the village. These people are reported to come from Vietnam, China and Cambodia.
10.	Do nothing at all .

Saitong is another villager who looked everywhere and for anything that would help with his problem. At the age of 17, Saitong developed painful sores all over his body, which he did not know how to cure. The problem was acute and left him unable to work and ashamed of his appearance. When I met Saitong, he had lived with this disease for 25 years. During interviews, Saitong reported trying every treatment option listed in the table above. He tried many of these treatment options multiple times, and many of them were prohibitively expensive. In one instance, for example, Saitong reported paying a medicine seller from Vietnam US\$40 for a sticky, black concoction of plants that the seller claimed would heal his skin. Except for visiting a leprosy clinic that was set up at another village not far from Phatang village a number of years earlier, Saitong had never sought help from a public health care centre for his problem. During the course of this research project, Saitong was taken to the dermatological hospital in Vientiane, where he was diagnosed with severe psoriasis and received a supply of medicines that completely healed his skin. These medicines are expensive and difficult to obtain, as they are only available for sale in Vientiane. During data collection for this project, his skin remained healed, but news from the village since our departure reports that Saitong's skin has returned to painful sores, even worse than before. Without assistance, Saitong was unable to maintain his healthy skin. The complex, 25-year search for a solution to painful skin as related by Saitong is outlined in Table 8.

The health-seeking options presented in Tables 7 and 8 are enmeshed. Not only might villagers who participated in this study engage in several treatment options

simultaneously, but health practitioners might administer treatments or medicines from different health sectors at the same time.

Table 8: Reported Costs for Various Treatments* Sought by Saitong

Treatment	Reported Cost
Medicines (herbs to be boiled with water) bought from a walking medicine seller	200,000 Kip / US\$20
Steroids purchased from private pharmacies	Unknown
Multiple spirit healing ceremonies over 25 years	Unknown
Herbs collected from forest to be boiled with drinking water	Free
Chinese treatments (acupuncture)	50,000 Kip / US\$5 per treatment
Creams (aloe vera; cacao butter) sent from America	Free.
Other traditional medicines purchased from local healer	200,000 Kip / US\$20
Other medicines purchased from walking drug seller	200,000 Kip / US\$20
Small tube of cream used only for face and hands. Purchased from leprosy clinic	80,000 Kip / US\$8 per tube**
Diagnosis and consultation at dermatology hospital in 2007	Free
Prescription creams after diagnosis at dermatology clinic in Vientiane in 2007	230,000 Kip / US\$23 per month***
Blood tests for diagnosis in Vientiane	100,000 Kip / US\$10

**This list is not exhaustive and represents only the treatments demonstrated and/or spoken about during interviews in 2007*

***Requires about 50 tubes per year.*

**** Only for sale at the dermatology clinic in Vientiane so requires transportation.*

Some health practitioners work in both the public and the private sector. Others are able to administer both Western-style and traditional medicines. The midwife in Phatang village, for example, practises traditional medicine, but she also has a small amount of training from several international non-governmental organizations and is regarded by villagers as a bit of an expert on Western medicine. Villagers might ask her opinion about medicines, or they might purchase medicines from a private pharmacy and ask her to administer them. The private pharmacy in the village sells both Western medicines (antibiotics, etc.) and locally made pharmaceuticals that are in high demand. For

instance, villagers might purchase a product called Stemina Injection,³⁸ which they understand is good for general malaise and poor appetite, and then ask a doctor at the clinic to administer it either at the clinic or in their home. This product is made in Lao PDR, costs US\$5, and requires a five-hour IV drip. Stemina Injection is not for sale at the village health clinic (although many villagers think it should be, as it is a well-regarded medicine in the village). Another common practice in the village is to seek help from a public health care facility while also seeking assistance from a traditional healer. Lao villagers are very aware of the limitations of Western medicines, particularly the inability of Western medicine to solve problems with spirits, luck or merit. Many Lao villagers engage in public and traditional health seeking simultaneously in order to maximize the probability of recovering from an illness episode.

Do Nothing

A number of people who participated in this project reported that they do nothing when they become ill or disabled. These are the people who have no means to do anything, so they do nothing by default. They have no money, no bicycle and no time nor energy to move their feet to a health centre. Sometimes these people lack resources to access even

³⁸ According to the package, Stemina is an IV infusion of amino acids that are intended to be administered to patients pre-surgery. The village pharmacy sells two versions of this product. The Lao version costs US\$5 and is a combination of four amino acids. The Thai product costs US\$8 and comprises eight amino acids. The village pharmacy owner says these products are her best sellers. She sells 8 or 9 of the Lao product each month and 6 or 7 of the Thai product. The village midwife, the village health volunteer and staff from the public health care clinic are all able to administer this product. Most villagers prefer to have Stemina administered at home.

traditional village medicines or practices, unless the practices are common knowledge or the medicines can be gathered by the family for free or are provided gratuitously. Lao villagers who do nothing when they are ill are not reluctant or culturally wary. They are quite simply the very poorest people in the world. If poor villagers had other choices, they would exercise some of these choices. The types of treatments poor villagers seek, and the order in which they seek them, are partly a reflection of culture, but they are also a reflection of the resources and options available to them.

The following story illustrates the complex connection between culture and public health care centre utilization. One Sunday, shortly after our arrival in Phatang village, a woman came to our house with her four-year-old son. The story is that her son was hugging a cement post when a *duk duk*³⁹ passed by and crushed the boy's arm. The accident happened several weeks before our arrival in the village. I could see a large bump between the boy's wrist and elbow and also a crust of sticky grey pus at his wrist. When I asked the woman what she had done for her son, she said that she had done nothing except give him some traditional medicines she had found in the forest. She said she was poor and could not afford to go to the clinic. When I asked her if she would like to take her son for an X-ray at a nearby hospital,⁴⁰ she was grateful and eager. However, she soon became anxious. She wanted to know if the hospital would be open on Sunday, and worried that she would not know what to do once she got there. A great discussion

³⁹ A *duk duk* is a tractor that can drive through water.

⁴⁰ X-rays are not available at the Phatang health centre. In order to get an X-ray, this woman had to take her son to the Vang Vieng District Hospital, which is 18 kilometres away.

ensued between the woman and a gathering of villagers who had congregated to see what was happening. They all had advice for her and, interestingly, they knew exactly how much an X-ray would cost. In the end, I gave the woman enough money to get to the hospital and pay for the X-ray (5,000 Kip or US\$5). I also arranged to meet her at the hospital later in the day to help her navigate what to do there.

This woman was clearly concerned about her son, and she did the best she could for him given her circumstances. While she likely thought the traditional medicines were helpful, she also knew that other options were available and accepted the offer to try one. At the hospital, the X-ray showed that the boy's arm was broken, but that the bones had already begun to set. The hospital staff gave the woman a bottle of penicillin and sent her home, telling her that there was nothing more the hospital could do to help her son. The woman was very pleased with the result. She took the X-ray to the village leader as proof that the arm was broken, and the village leader required the *duk duk* driver to pay for treatments for the child. The *duk duk* driver paid for the woman to travel twice a day, for seven days, to Somsinxay village, about five kilometres away, where the child received treatment from a traditional healer, called a *moh mung*, who specializes in bone problems. The traditional healer used banana leaves, ointments created from forest products and special ceremonies to drive away spirits and heal the arm. Except for a small bump, the arm healed beautifully, for which the woman credited the skill of the traditional healer. She thanked me many times for helping her, stating repeatedly that the arm would never have healed had I not made it possible for her son to go to the traditional healer.

While the “do nothing” theme runs through all the data collected for this project, data collected at Somsavat village reveals a particularly strong theme of do nothing. As stated, most villagers from Somsavat are very poor, and many of them are landless. During interviews, villagers were nearly awestruck by questions that inquired about what they do when they find themselves ill or disabled. A frequent response to such questions was to state the obvious, which is that they do nothing. When Somsavat villagers become ill, they lie down and hope the problem goes away. They go to sleep and try to be patient. If they become disabled, then they try to live with it. Only one shop in Somsavat village sells a small selection of medicines, although villagers report that these medicines are “weak,” and most people cannot afford them.

One story from Somsavat village requires telling. One day during data collection at Somsavat village, we met Vanly, who had just returned from the upland field that she was clearing for the coming rice season. Because she was landless, she and her husband were clearing a mountain field, about five kilometres away from their home. She had just walked home with her four children, who were between the ages of 4 and 12. As we talked, she tended a small fire and a pot of boiling water, which she was preparing for making rice. Her house was a small two-room bamboo structure with dirt floors and no furniture. We crouched in the main area of her house, and our bodies took up nearly the

entire space.⁴¹ This family was identified as poor, according to the records located at the Phatang Health Centre, and they were to have a card that entitled them to free public health care. Vanly had a card, but it was not an exemption card.

As Vanly spoke to us, she rested her hands on her lap. Her hands were charred black and cracked with large blisters and thick scabs. She clearly had limited mobility in her hands due to substantive damage. Presumably her hands were damaged from clearing burnt grass, shrubs and trees from her mountain field without any protection. The children were dressed in tattered clothes, all of them filthy, with charcoal stains everywhere. Vanly had almost no interest in our questions about her so-called right to free health care. She said it would not matter if health care were free, as she could never get to the health centre. She said that if foreigners wanted to give her something, then they should come to her house and give it to her. It will never reach her, she said, if it goes through local routes. Vanly looked at me as if I didn't understand something very simple when I asked her what she does when someone in her family gets sick. She said she does nothing. What else can she do, she wondered. I couldn't help Vanly; although I promised that I would tell her story. When I made this promise, Vanly looked uninterested, as if she fully expected never to see me again, and that nothing in her life would change.⁴²

⁴¹ There were four of us in the room. In addition to the woman, I was present along with my translator. Another local villager accompanied us to help with translation of the local dialect. Her children were huddled in the other room, peeking out at us from behind a curtain. My children were at home being cared for by Phatang villagers.

⁴² I did return to Vanly's home. Near the end of data collection, I returned to donate some of my belongings to her family, and I also brought her and her husband some work gloves. I told her that I had tried to work out the problem with her health card but had not had any luck. She did not seem to mind.

Family Priorities

The process that villagers who participated in this study engaged in when they looked for a cure to an illness or disability was influenced by family priorities. Managing health problems is always a juggling act for poor families, who must weigh health-seeking options based on what they know about a problem and how different treatment options might help. Possible solutions must be considered within the practical constraints in which villagers live. The circumstances of poverty forces families to prioritize who will get treatment for a health problem and what kinds of treatment different family members will receive. Children, for example, who do not yet contribute economically to the family, are sometimes not taken for expensive or time-intensive treatments. However, a family member whose income or labour is important to the whole family's survival will often receive the best possible treatment, or combination of treatments, that the family can provide.

To illustrate, one day during data collection at the Phatang Health Centre, a family arrived from a distant village. The family came because the father was very ill with painful stomach cramps, vomiting and diarrhea. The father was admitted to the clinic and was treated with fluids and antibiotics. The man had come to the clinic with his wife and two children. One child was suffering from weepy eyes and some kind of skin disorder. The other child was a small girl who was carried in her mother's wrap. The child, two years old according to her mother, was naked, emaciated and listless. On the child's right

cheek was a huge, red, swollen boil. When I asked the mother if she wanted the clinic doctors to examine her children, she said no. I decided to go and talk to health centre staff about the children. I wondered if the woman did not understand me and that maybe I could get staff to look at the children. When I returned to get the mother, I learned that she had left for her village with her children.

It is not clear what motivated the mother to return to her village despite an offer to help her children. While the boy with the weepy eyes seemed otherwise energetic, the child held in the wrap was clearly in an advanced stage of illness. After the family left the health centre, I tried to locate the family, but I was unsuccessful. Health centre staff reported that the family lived far away and could not return.

On that same day, another family arrived at the same time.⁴³ In this instance, grandparents arrived with their 12-year-old granddaughter, who was very ill with a high fever. After an examination, health centre staff determined that the girl had malaria⁴⁴ and suggested that she stay overnight at the clinic to receive fluids and medication. The family only had 2,500 Kip (US\$2.50) with them, which was not enough money for an overnight stay. The researcher offered to pay the bill. Before I left the clinic for the evening, I asked the family if they had any food. The family responded politely that they had food. They pulled from their belongings a small bag with about two cups of cooked

⁴³ To save money, the two families had hired a *duk duk* together.

⁴⁴ Health centre staff administered a malaria test, which revealed a negative result. Nevertheless, they determined that the girl had malaria due to her symptoms.

sticky rice. It is not clear what would have happened had I not offered to support this family. In the end, I paid 5,000 Kip (US\$5) for all of the medical treatments, including drugs to take home, and about another 2,000 Kip (US\$2) for food.

Both of these stories illustrate family priorities. The first family had clearly made it a priority for the father to receive care at a public health care centre, but was unable or unwilling to seek care for the children for reasons that are not clear. The second family had decided to do what they could for their ill granddaughter and so had gathered what limited resources they had. While they wanted to help their granddaughter, they were limited by what they could afford. What is not known is what types of treatments these families had sought before resorting to the public health care facility and how much these treatments cost. As both patients arrived with advanced problems, it is clear that the families had tried to manage the problem at home for several days before they decided to seek help. It is not known what happened to these families once they returned to their village, or whether the treatments on which they spent precious resources resolved the problems.

PERCEPTIONS OF PUBLIC HEALTH CARE

Public health care has a mixed reputation in the Lao villages sampled for this project. While villagers who participated in this study understood that public health care has the potential to vastly improve their lives, they also understood that the health services

available to them were inferior in many ways. Most villagers are not oblivious to the tremendous worldwide disparities in how Western medicine is delivered. In Phatang village, an inverse relationship exists between the perceived quality of health care and the accessibility Lao villagers have to different venues that offer health care services. Most Lao villagers who participated in this study viewed the most easily accessible public health care services to be of poor quality. Villagers describe the village health centre as offering only limited services, administering poor or weak medicines, and having some staff who were poorly trained, unmotivated, unfriendly to villagers, and not wanted elsewhere. It should also be noted that many villagers thought highly of other staff at the health centre. The farther away an alternative public health care service was, the better the health service was perceived, even if villagers had never personally sought treatment for a health problem from any of these less-accessible places.

While villagers who participated in this study reported that health services elsewhere were better than what was available to them, they also indicated that the village health centre was by far the most accessible public health care service available to them, even if they thought that the quality of care offered there was comparatively poor. In addition to being in close proximity, the village health centre was also more culturally aligned with villagers, more tolerant of very poor or distant villagers, and more affordable. Of all the public health care available in Lao PDR, the village health centre has come closest to bridging the cultural disconnect between Western medicine and traditional health practices.

Phatang villagers talk about their health centre. An afternoon spent on my neighbour's patio would inevitably result in a conversation about who was working at the health centre. Villagers always knew who was working at the health centre and, if they wanted to use the health centre, they would wait for the staff they preferred to be on duty. It is noteworthy that the most popular health centre staff member, who was not a trained doctor, was a local resident who had a long-term connection to the village and had provided health services to villagers in one form or another for decades. Other staff who were posted at the health centre and either did not live in the village or boarded in the staff housing at the health centre, were regarded skeptically by villagers, even though their training credentials were supposedly better.

Phatang villagers also reported that the village health centre was the least expensive public health care service available to them and that the staff did not overcharge them or charge unofficial fees. Many informants also stated that the user fees charged by the village health centre were reasonable. Villagers understood that it costs money to operate a health centre, and users of the centre need to pay for what they use. Villagers mostly agreed that the health centre had no choice but to charge user fees, and no one thought free services were feasible, not even for the very poor.

ILLNESS AND DISABILITY NARRATIVES

Villagers who participated in this study had opinions about public health care based on stories about these services that circulated around the village. Lao villagers do not have a cultural history that includes Western medicine, and many do not have a repertoire of stories that tell how their own or their relatives' serious, chronic or long-term health problem was successfully solved by a public health care centre in Lao PDR. A remarkable finding from this project is that many villagers who participated in this study were unable to talk about their serious health problems as something that was resolved. Most of the villagers who informed this project were in the process of looking for a solution to their problem, and many had been looking for many years. The success stories that did circulate around the village were usually related to mild and short-term illnesses or problems that were resolved outside of Lao PDR, often in Thailand.

A number of villagers who informed this project did recover from a major health problem, and in every case these villagers received treatment for their problem from a distant location, often outside of Lao PDR. While stories such as these are rare, they are powerful. In small, rural and very poor places, it is possible to talk to people who have undergone complicated surgeries that involved mastectomy, ileostomy or hysterectomy, to name a few. Usually people who have undergone such complicated procedures are thought to have experienced tremendous "luck," and their wealthier relatives nearly always assisted them. The stories these people return with are miraculous. It is through

these stories that villagers know that Western medicine is powerful, even if the version they experience in their village does not live up to the ideal. In particular, Lao villagers who participated in this study held Thailand in high regard as the place where excellent health services could be found, and most would willingly go there to seek help for a health problem if they could afford it.

A notable example is a woman named Bulee who became ill and went to a hospital in Vientiane. At the hospital in Vientiane, Lao doctors gave Bulee oxygen and some other medicines, but these medicines burned her throat. The doctors in Vientiane tried to repair her throat with surgery, but they were unsuccessful. Bulee's family then rushed her to a government hospital in Thailand,⁴⁵ where she received a tracheotomy that saved her life. The operation cost US\$2,000, which her family paid for by selling their land and animals. After six months, Bulee could have returned to the hospital in Thailand to have the tracheotomy reversed, but she could not raise the money. When I met Bulee, five years after the operation, she still had not raised enough money, and she had never returned to Thailand, not even to have the tracheotomy checked. When I spoke to her, Bulee was hopeful that she would soon have enough money to return to Thailand, but she worried that maybe she had waited too long and that a reversal would be impossible. She also worried that she might have to make multiple trips to Thailand and that she would not have the money for it. She could only afford one trip. Bulee's situation was further

⁴⁵ Thailand has both government-run and private hospitals. Private hospitals are considered better, but they are prohibitively expensive. Lao villagers still consider government-run hospitals in Thailand to offer good services.

intensified because her tracheotomy tube was getting old and not working well. When asked, she said that no hospital in Lao PDR would be able to help her with her problem. Later, I learned that Lao doctors have the skills to close a tracheotomy, although they may not have had these skills five years earlier when Bulee first had the surgery. When I informed Bulee that her tracheotomy could be closed in Lao PDR, she refused to believe it. She continued to save her money for the day when she could return to Thailand.

Stories such as this send important messages to villagers. From this story villagers understand that Western medicine can save people's lives, yet the types of services offered in Lao PDR might be dangerous, and Lao doctors might have poor skills. Villagers also learn that public health care, both inside and outside Lao PDR, is prohibitively expensive, especially for poor villagers. Villagers who do not have a wealthy relative know that more than anything, they need good luck to keep them healthy. Luck is one of the few things that poor villagers possess. This story further tells villagers that health services in Lao PDR are limited, and that there are many sophisticated things that Western medicine can perform, although not in Lao PDR.

Many other stories about public health care pass through Lao villages, and most do not reflect well on the usefulness of the types of public health care offered in Lao PDR. A story often told by villagers who had a very serious health problem is that they travelled to a public health care centre looking for a solution to their problem, often at great expense and often after months or years of unsuccessfully navigating many other health

systems (public, private and traditional). The story goes that villagers were told that a solution to their health problem *does* exist, but that the villager could not have it unless he or she raised the money to pay for it. Many villagers tell this story, and every villager knows this story. Often the required cost went well beyond the savings or earning potential of the villager, and always the cost was many times more than the official user fees of public health care in Lao PDR. Many poor villagers who participated in this study have accessed public health care at devastating expense to their livelihood. Some villagers have sold their land or animals; others have incurred impossible debts. Some have sought financial assistance from family members working in Thailand or overseas, while others have had to make do without any treatment, often with severe consequences.

Another common story comes from villagers who are very poor, ethnic minorities, disabled, or considered “crazy.”⁴⁶ These people, and their families, report poor or offensive treatment at public health care centres. In some cases, villagers report being denied treatment altogether. This poor treatment is well known and frequently discussed. Sometimes rude and discriminatory treatment from staff at public health care facilities deters the very poor or ethnic minorities from seeking help from a public health care centre at all. For many of these people, getting to a public health care centre requires significant expense and organization, an undertaking that might not be worth it if services are denied, hastily given, or if the person has to endure degrading treatment while there.

⁴⁶ In this instance “crazy” is a village term.

One day while I was at a health centre, a family arrived from a distant village with a toddler who was feverish from infected burns on her feet. The family were ethnic minority people and very poor. Two weeks earlier the child had walked through the hot coals of a fire. After a brief examination, staff at the clinic half-filled a small metal pan with water and, with a coarse brush, scrubbed the dirt, black pus and dead blisters off the toddler's feet. Her raw, but not yet clean feet were then doused with iodine. The child screamed hysterically as her mother and clinic staff pinned her down for the procedure. The whole process took less than half an hour. When it was finished, the family left with five days' worth of penicillin and a full bottle of iodine.

I tried to follow this family, but they left very quickly. I worried that this child would become the next under-five mortality statistic in Lao PDR, and that she needed better and kinder treatment. While I cannot draw a direct line between this family's ethnicity and the poor and hasty treatment they were given, they clearly were not made to feel welcome at the health centre. The poor and rushed treatment, which was not typical of most interactions between staff and patients, suggested that staff were not concerned about the survival of this child. Importantly, the story that this family will bring back to their village will likely not reflect well on the health centre or encourage other families to spend their meagre resources to seek help from it.

Another group of people who are reported to be particularly unwelcome at public health care facilities in Lao PDR are people who are considered "crazy." Families in Phatang

village who have such a family member report that they never take their family member to the health centre, and that the “crazy” person could never receive treatment there, even if the problem is not at all related to being “crazy.” When a so-called crazy person gets sick, families must rely on traditional medicines or other medicines sold at a private pharmacy.

STORIES OF HOPE

In the village, stories that circulate about public health care matter. In particular, these stories matter in the amount of hope that they either build or dispel. Probably one of the most important obstacles to improved utilization of public health care in Lao PDR has to do with the ability of public health care centres to harness hope. Lao villagers who participated in this study knew that public health care centres can and often do administer good quality—and often life-altering—health care services, but their personal and community experiences, in particular with the types of health services that are most accessible to them, do not resonate with what they understand is possible.

Traditional and private health practices in Lao PDR, including private pharmacies, are much more successful at dispensing hope than are public health care services. Hope draws people in. When people are ill and suffering, they look for compassion and hope that their problem might someday be resolved. Stories that tell people who are poor, ethnic minorities, remote, or “crazy” that they are unwelcome or that they should go

home and die, are stories that essentially tell people that their problem is hopeless.

Hopelessness is a strong deterrent to health care utilization in Lao PDR. When people attend a public health care centre, what they want more than anything is validation that their time and precious resources were well spent and that someone listened to their problem and offered a hopeful solution or a compassionate response to their problem.

The relationship between health care and hope in Lao culture is essential. Traditional health care in Lao PDR, for example, always gives families hope that a health problem might be resolved, and this hope is renewed every time a family seeks help from a traditional healer. A traditional healer will always agree to conduct a healing ceremony or prepare another medicine, even if the healer has tried other treatments that did not work. Moreover, the cost of the treatment is usually within the family's reach. The price a family pays for traditional health care is usually determined on a case-by-case basis and is influenced by what the family can afford, especially if the healer is a local person,.

Even the private pharmacy has harnessed the power of hope. While private pharmacies in Lao PDR are highly criticized for their unregulated and possibly dangerous practices, these pharmacies understand that their business success depends on how much hope they can sell to villagers. Every villager who seeks help for a health problem from a village pharmacy is offered a medicine in a quantity that is affordable. For better or worse, hope is always for sale at the village pharmacy.

While the public health care centre is useful to villagers, it does not dispense luck or do things to keep essential spirits in balance. More significantly, public health care staff often fail to give villagers hope and sometimes even send people away feeling desolate and more hopeless than they did before they arrived. Many people who participated in this study reported seeking help for a health problem from a public health care centre only to learn that there was nothing the health centre could or would do to help with the problem.

The essential connection between luck, merit, hope and illness in Lao PDR creates a fundamental disconnect between Lao and Western cultural perceptions about what is possible. In Lao PDR, health services that tell people their situation is hopeless are fundamentally offensive, if not impossible, according to Lao cultural ways-of-being. Observations from this project indicate that many health centre staff in Lao PDR are unwilling or very uncomfortable telling patients that a health problem is chronic or terminal. In many cases, this discomfort stems from their own cultural belief that it is always possible for a patient's luck to change.

In chapter four of this thesis, the story of Koa, who suffered from a terminal illness called thalassemia, was recounted. While Koa received treatments for his condition, it is notable that no staff member at the hospital he attended told the family that Koa's condition was terminal or genetic. The family left the hospital unaware that the treatments received by Koa would not cure him, and moreover, that their other children or any future children

could also suffer from this disease. According to entrenched Lao cultural values, it is astonishingly rude to tell a family that their child will die or that their other apparently healthy children could become sick. That some public health care practitioners in Lao PDR *do* tell people that they will die, or that they will not recover from an illness, creates abhorrent impressions about the staff who work at public health care centres and the types of health care they administer.

In Lao PDR, villagers always have hope, luck and merit on their side. No matter how poor, isolated, hungry or ill people are, they can still hope that maybe their luck will change or that maybe they will acquire enough merit to hoist them to a better path in life. Hope also allows people to continuously search for a solution to their complex health problems. Villagers will never be won over to the value of public health care in Lao PDR and the possibilities these services might improve their lives, if stories of crumbled hope continue to spread through villages.

SUMMARY

In Lao PDR, Western-style medicines offered at public health care facilities are always partial treatments. The medicines and treatments dispensed may alleviate pain and suffering, but these symptoms are not necessarily understood as the core problem. In Lao PDR, pain and suffering are sometimes understood as the symptoms of a missing spirit, bad luck or inadequate merit. In their quest to be healthy, Lao people seek treatments that

incorporate culturally held root causes of illness and disability into healing trajectories, especially if the problem is long-term or chronic.

Lao villager who participated in this study did not view traditional versus Western approaches to illness and healing as dichotomous practices that could be selected in a this-or-that kind of way. Gaining merit, seeking luck and appeasing spirits are not optional health practices for Lao villagers. Data from this project indicate that Western medicine never works in isolation from traditional health practices in Lao PDR. While Lao villagers who participated in this study sometimes looked to cure a health problem with only traditional medicines, or they sometimes choose both traditional and Western medicines, no villager who connected with this study chose to seek help for a complex health problem from only a Western-style public health care facility.

Lao villagers who participated in this study looked into every option within their means for a solution to their health problems. The lived experience of looking everywhere is that villagers sometimes embark on long journeys that take them to many healers from all health care sectors, and sometimes even take them out of the country. Other times, a villager has no option but to resort to his or her bed and hope that the problem will resolve itself. Like everyone else in the world, Lao villagers who experience pain and suffering relentlessly look for solutions where they can and when they can because they are hopeful that somewhere a solution might eventually be found.

Public health care facilities in Lao PDR have failed to harness hope. More than anything, villagers who participated in this study looked for hope when they embarked on a health-seeking journey. Hope also influenced the ways in which villagers talked about public health care as well as the resulting community perceptions about different health care options. Many poor villagers who participated in this study experienced hopelessness when they encountered public health care facilities in Lao PDR, especially at secondary- and tertiary-level facilities. Hopelessness pervades the stories that circulate around poor villages where data for this project were collected about what public health care facilities in Lao PDR can do for poor people. Stories about poor villagers who were treated badly, sent away to die, not healed or even made sicker, or subjected to frightening healing regimes are commonplace amongst poor Lao villagers. These stories tell a tale of hopelessness that keeps poor villagers away from public health care facilities.

Poor utilization of public health care facilities in Lao PDR is not fully explained through cultural aversion rationalization. Moreover, culture does not dictate how villagers respond to illness or disability. Cultural aversion theories of poor utilization of public health care fail to recognize the complex and emerging nature of lived experience. Cultural discourses around illness and disability in Lao PDR are slowly merging with new discourses and treatment possibilities. Poor Lao villagers who discover themselves ill or disabled live in a time of shifting perceptions about what can be done to relieve suffering. Villagers make decisions about how to treat an illness episode based on cultural

interpretations of illness and disability, but their decisions are also influenced by other practical conditions of lived experience.

For many Lao villagers who participated in this study, seeking a solution to a health problem is a complex process that leads to bewilderment. Lao villagers can choose from many different health care options, and each of these options must be weighed against lived realities. Some of these options require that villagers absorb new ways of understanding illness and disability and how they might be resolved. Taken together, the experience is often bewildering. Chapter six joins together the discussions about the cost of health care in Lao PDR and the process of searching for a solution to health problem in a complex system through the framework of bewilderment.

CHAPTER SIX: BEWILDERED BY HEALTH

Bewilderment is what Lao villagers who participated in this study experienced when they confronted the public health care system. Poor Lao villagers who participated in this study were bewildered by the extraordinary costs they were asked to pay for public health care; they were bewildered by the cultural context that underpins public health care; they were bewildered by the offensive and discriminatory treatment they received when they entered the public health care system; they were bewildered by the complicated processes they went through to access public health care; and they were bewildered by the logistical dilemma they faced if they needed to use public health care services that were far from their homes. They were also bewildered by the frightening and often demoralizing stories that circulated around their villages about what happens at public health care facilities in Lao PDR.

To some extent, bewilderment is a by-product of the cultural clash between scientifically influenced public health care offered in Lao PDR, and the cultural ways-of-being that epitomize village life. Bewilderment, however, is also the result of a world order that has systematically prevented the world's poorest people from attaining even the most basic standards of living and health care. Villagers who participated in this study were bewildered by a health care system they did not understand and to which they had little access. When villagers get desperate enough to access public health care, especially

hospitals, the processes they go through are incomprehensible and often unmanageable for poor people.

This chapter discusses the bewilderment experienced by poor Lao villagers who participated in this study as they navigated the public health care system in Lao PDR in search of a solution to their complex health problem. The discussion pertains primarily to the experiences that villagers had obtaining services from secondary or tertiary level public health care, and in particular, hospitals. No villager who informed this study chose to go to a hospital unless the problem was advanced and usually very complex. This chapter examines factors that cause fear and distrust of hospitals in Lao PDR, and the complex processes that villagers went through during hospitalization. The chapter draws on numerous stories to illustrate key points.

FEAR AND DISTRUST

Data from this study indicate that the lived experience of bewilderment manifests as fear and distrust of the public health care system in Lao PDR. Villagers who participated in this study expressed fear and distrust at the prospect of using public health care facilities, especially secondary or tertiary facilities, partly because the health care practices administered within these facilities were culturally bewildering. They were also leery of the unimaginably complex systems that run these facilities. Rude or unwelcoming behaviour toward people who are poor, ethnic minorities or vulnerable further intensified

distrust of the public health care system amongst villagers who participated in this study. For many villagers who participated in this study, the experience of navigating the public health care system was fraught with problems, had a high potential for failure, and was a demoralizing and catastrophic experience.

What is this Building?

Many Lao villagers who participated in this project were apprehensive about seeking health services from hospitals without assistance. While cost was a major obstacle, villagers were also dubious about their ability to navigate the complex health system on their own. While villagers wanted to look for a resolution to their health problem from a hospital, they also wanted me to accompany them there and help them sort out what to do.

From the perspective of poor villagers who participated in this study, the public health care system in Lao PDR is overwhelmingly complex. While health centre design is well known to most Westerners, poor villagers who enter a hospital are often awestruck at the size and complexity of such centres. Many times, the only knowledge villagers have about a hospital is whatever rumours or advice they have gathered from other villagers. Many villagers have no previous personal experience about what to do once they arrive at a hospital. Even as a foreigner who had a language barrier, I was much better equipped to navigate public health care facilities in Lao PDR than were the poor villagers I accompanied because I understood basic things about the way health centres operate.

For example, upon entry into a public hospital, I knew that we needed to look for a reception area. I was aware that reception areas in hospitals are usually the first point of contact for patients and that I should look for a counter with administrative staff on one side and a space on the other side where patients would give information about themselves. I understood that patients who arrive at a hospital are triaged according to their needs. I was also familiar with the various forms, tests and procedures that sometimes occur when a person enters a hospital and what the purpose of these procedures might be. This insider knowledge made for a paradoxical experience. I was a foreigner leading local people through a health facility that was foreign to both parties, but far better comprehended by me.

In 2007, there was only one social worker in Lao PDR. At the time, this very important public servant was employed to operate community outreach programs in a Vientiane neighbourhood that had high levels of drug use. In Cambodia, it was discovered that social workers who were hired to assist poor people navigate complex procedures within health systems greatly increased utilization of health care facilities by poor populations. These social workers also helped inform patients about their rights to subsidies and protect them from unreasonable unofficial costs. These findings indicate that neither cost nor culture fully explain why poor people do not utilize public health care.

What poor and frightened villagers need when they enter a health facility is a person who guides them through the facility. This person would explain what the parts of the facility are and the types of things that can happen there, what patients need to do and what they can expect. Just as poor people need educational campaigns to inform them about the reasons for immunizations or the importance of toilets, Lao villagers need information about what hospitals do. From my experience, poor Lao villagers who enter a public health care facility are ignored, possibly even denied information, and left to their own devices about how they should proceed at the health facility⁴⁷.

What Does this System Do?

Processes that make the health system in Lao PDR complex are related to infrastructure and reflect assumptions that the users of the system can and will provide everything they need to support their stay at a health facility. Hospitals in Lao PDR are buildings with equipment in them. There is a lack of essential “soft” infrastructure inside Lao hospitals. Soft infrastructure refers to food for patients, staff to look after the personal needs of patients, and even medicine. Another layer of complexity is the health system structure that requires users of health facilities to pay for services on an as-needed basis, without notice as to what these service, or the costs of them, might be.

⁴⁷ Data from this project do not include the experiences of Lao people who were not poor. It is not clear whether the indifferent attitude demonstrated to poor villagers is the typical experience of any person entering a health facility, or whether the indifference directed toward poor villagers was exacerbated due to ethnic/economic intolerance.

Villagers who participated in this study and travelled to a distant health facility brought everything possible to support their stay. Families brought bedding, cooking pots, food, clothing and anything else they thought they might need, all stuffed into plastic bags. Because the indirect costs of a hospital stay are very high, poor villagers need to anticipate what they will need, and bring it from home in as large a quantity as they can carry. A hospital stay is often a very stressful time for families who are far from their homes. If a poor villager forgets to bring something important to a hospital, then he or she will need to survive without it, as purchasing supplies from the market or returning home to get it are not usually viable options.

Food is an important item that villagers brought with them to a hospital. All the villagers I accompanied to the hospital brought rice with them, and sometimes in large quantities. Hospitals in Lao PDR have designated areas where villagers can cook for themselves. For wealthier Lao people, many vendors sell cooked and raw food from makeshift shops across the street from main hospitals. Poor people, however, depend on what they can bring with them. Food is problematic for poor villagers because it is difficult to carry enough of it, and some kinds of food, such as chicken, eggs or vegetables, which many villagers would eat from their subsistence farms, are impossible to carry to a hospital. Without money, poor villagers manage without these things. Data from this project indicate that hunger might be a problem for poor villagers who stay at hospitals that are far from their subsistence farms. Hunger might even cause people to decide to leave a hospital and return home.

The story of Tran illustrates the problem of hunger, along with many other complexities that poor villagers face when they seek health care from a hospital. Tran was a 12-year-old boy from Namuang village who was diagnosed with a dangerous infection in the bone of his left leg. On the day I met Tran, I travelled to Namuang village with a visiting Canadian doctor who had agreed to spend the day seeing patients at the clinic. Namuang villagers had no notice of our intended visit, so when we arrived, the clinic was completely empty.⁴⁸ Within an hour of our arrival, the clinic was packed, with people lined up off the veranda and into the yard. The Canadian doctor saw many patients that day.⁴⁹ One of them was Tran.

Eighteen months earlier, Tran had been playing soccer when he fell and hurt his leg. His family tried to care for him at home, but after some time his leg became very painful and pus began to form on his left shin. His family took him to the health centre, but the medicines they gave Tran did not help his painful leg. The family did not take Tran to the district hospital, located 12 kilometres away down a mud road

The Canadian doctor suspected that Tran's problem was serious. She suggested that Tran be taken to the nearest district hospital for a diagnosis and an X-ray. A few weeks later, I

⁴⁸ It is noteworthy that the clinic was empty every time I visited. The student interns said that it was empty because I always came in the afternoon, which is when I could get there due to the travel time. They said that patients came most mornings.

⁴⁹ But not everyone. When we needed to leave, there was still a crowd of villagers who had hoped to see the doctor.

returned to Namuang village to check on the family. The family had gone to the hospital where they were told that Tran had a serious problem, but that treatment would cost between one hundred and two hundred dollars. They were also told that if they could not raise the money, then they should return to their village and allow Tran to die naturally. When I met the family on this second visit, they were demoralized and angry. Before they went to the hospital, they had hope that Tran would eventually recover. The visit to the hospital made them fearful, and they could not afford the payment. When the mother told me her story, she looked down, shook her head and said there was nothing she could do for her son. She would try to raise the money.

When I inquired about Tran at the hospital, however, I received different information. I was told that everything was possible. I was instructed to arrange for Tran and his family to arrive in Vang Vieng⁵⁰ on Friday morning, when they would travel free of charge in a truck that was going to Vientiane. In Vientiane, Tran was admitted to a hospital at no cost to the family, under a special exemption policy for the very poor. Another Canadian doctor oversaw Tran's care and arranged for the family to receive the exemption. Tran received six weeks of intravenous antibiotics and care that saved his life. His mother and father remained with him in Vientiane during the entire six weeks that he remained in hospital.

⁵⁰ Vang Vieng is 12 kilometres from Nam Namuang.

Even though Tran's family was provided with free health care and transportation, his family still experienced a major crisis as a result of Tran's hospitalization. Not long after Tran was admitted to hospital, the family contacted me. They were upset because they were suffering. They had no money for food or other daily needs. They were hungry. I met Tran early on during data collection, and he was the first person I helped admit to a hospital. I was not aware of the indirect costs that the family would have to absorb, or how high these costs could be. Sending Tran to the hospital was a learning experience for me about the indirect costs that families must pay when they go to a hospital.

Tran's story captures many of the complexities of seeking health care in Lao PDR. Notably, Tran was the only person I met during this project who received a full exemption from health care costs, including transportation. It is clear, however, that he would not have received this exemption were it not for major interventions from myself and other foreigners on behalf of the family. However, even with the exemption, Tran's family was still unable to afford this "free" health care.

The complexities go deeper than this. For example, hospitals in Lao PDR usually require that users provide their own medicines. Medicines can be purchased at private pharmacies, either on the grounds of the hospital or outside on the road. In Vientiane, many private pharmacies have established businesses directly across the street from hospitals. The process that requires patients to purchase their own medicines from private pharmacies is worrisome. The unregulated nature of private pharmacies in Lao PDR,

raises serious concerns regarding how these pharmacies store and administer medicines, the quality of the medicines they sell, and the possibility that poor people will try to save money by buying “cheaper” drugs from less reputable pharmacies indicate major structural problems in the way health care is delivered at hospitals in Lao PDR.

Other processes within hospitals are also complex. A typical sequence of events might be that the ill villager and his or her family arrive at a hospital and receive a consultation from a doctor. The doctor will diagnose the problem and probably tell the family the cost that the health facility will charge to treat the problem⁵¹. After the consultation, if the family decides to stay, the family might be given a prescription for medicines or tests from the doctor. If the ill person requires a test, then the family must first pay for the test, and then proceed to the area where the test will be administered. If the ill person requires medicines, then a family member will need to run out, buy the medicines, and return with them to the hospital, where the staff will administer them. Processes such as these require that at least two family members travel to the hospital with an ill person. One family member is required to run errands, pay the bills and organize the treatment, while another family member is required to stay with the ill person.

⁵¹ When I accompanied poor villagers to secondary hospitals in Lao PDR, I was never given a lump sum amount that the health facility would charge to treat a health problem, although this is the experience that poor villagers who participated in this study reported when they ventured into the health centre on their own. During data collection for this project, I paid various hospital bills at intermittent times during the hospital stay or at the end of the hospital stay. I paid whatever was requested on the bills, and I assumed these were the official costs.

In one instance, a family member had to travel to a different health centre across Vientiane to obtain blood for a relative who was scheduled for surgery the next day. In another instance, a villager required a blood test. He was directed to the blood test area of the hospital. When he arrived at this area, he was told that he needed to go to another area, where he should pay 100,000 Kip (US\$10) for the test and also obtain a proof-of-payment ticket. Once he had the ticket, he returned to the blood test area, where he was informed that blood tests were finished for the day, and that he should come back on Monday morning.⁵² Fortunately, this villager had relatives living near the hospital, and he was able to spend the weekend with them. Had this villager not had family close by, waiting two days in Vientiane might have been a catastrophic experience.

Seeking hospital care in Lao PDR is further complicated by unknown costs. A family who travels to a hospital has no way of knowing what types of medicines or tests an ill family member will require, or even if additional tests or medicines will be required once the ill person is admitted. Further, families might also need to organize transportation between locations where health supplies can be purchased and the hospital that is treating the ill person. The process of gathering medicines, obtaining tests, travelling around a foreign city and having to pay unknown amounts of money was a daunting experience for the poor and rural families who participated in this study.

⁵² It was Friday afternoon, and outpatient blood tests are not administered over the weekend.

The experience of having no idea how much a health problem will cost at a public health care facility was terrifying for poor families who participated in this study. These families function within very small economic scales and are vulnerable to catastrophic consequences if they discover themselves trapped in a hospital they cannot afford but are also unable to leave. The terror of such an event is often enough to steer poor families away from public health care facilities, and toward other, more user-friendly and predictable forms of health care. Many poor villagers who participated in this study were fearful that they might experience first-hand the catastrophic costs of seeking a solution to their health problem at a public health care facility in Lao PDR, and in particular a hospital.

What are These Treatments?

Poor and rural villagers who participated in this study were also fearful about the types of treatments they might be subjected to once they got to a public health care facility. This fear sometimes deterred villagers from seeking help for their health problem from a public health care facility. Lao villager who participated in this study have heard and witnessed many amazing stories about what happens at public health care facilities, and these stories create dubious feelings about the types of things health facilities do to people. In and around the tiny village of Phatang, for example, there were villagers who had had major parts of their bodies cut off; a woman with a frightening tube (tracheotomy) stuck in her throat (which villagers understood she needed because of a

botched procedure performed at a hospital in Lao PDR); two people from nearby villages who had returned from surgery with tubing (ileostomy) protruding from their bellies; a woman whose hair fell out from treatments at a hospital; and several villagers who had received such damaging treatments from a hospital in Lao PDR that their families had to rush them to Thailand, where the problem was resolved at tremendous expense.

Another family in a nearby village was waiting for representatives from an NGO to come and take their two-year-old daughter to the United States for heart surgery. The family understood that the child would travel alone with NGO representatives and would be returned at some point after the mystifying surgery was finished. They had no idea when someone would come for their child, who that person would be, what would happen to their daughter in the U.S., or when she would be returned.⁵³ To prepare for this event, the mother travelled to Vientiane, where she obtained a passport for her daughter. The child was frail, very thin and tiny for her age. She had blue fingers and blue lips and was clearly unwell. Other than wait for the NGO to arrive, the family could do nothing for their child. The mother reported that the heart surgery and all of the other costs for the child were to be paid by the NGO. No family member could travel with the child because the NGO could not cover the cost.

Poor Lao villagers who participated in this study did not have a repertoire of medical terminology to describe the types of things that happen at hospitals. They did not have a

⁵³ The mother mentioned that she thought her child would be away for about two months.

cultural history with hospital procedures, and they did not have a collection of stories about how certain procedures might solve health problems. Lao villagers also did not have a solid grasp of basic biology through which to understand Western medical practice. From the vantage point of Lao villagers who participated in this study, the types of procedures that they or their fellow villagers witnessed at public hospitals were downright frightening and, based on good, solid observation, often dangerous.

Desperation

Villagers who participated in this study did sometimes travel to hospitals prior to our arrival at Phatang village, and they travelled alone. Usually, however, these hospital visits were made out of desperation and at the last minute. Nearly every villager who told a story about going to a hospital told a near-death story in which the person was rushed to the hospital barely alive, often at great expense.

One mother, for example, told about her teenage daughter, Noi, who bought pills from a private pharmacy that she understood would make her thin. Noi took the pills and then went to work on the farm. At the farm, she started to feel unwell so her family brought her home and put her to bed. Noi stayed in bed for one week. During that week, the family asked a traditional healer to come, and then a doctor from the health centre, but Noi only got sicker. She developed spots all over her body, had diarrhea, and did not recognize anyone. When the family had exhausted all of their options for home and local

remedies, they rushed Noi to hospital in Vientiane. The transportation cost US\$70 and the hospital charged another US\$300 to treat her.

Given support, both financial and practical, many Lao villagers who participated in this study were willing, even eager, to access help for their health problem at a public health care facility, including hospitals. They were also willing to access this health care closer to the onset of an illness episode than they might have otherwise. It is clear, for example, that Noi's family wanted to help her. When she became ill, they began by trying the things that were most familiar to them. As these treatments proved ineffective, they moved on to other options, which were still within their reach and comfort zone. When Noi's life was clearly in danger, they became desperate enough to try the thing that was most unfamiliar to them. While Noi's family was certainly frightened about the cost they would incur at a hospital, they were also unsure about what would happen if they took their daughter to a hospital. Other than let her die, Noi's family had no choice. If health care utilization is ever to improve in Lao PDR, especially at the secondary and tertiary levels, then villagers need knowledge about the types of treatments that are offered at hospitals and when they should take a sick person to a hospital. They also need assurance that someone will help them navigate the complicated system when they get there.

Fear of the types of procedures that occur at public hospitals is demonstrated by the story of Ban. One day I interviewed a woman who reported that her eight-year-old son could not talk and he choked a lot, but he was very bright and could draw beautifully. Ban was

not permitted to attend school due to his problem. This child perplexed me, and after a while I wondered if he might be tongue-tied. I contacted an ear, nose and throat specialist at a hospital in Vientiane, who agreed to see the child. When I asked the family if I could take them to see the specialist, they were very afraid. It was my fault. When I talked to the family, I explained that I thought there might be something wrong with Ban's tongue. I explained that there are simple procedures to release the tongue. I was talking through my interpreter, and I used the word "cut," which was interpreted for them. The family was terrified. The mother explained that her husband loved Ban very much and he did not want the hospital to cut Ban's tongue. On several occasions, I tried to quell their fear about the cut tongue. I tried to convince them that they did not have to accept any treatment they did not want. They could just talk to the doctors in Vientiane. I thought that if I could convince the family to go to Vientiane, then the doctors there could do a proper assessment and better explain any treatment options. I was unsuccessful. When I left Phatang village, I left information with Ban's mother that she could follow up herself, if she ever chose to do so. Amazingly, about a year later, the family did follow up on their own. While I am unaware of the exact circumstances, I understand that the family took Ban to a specialist in Vientiane and that he underwent a procedure to release his tongue, which resolved his problem entirely. I understand that he still draws beautifully and that he is now learning how to draw letters and words at school.

There were other examples of illness for which villagers who participated in this study did not want to go to the hospital. In particular, villagers who had broken bones had no

desire to receive treatment for this problem from a public health care facility. While villagers knew about casts, no villager wanted one, and many were afraid of them. According to informants, casts contain the spirits within the body in ways that are unacceptable to Lao people. People who participated in this study preferred to deal with broken and problem bones by visiting the local bone healer (*moh mung*). During my six months in rural Lao PDR, I never once saw a rural person with a cast, although I met numerous people with broken bones who were being treated by the *moh mung*. Bones were one thing that Lao villagers, and even health center staff, were unanimously sure about. In every case, villagers were sure that traditional medicines surpassed Western medicine in knowledge about bones and how to heal them.

PAYING FOR HEALTH SERVICES

The process of paying for health services from a public health care facility in Lao PDR, most notably at secondary and tertiary hospitals, is a complex process that requires a sophisticated knowledge of how the health system works. Hospital bills for varying amounts of money must be paid at different locations within and outside the hospital and at different times during a hospital stay. While I never had the opportunity to observe how poor villagers managed the complex processes by themselves, I did wonder how poor people, who are confused by the system in the first place, managed to navigate the public health system in Lao PDR and leave with all their bills paid.

Figures 3, 4 and 5 illustrate various hospital bills that I paid for Koa's hospital stay. Koa is the boy who suffered from thalassemia, and his story is discussed in all three results chapters of this thesis. His story is a tragic example of nearly every struggle that poor villagers encounter when they confront the health system in Lao PDR. The bills that follow are noteworthy because of the complexity they represent. To start, the bills are a fascinating account of how hospitals charge for supplies. Figures 3 and 4 document miniscule amounts of supplies (swabs, needles, stitches) and medicines (oxygen charged by the hour) that were used by Koa both in and outside of surgery. These totals were presented to me as individual sums that I was to pay. How the hospital manages to keep track of who uses what and when is unclear. It is also noteworthy that these bills are in English, considering that very few, if any, of the staff, and none of the families, would have English language skills.⁵⁴

⁵⁴ Possibly the bills are written in English because Lao words do not exist for many medical terms and items. Medical words written in Lao language are often written phonetically, and disagreement exists about the spelling of such words. It was suggested to me that medical words written phonetically in Lao script might not be easier to read by Lao medical staff than are words written in English.

Figure 3: Medical Bills for Koa

ສາທາລະນະລັດ ປະຊາທິປະໄຕ ປະຊາຊົນລາວ

ສັນຕິພາບ ເອກະລາດ ປະຊາທິປະໄຕ ເອກະພາບ ວັດທະນາຖາວອນ

ໂຮງໝໍ ແຂວງວຽງຈັນ
ພະແນກວາງຢາສະຫຼົບ

578A

ໃບຄິດໄລ່ວາງຢາສະຫຼົບ

ຊື່ຄົນເຈັບ ທ. ສິມ ອາຍຸ 7 ປີ, ອາຊີບ ປູ ບ່ອນຢູ່ ບ້ານວິໄນ
ເມືອງ ວິໄນ ແຂວງ ວິໄນ
ມະຕິພະຍາດ Thalassemia (splenomeg)

ລ/ດ	ລາຍການຢາ	ຫ/ຫມ	ຈຳນວນ	ລາຄາ	ມູນຄ່າ
1	Pavulone, Vaculone	Amp	1		45.000
2	Succinyl	Vial	1		45.000
3	Thiopental, Ketamine	Vial	1		45.000
4	Dolosal, Fentanyl	Amp	1		1000
5	Atropine	Amp	2		130.000
6	Propofol	Amp	2		
7	Hypnovel, Valium	Amp			
8	Marcaline 0,5%	Amp			
9	Lidocaine 2%, Procain 3%	Amp			
10	Adrenaline 0,1%	Amp			
11	Hydrocortisone	Vial			
12	Aldalate	Tabl			
13	Lasix	Amp			
14	Oxytocine, Meterzine	Amp			
15	RL 1000ml, 500ml	MI	1		12.000
16	D10W 1000ml, 500ml	MI			
17	D5W 1000ml, 500ml	MI			
18	D1/3S 1000ml, 500ml	MI			
19	D1/2S 1000ml, 500ml	MI			
20	NSS 1000ml, 500ml	MI			
21	Plasmakine, 500ml	MI			
22	Haliathan	Hour			30.000
23	oxygene	Hour			
24	Syringe 5 cc	Piece	4		4.000
25	Syringe 10 cc	Piece	4		4.000
26	Needle spinal N:	Piece			
27	Stomach tube N:	Piece			
28	Suction tube N:	Piece	1		35.000
29	Endotracheal tube N:	Piece	1		10.000
30	T-way + Extension	Piece			
31	IV-catheter N:	Piece	1		6.000
32	Gloves sterile	Pair			
33	Gloves no sterile	Pair			
34	Electrode	Piece			
35	Paste	Piece			2.000
Total					251.000 ກີ. / 21.607

ໂຮງໝໍແຂວງວຽງຈັນ, ວັນທີ:

Figure 4: Medical Bills for Koa - Medical and Surgical Supplies

ສາທາລະນະລັດ ປະຊາທິປະໄຕ ປະຊາຊົນລາວ

ສັນຕິພາບ ເອກະລາດ ປະຊາທິປະໄຕ ເອກະພາບ ວັດທະນາຖາວອນ ເລກສັນຕິພາບ.....

ໂຮງໝໍແຂວງ ຫຼວງຈັນ ເລກສັນຕິພາບ.....

ພະແນກຜ່າຕັດ(OT) ໄປຄິດໄລ່ມູນຄ່າແລະອຸປະກອນຜ່າຕັດ. ເລກທີໂທ້ວຮ້າ 15784 / OT

ຊື່ຄົນເຈັບ ທ. ດ ອາຍຸ 7 ປີ. ມອນຢູ່ປະຈຸບັນ ບາງ ສາວ

ເມືອງ ຫຼວງຈັນ ແຂວງ ຫຼວງຈັນ ຍິ່ງມະຕິພະຍາດ Splenomegalie (Thalassemie)

ລ/ດ	ລາຍການ	ຫົວໜ່ວຍ	ຈຳນວນໄຊ້	ລາຄາ / ຫົວໜ່ວຍ	ມູນຄ່າ / ກີບ
1	Dexon N:	ຊອງ			
2	Vicryl N:	ຊອງ	3	41000	123000
3	Silk N:	ຊອງ		410	
4	Ethilon N:	ຊອງ	1	22000	22000
5	Catgut N:	ຊອງ			
6	ມີດປັດ N:	ດວງ	1	2500	2500
7	Glove sterile N:	ຄູ່	4	4000	20000
8	NSS 1000ml	L			
9	Sond vesical N:	ເສັ້ນ	1	20000	20000
10	Urin bag	bag	1	7000	7000
11	Betadine	Fl	1	20000	20000
12	Compress	m	5	2000	10000
13	Abdominal compress	ສົມ	5	2000	10000
14	Mefix	ກີ້	1	6000	6000
15	ຖົງຍາງໃຫຍ່	ຖົງ	2	2000	4000
16	Alcol 90 %	ml			
17	Dexton	FL			
18	Drian	ເສັ້ນ			
19	Musk	ສັ່ນ	5	2000	10000
20	Caps	ສັ່ນ	5	2000	10000
21	ບັງຄິດ	ກີ້			
22	ບັງຄິດສຳມະດາ	ກີ້			
23	ແບັງໂອຍ N:	ກີ້			
24	Syring N:	ໂອຍ			
25	Syring Acepto	ໂອຍ			
26	Glove non sterile	ຄູ່	5	1000	5000
27	Vaslin	mg			
28	ນ້ຳສະບູແຫຼວ	ml			
29	ແຟບ	ຖົງ			
ລິ້ວມມູນຄ່າທັງໝົດ >>>>				ຄຸນຄ່າທັງໝົດ 21 ຫ້າວກີບ (21.000 K)	

ລາຍເຊັນທ່ານຜ່າຕັດ ລາຍເຊັນຜ່າຕັດໄລ່ ປັນທີ 21 ຫ້າວກີບ ແຂວງ ຫຼວງຈັນ ມີ 07

Figure 5: Various Medical Expenses for Koa

ໂຮງໝໍແຂວງວຽງຈັນ No 28568 /ສໝຂວຈ ໃບຮັບເງິນສົດ ລະຫັດຄົນເຈັບ 1788 ຄົນເຈັບ ບ.໗໓ ວັນ ເດືອນ ປີ 1/1/2019 ປະເພດຄົນເຈັບ ຄົນເຈັບພາກສວນ 251610 ຊະໜາງ	
ເລກບັນຊີ	ລາຍການຈ່າຍເງິນ
200	- ຄ່າຢາ.....ກີບ
216	- ຄ່າຢາສະຫລົບ 2.510.000.....ກີບ
236	- ຄ່າອຸປະກອນຕາບັດ.....ກີບ
234	- ຄ່າອຸປະກອນກະດູກ.....ກີບ
226	-ກີບ
227	-ກີບ
ລວມເງິນທັງໝົດ = 2.510.000 ກີບ	
ເປັນຕົວໜັງສື = (໒.໕໑໐.໐໐໐ ກີບ)	
ລາຍເຊັນຕູ້ຮັບເງິນ	

ໂຮງໝໍແຂວງວຽງຈັນ No 2134 /ສໝຂວຈ ໃບຮັບເງິນສົດ ລະຫັດຄົນເຈັບ 1788 ຄົນເຈັບ ບ.໗໓ ວັນ ເດືອນ ປີ 1/1/2019 ປະເພດຄົນເຈັບ ຄົນເຈັບພາກສວນ 251610 ຊະໜາງ	
ເລກບັນຊີ	ລາຍການຈ່າຍເງິນ
213	- ຄ່າບໍລິການສຸກເສີນ.....ກີບ
220	- ຄ່າອີກຊີແຊນ 10.000.....ກີບ
241	- ຄ່າຮິມຢາ.....ກີບ
242	- ຄ່າແຢງໄຊ.....ກີບ
ລວມເງິນທັງໝົດ = 10.000 ກີບ	
ເປັນຕົວໜັງສື = (10.000 ກີບ)	
ລາຍເຊັນຕູ້ຮັບເງິນ	

ໂຮງໝໍແຂວງວຽງຈັນ No 28569 /ສໝຂວຈ ໃບຮັບເງິນສົດ ລະຫັດຄົນເຈັບ 1788 ຄົນເຈັບ ບ.໗໓ ວັນ ເດືອນ ປີ 1/1/2019 ປະເພດຄົນເຈັບ ຄົນເຈັບພາກສວນ 251610 ຊະໜາງ	
ເລກບັນຊີ	ລາຍການຈ່າຍເງິນ
200	- ຄ່າຢາ.....ກີບ
216	- ຄ່າຢາສະຫລົບ.....ກີບ
236	- ຄ່າອຸປະກອນຕາບັດ 269.000.....ກີບ
234	- ຄ່າອຸປະກອນກະດູກ.....ກີບ
226	-ກີບ
227	-ກີບ
ລວມເງິນທັງໝົດ = 269.000 ກີບ	
ເປັນຕົວໜັງສື = (269.000 ກີບ)	
ລາຍເຊັນຕູ້ຮັບເງິນ	

Figures 3, 4 and 5 represent only a portion of the total bills paid for Koa. The bills include some of the supplies and medicines used to treat Koa up to and including the surgery that removed his spleen. Interestingly, prior to receiving these bills, I had asked hospital staff on numerous occasions for an estimate of the cost of Koa's entire treatment. I was looking for some reassurance that I would be able to afford it. No staff person that I spoke to at the hospital was able to estimate how much Koa's hospital stay would cost. What followed was an interesting and frightening experience, during which I was left floundering, in much the same way poor villagers are left uninformed about what is happening to them or their family member while they are at a hospital in Lao PDR. Up until the moment when I paid the bills, I had no idea whether supporting Koa would become a disastrous financial experience for me. A key difference, of course, is that I had access to many more financial resources than would a poor villager.

Another interesting observation about Koa's bills is the number of them and the way they all account for different things. When I went to pay these bills, I first had to go to one office, where I was presented with a few bills. I was asked to pay each bill individually. Once those bills were paid, I had to go to a different office, where I was asked to pay different bills, and again each of these bills was to be paid individually. The process took two hours and left me dumbfounded, doling out large and small sums of money, in both kip and dollars, to anyone who presented me with a white or yellow slip of paper. Interestingly, no staff person in the hospital was able or willing to add up all the slips of paper and give me a grand total. On a similar note, once these bills were paid, I asked for

another estimate for the remainder of the hospital stay, but no one was able or willing to suggest an amount.

In the end, I paid approximately \$US60 for Koa's medical bills. This cost is in considerable contrast to the estimate of US\$200 that the family received from a district hospital for another treatment that included surgery. Also noteworthy, I paid approximately another US\$100 (or nearly double the cost of the hospital bills) to transport Koa's family to and from the hospital and to support them (with food, etc.) during their stay at the hospital.

A key difference between my experience with Koa's hospital bill, amongst the others I paid, and the experience that poor villagers might have at a public hospital in Lao PDR is that I paid actual bills. I was never offered a lump sum amount that would cover all of the hospital-related costs (but not the indirect, or out-of-hospital costs) to treat the problem. Perhaps hospital staff were unable to estimate a lump sum cost for Koa's treatment. Lump sum payments clearly include unofficial costs—often extraordinarily high unofficial costs—but to my knowledge, I was never asked to pay these. It is possible that a lump sum payment is considerably less complex for villagers, even if the lump sum amount is extraordinarily high.

THE STORY OF SOMXAI

The following story embodies bewilderment. I chose to tell this story as a conclusion to this discussion on bewilderment, and also as a conclusion to all three of the results chapters, because of the deep complexity it represents. I left Phatang with many stories that needed to be told, but this story left me desperate to tell it. For Somxai, and all the other villagers who contributed to this thesis, I hope your stories are heard.

Near the end of data collection for this project, I asked villagers if they might introduce me to more people in Phatang village who were sick or disabled.⁵⁵ The villagers had to think hard because they had already introduced me to many people, and they were running out of ideas about whom I might want to talk to. Eventually they wondered if I might want to talk to Somxai's family. According to villagers, Somxai's problem was that he "walks around the village."

On the day I met Somxai, I met with his family in the bottom level of their house, which was a bricked-in structure, indicating that this family had a modest income. We sat on plastic mats and drank water from worn glass cups. Many members of Somxai's extended family were present at this meeting—about eight people, representing several generations. After greeting each other, the family wondered if I might like to "see him."

⁵⁵ When the researcher asked villagers to introduce her to "disabled" people, she asked about people who had trouble seeing, hearing or walking or who had other health problems. The researcher did not use the term "disabled" because it is not easily interpreted into Lao language.

They led me through their back door, where they introduced me to their son, uncle, brother and father. Somxai was sitting on a wooden floor with his back to me. All around him was a wooden cage. The family had built the cage, but other villagers had donated nails and wood. There was a door, but it was nailed shut.

Upon reflection, there were two things that struck me about the way I met Somxai. First, I was introduced to Somxai very late in the data collection process. I think it took villagers a very long time to trust me with their secret. In his home, Somxai is hidden in the backyard, and I never would have seen him from the road. Villagers had to want to tell me his story. Second, that the community had donated materials to make Somxai's cage tells me that Somxai was a community problem. In rural Lao PDR, illness and disability are family affairs and not something that non-family members would normally help with, especially if the helping costs money. In places of deep poverty, families need to look after themselves.

In 2007 Somxai was 43 years old. The story goes that one night eight years earlier Somxai went out drinking. When he came home, he became very ill and fell on the floor. His body shook uncontrollably, his tongue fell out from his mouth, and eyes rolled back in his head. Since that night Somxai has not recognized anyone except his mother. Prior to becoming sick, Somxai was a schoolteacher. He also had a wife and a child. His wife has since remarried, and she lived elsewhere in the village. When I met Somxai he lived

at his mother's house (in his cage) because she was the person who was able to look after him. His mother thought she was about 80 years old.

The problem with Somxai is that he walks into people's shops, houses and yards and takes what he wants. He can be aggressive, and he sometimes scares people. According to his family, the other villagers "hate" him. Somxai's sister reports that she once took Somxai to a public health care clinic because he had the flu. The clinic refused to see him because he is "useless." She had to get medicine for him from the pharmacy.

The design of the cage is ingenious. It is about eight feet wide by twelve feet long with a raised wooden floor. The bars are wooden and nailed together both vertically and horizontally. The roof is solid in order to keep the rain out. There is a hole in the floor at the back where Somxai can relieve himself. The floor is raised high enough so that the pigs can get underneath and clean up the mess. The family has connected a garden hose close to the cage. They pass the hose and some soap through the bars so that Somxai can wash himself. They also pass food and water through the bars. On the floor of the cage is a sleeping mat. The family says that they would like to build a toilet for Somxai, but they do not have the money

In the spring of 2007, the cage was just a few months old. Prior to building the cage, the family allowed Somxai to walk around the village, and when he became too much of a problem, they tied him to a tree in the backyard or to a pillar in the house. The family and

the other villagers decided together that a permanent cage was a better solution for Somxai than letting him walk around and tying him up. In order to lure him into the cage, they put money, cigarettes and food inside. When Somxai went in to get these things, they closed the door and quickly nailed it shut.

For me, seeing Somxai in the cage was a sobering moment. Even the family, who told their story lightly, and with a bit of humour when they were inside their house, became quiet when we stood in the yard and looked at their relative. They said that they had no other choice. They said that they felt badly for him. Every day they pass him nearly two packages of cigarettes through the bars of his cage. The cigarettes, they say, are expensive.

The family has tried everything to help Somxai. Over the years they have slaughtered four pigs and held many traditional ceremonies. They even took him to two different hospitals in Lao PDR. The first hospital was unable to help Somxai, but the second hospital, in Vientiane, took him in. At that hospital, Somxai was given drugs that made him sleep all the time. The hospital wanted him to stay for a year or more, but the family could only afford one month of treatment. However, because Somxai used to be a schoolteacher, the government paid for half of the hospital bill. When Somxai returned from that hospital stay, he was given some medications to take at home. These medications gave him spots all over his body, so his family stopped giving them to him.

They did not know that different medications might be available. Since this time, they just gave him whatever traditional medicines they found and hoped might help.

During the course of this research, Somxai was taken from his cage and admitted to the only psychiatric ward in Lao PDR, where there were 15 beds and a small number of trained staff⁵⁶. In this ward, Somxai was given a room about the size of his cage. This room had concrete walls and a concrete floor. The floor was smeared with stains and dirt, a legacy of all the patients who had come before Somxai. A single spring bed took up nearly all the space in the room. Once admitted, Somxai was chained to the bed. The door going into his hospital room was cast from thick steel, which was painted green and had a tiny bar window at the top and a big lock on the handle. Somxai's brother slept on the floor of this room the entire time Somxai was in the hospital. At the hospital, Somxai was given psychiatric medications and also some counselling. The medications had to be purchased by the family from a private pharmacy that was located across the street from the hospital. The brother also received counselling on how he and his family might help Somxai at home. Given the circumstances, the hospital in Vientiane did the best they could.

Getting Somxai to the hospital was a major undertaking. The family hired a private *tuk tuk*, owned by a fellow Phatang villager, and the owner agreed to allow the family to build bars around the seating area so that Somxai could not jump out. The tuk tuk owner

⁵⁶ In 2007, there were two psychiatrists in Lao PDR. Both of them were stationed at Mahosot Hospital in Vientiane.

also agreed to volunteer his time. He asked only that the family pay the cost of gas for the tuk tuk. The family then had to lure Somxai out of his cage by telling him that they were taking him to visit relatives far away. Once on the tuk tuk, the family tied Somxai to the seat and fed him chicken and rice to keep him appeased for the three-and-a-half-hour journey. The journey required three family members to manage Somxai. I met the family when they arrived at the hospital. Where the tuk tuk let them off, one family member tied himself to Somxai so that they could walk down the lane and into the hospital ward. While we were sitting in the hallway of the hospital ward waiting to be admitted, Somxai said the only words I ever heard him utter. He said, "Go home." I immediately wondered if this was a good idea.

Somxai stayed in the hospital for about one month. After one month his brother wanted to go home, as it was time to plant rice, and his family needed his help. Also, Somxai had escaped once from the hospital, and his brother spent a frightening day frantically searching Vientiane for him. Somxai was eventually found at the market, eating all the lovely food he could find. The event was disturbing, and perhaps caused the brother to worry that he could not keep Somxai safe in the city. His brother also seemed tired of sleeping on the floor in his brother's hospital room. The hospital agreed that Somxai could go back to his village and continue to take his medications there. Everyone agreed that Somxai was "better" than when he came to the hospital.

Back in Phatang, Somxai lived out of his cage until the time I left Phatang village. The family was happy that Somxai could once again walk around the village and that he was less of a nuisance to other villagers, and also less aggressive. They tried hard to keep him out of the cage. Unfortunately, for reasons that are unknown to me, Somxai was eventually returned to his cage after I left. It is not clear what the exact circumstances were. I have wondered, however, if the family, and possibly the other villagers, kept him out of the cage until after I left for my benefit. They knew that I did not like the cage and that I had tried to help Somxai. Quite likely Somxai remains in his cage to this day.

The above story epitomizes bewilderment in health seeking in Lao PDR, but it also represents many other barriers that cause bewilderment and force poor villagers to live with suffering despite earnest, and often long-term attempts to solve complex health problems. While Somxai's illness would be challenging to treat in any country, his situation echoes the experience of many poor villagers who desperately want to be healthy but cannot find a way.

Somxai's family is not the poorest of the poor. They have land to grow food, and several family members earn a small income. Over the years, the family has managed to earmark bits of money here and there to support Somxai and search for a solution to his problem. All of this spending and searching has been in vain. It is impossible to tell what might be different for this family had they not spent every bit of extra income they had for the past eight years trying to help Somxai.

Somxai's family searched everywhere and for anything that might help him. They also embraced the possibility that either traditional or scientific medicine might help, and they were willing to try remedies that were culturally unfamiliar. During their quest, the family received a so-called discount on health care for Somxai, although the costs were still extraordinarily for them. Over the years, they navigated barriers of distance and unfamiliarity in their unyielding quest to help Somxai. Furthermore, despite tremendous discrimination, they plodded forward, always searching, always hoping. The cage was perhaps a symbolic and real resignation that the family had lost hope for Somxai. However, when they were offered support to hope again, they willingly pried open the cage and rallied together once more to see if a foreign researcher might be their last source of hope. Despite resorting to locking Somxai in a cage, Somxai's family is an exemplar of deeply held love, compassion, commitment and sacrifice that is not often recognized through research that examines the plight of disabled people in poor places.

SUMMARY

This chapter discusses bewilderment, which is distinct from what might be called a cultural aversion to seeking health care from public health care centres in Lao PDR. The distinction is important. When poor utilization of public health care facilities in Lao PDR is understood from a cultural aversion point of view, the cultural aversion rationalization of the problem becomes justification for inertia. When it is understood as a cultural by-

pass, there is little that can be done to resolve the problem of a health system that is inaccessible to poor villagers. Cultural aversion theories envision villagers who are so culturally bound that health systems, despite good intentions, are unable to help them. Understanding the problem as bewilderment, however, allows for possibilities and resolutions. Bewilderment envisages people who are floundering and trying to access a system but who are unsuccessful for reasons that are surmountable. Bewilderment, over time, can turn to harmony.

This chapter focused on how villagers who participated in this study navigated the Lao health system when they encountered a long-term and complex health problem. While Lao villagers have cultural ways-of-being that inform how they seek health care and from where, culture is not what keeps villagers away from hospitals when a complex health problem strikes. In every case, villagers who were faced with a health crisis tried to get help from a hospital, if it was within their means to do so, even if it resulted in economic catastrophe.

Altogether, villagers who participated in this study and who were fearful of the public health care system became distrustful of that same system. Barriers such as administrative procedures, food security, the demands of a subsistence life that make it difficult to survive away from home, and procedures that make it impossible for villagers to anticipate what will happen at a health centre and how much the care there will cost left villagers bewildered by a health system that ultimately became inaccessible to them.

When I accompanied villagers to a hospital, some of these barriers were overcome. Villagers wanted me to help them access the health system because they wanted the security of knowing that they could afford the treatment they might receive there. They also wanted me to help them find where they should go and whom they should talk to. Furthermore, they wanted reassurance that the treatment they might receive at a public health care facility was the correct treatment for their health problem. This was a tall order for a woman who travelled to a little village intending only to collect stories.

The combined experiences that villagers who participated in this study had with the public health care system in Lao PDR created entrenched distrust of the system. In every village where data for this project were collected, stories circulated about the public health care system and what it has done to people. In some cases, the stories were about amazing procedures, and in others they were about traversing a nearly impossible system. The most disturbing story, however, was the one that told about poor people who were sometimes sent away from public health care facilities once they get there—or even during treatment for a serious health problem—because they ran out of money or were unable to gather more money quickly. The story of being sent away from a public health care facility, even if the person presented at the facility near to death, induced immense distrust amongst poor villagers, who suspected that public health care facilities in Lao PDR might purposely treat poor people badly and possibly even cause them harm. In Lao PDR, this story must change to one in which villagers narrate how they were welcomed at health centres as a precursor to public health care reform.

CHAPTER SEVEN: CONCLUSION

This chapter brings together the discussions presented in chapters four, five and six, in which the themes identified by this project are discussed separately. The discussions in these chapters create a base from which to understand many important factors that influenced health care utilization in the villages that were studied in this project. This chapter integrates these findings into a whole understanding of the problem. The chapter begins with my own reflection on my experience in Lao PDR and then moves on to discuss how complexity helps us understand the data collected in this project. From the standpoint of complexity, eight key findings are presented, which have implications for practice. The chapter ends with suggestions for future research.

REFLECTIONS OF AN ETHNOGRAPHER

I arrived in Phatang village with an agenda to observe and record how villagers understood illness and disability. I wondered about the types of treatments villagers sought when they became ill or disabled and the reasons for which they chose different kinds of treatments. I quickly discovered that my research questions were poignant in a village where many people suffered from preventable, and often treatable illnesses and disabilities.

I collected stories in Phatang village and the surrounding areas. Whenever possible, I walked through dusty village lanes, guided by my interpreter and other villagers who became self-appointed key informants, to the homes of villagers. Here I listened to people narrate their stories of pain and suffering. On many days, however, stories unfolded on my veranda. Sometimes, as I prepared to head out for a day of data collection, a story that arrived on my veranda would waylay my plans. Sometimes these stories were urgent, but often they were old stories. Many of the villagers who came to me were looking for a solution to their chronic or long-term health problem.

The stories that I collected in Lao PDR are largely stories of partiality. They were stories without endings. When I arrived in Phatang village, the owners of these stories were wandering aimlessly, looking for an end to their story. They visited my veranda because they wondered if I might know how to end their story. In this way, I became a character in many stories, muddling around with the other characters, seeing if together we might discover how to end the pain and suffering. Very few poor and rural people who connected with this project could tell a story about searching for a solution to a health problem that had resolved.

My ethnographic purpose in Phatang village was a constant struggle for me. I was well versed in the traditions of ethnography so I knew about *grand tour questions* and *descriptive questions*, and all the other strategies that ethnographers should use in the field (Clifford, 1986c; Denzin, 2007; Spradley, 1979, , 2006). I struggled, however, with

what seemed right to do. Even my previous experience as an ethnographer in Swaziland did not prepare me for the desperate responses that my questions would evoke from informants.

In her work on qualitative research methodology in poor African communities, Verma (2001) observes that “*local people are not passive, powerless, unknowledgeable, gender-neutral objects, but actors who can institute change, create and perpetuate knowledge, and play a hand in shaping and transforming the social and physical worlds around them...*” (p. 5). Although villagers seemingly tolerated my ethnographic *raison d’être* in their village, they quickly dismissed all my claims that I was merely a researcher and decided that I would be useful to them, whether or not I wanted to be. Formal medical qualifications are apparently not important to Lao villagers. Having decided that I knew enough about illness and disability, and that this knowledge could be of tremendous benefit to them, villagers set out to crack my crusty ethnographic shell and find the human underneath.

When I returned to Canada, I was not sure if I could relive the stories through the processes of analyzing the data. It was not until I rewrote the stories as my stories, all muddled with my own pain and suffering, that I realized the power of the stories that I had to tell. As hard as it was to listen to, watch, feel and play a part in all those stories, I am glad I did it. Change is not possible unless we stand on the ground and look at the face of the problem.

When I arrived in Lao PDR, I thought that I would return with a story about villagers. What I discovered is that the story is about me. This is my story about my experience living amongst some of the poorest people in the world and asking if I could listen to their illness and disability narratives. It is a story about my journey as a mother, friend, researcher and village guest.

COMPLEXITY

Analysis of the data from this project identified three broad issues that influence the experience of seeking health in the Lao villages that were included in this study. Broadly, the cost of health care, including indirect and unofficial costs; cultural traditions for seeking health care; and complicated systems that exclude poor and rural people are all major barriers that rural villagers who participated in this study encountered when they tried to access the health system in Lao PDR. The greatest challenge in writing this thesis was the process of pulling these topics out of the data and discussing them in isolation. Neither cost, nor culture, nor complicated systems alone can fully explain the challenge of improving health care utilization in Lao PDR. Ultimately, the problem of health care utilization in Lao PDR requires simultaneous reflection on all parts of the problem.

Health seeking in Lao PDR is complex. The stories recited in this thesis represent this complexity. In complex problems, the parts of the problem are not easily distilled from

the whole problem, nor do the parts fully explain the entirety of the problem (Westley, 2007). The health seeking problems identified in this thesis blend together in ways that create subtle circumstances that could not have been predicted. These circumstances are emergent, evolving and influenced by rules of engagement that cannot be seen.

The problem of health seeking in Lao PDR must be understood through all its complexity. Westley (2007) describes the process of social innovation that requires innovators to “stand still” and try to understand complex problems in their entirety. Standing still involves talking and listening to the people who are most affected by the problem. If we stand still long enough, it becomes possible to see things differently. Standing still can change what we see, how we see it, and what we do (Westley, 2007).

Because complex problems are not easily pulled apart, they sometimes appear insurmountable. Too often, complexity becomes an excuse for inertia. Complexity, however, is an opportunity for change. The theory of change suggests that complex problems are usually governed by very simple rules. By standing still, it is possible to observe the simple rules that govern complex problems. Very often change requires little more than the conviction that it is possible to do things differently, and that this difference can cause whole complex problems to shift in a better direction (Westley, 2007; Wheatley, 1999).

This thesis is an example of standing still. The results chapters derive from six months of standing still in a rural village. The chapters offer a rare look at the lived experience of health seeking in rural Lao PDR. They pry open the whole of the problem to discover the parts. The key messages that follow are the result of amalgamating those parts again, to understand the problem of health seeking in all of its complexity.

KEY MESSAGES

This study identified eight key messages. These key messages emerge from all of the stages of work conducted for this project. They emerge from the literature, which provided background information on this topic, from writing and rewriting stories, from pulling apart stories to examine their inner bits, to putting them back together to look at them in their entirety. The key messages present main findings as well as implications for practice.

1. In its current form, scientific medicine can only supplement long-held cultural traditions of understanding and coping with illness and disability in Lao PDR. In order for public health care centres to operate more usefully, a fundamental shift in the way public health care facilities operate is necessary. In Lao PDR, health centres have the capacity to treat the causes of illness as they are understood by Western medicine, but limited capacity to treat what villagers sometimes understand as root problems. Lao villagers often attribute the cause of an illness

to a problem of spirits gone awry, insufficient merit or bad luck. Culture necessitates that villagers attend to long-held traditions for dealing with illness episodes, even if they also seek care from a public health care facility. Often villagers will need to pay for both traditional and public health care options. If they have enough money for only one option, they often have no choice but to engage in long-held cultural forms of health seeking. The assumption that health facilities can resolve illness and disability without seeking partnership with local healing practices is a major barrier to public health care utilization in Lao PDR.

That medical science has the capacity to socially innovate and meet the cultural needs of communities is already demonstrated. In the developed world, hospitals and clinics everywhere recognize the need for families to pray for miracles or seek the strength of God. Most Western hospitals have a chapel, and many have religious ministers who visit patients. The possibility that Western medicine has the capacity to adapt to other forms of cultural practice is evident. It might not be such a leap for health centres in Lao PDR to welcome village spirit healers and traditional medicine people into their facilities. The presence of these long-valued healers in public health care centres would create important links to help villagers make sense of Western medicine and create new paradigms to understand illness and disability.

2. Poverty in rural areas in Lao PDR is largely documented in narrow terms that essentialize poor people as so culturally bound that health systems, despite good intentions, are unable to help them. The overarching vision for health care reform in Lao PDR is to “... *empower people [to take] responsibility for their own health*” (Taylor, 2006). Encouraging communities to take responsibility for their health is a common theme in many documents produced by both governments and non-governmental organizations (Japan, 2006; Lao PDR, 2006b; Taylor, 2006). It implies that the solution to poor health indicators lies in the people who do not take responsibility for, or have not been empowered to take responsibility for their health. Poor people in Lao PDR are seen to have ways-of-being that make them sick (Joralemon, 2006).

The cultural aversion theory to poor public health care utilization in Lao PDR creates a narrow understanding of a complex problem and becomes an excuse for inertia. While culture partly explains why some forms of Western medical practice are utilized, it is not the whole problem. It is necessary to relinquish the cultural aversion theory for a more complex understanding of the problem. Poor and rural Lao people who participated in this study were desperately looking everywhere and for anything to ease their pain and suffering, and the circumstances that kept them away from public health care centres were largely out of their control. In Phatang village, villagers were extremely concerned about getting sick and the disastrous consequences this could have for their family. What

is known is that villagers, when confronted with a serious illness or disability, seek help from all available health sectors (Jacobs, 2004; Khun, 2007; Nonaka, 2009; Paphassarang, 2002; Patcharanarumol, 2009; Syhakhang, 2004).

3. If health centres in Lao PDR are to draw people in, then they must discover ways to harness the power of hope. In his forward to the book *Getting to Maybe*, Eric Young (Westley, 2007) quotes Václav Havel, who would eventually become the president of Czechoslovakia. While he was imprisoned for protesting against human rights abuses, Havel wrote to his wife that “[*Hope*] is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out” (p. vii). Essential to the improved utilization of health services in Lao PDR are changed strategies that will disseminate stories of hope to poor villagers and also partner public health care centres with practices that villagers understand and trust are hopeful.

In their current form, public health care centres in Lao PDR mostly disperse stories of despair. Especially at the secondary and tertiary level, public health care centres are utilized as a last resort, usually in a time of utter desperation and often because of a near-death situation. Even if a person recovers physically from an illness episode, the outcome is often catastrophic due to high costs. Public health care in Lao PDR requires a rebranding. Villagers who resort to public health care facilities, especially hospitals, need to do so because they hope their

problem will be solved, not because they are in a state of despair because their problem appears hopeless.

An appreciation of the theory of diffusion can enlighten the problem (Rogers, 2003). Diffusion is the planned and spontaneous spread of new ideas. Usually a new idea requires that between ten and twenty percent of a population adopt it before the innovation reaches a tipping point, at which time a large percentage of the population will quickly adopt it. Scientific studies rarely influence how adopters accept an innovation. Mostly, people rely on information conveyed to them through other adopters, who are like themselves, about the acceptability of a new idea. For an innovation to be widely adopted, the innovation must prove its advantage over whatever it supersedes; show itself to be compatible with existing values and past experiences; and meet the needs of potential adopters. Often innovations are “reinvented” or modified by users to fit unique circumstances (Rogers, 2003).

In rural areas of Lao PDR where this study was conducted, public health care is struggling to diffuse. A critical mass of users has not been reached, and the information people share amongst themselves about the advantages of public health care over other forms of health care do not create the trust and hope necessary for large-scale adoption. Public health care in Lao PDR needs to devise strategies that will send people home with stories of welcome, acceptance and

hope. Projects, such as those found in Cambodia, that established zero-tolerance policies for unofficial fees and raised expectations that health care staff would provide accurate, timely and respectful care for all patients in exchange for living wages, are exemplars worth noting (Jacobs, 2003, , 2004, , 2005, , 2007a, , 2007b; Noihomme, 2007). Other small strategies, such as taking action when a researcher discovered that five poor families did not get the free health care they were entitled to, would go a long way. In Somsavat village, five pink exemption cards delivered to poor families by the donor agency that determined those families were entitled to exemptions would have created a buzz of hopefulness amongst villagers, who have otherwise given up hoping that their plight might ever be resolved.

4. At the secondary and tertiary levels, public health care in Lao PDR is fundamentally non-existent. What exists is a fragmented system operated by multiple donors and agencies that essentially functions as a private system. If the problems of secondary and tertiary public health care in Lao PDR are ever destined for reconciliation, then an honest view of the problem is necessary. So-called public health care facilities that effectively lock poor people out by charging them extraordinarily high unofficial fees and treating them badly is in effect a pay-as-you-go private system designed for the elite and masquerading as a public facility. Government and donor agencies exacerbate the problem by

refusing to acknowledge the system for what it is and by feeding it through perks and payments that for the most part do not benefit poor people.

If the secondary and tertiary public health care system were recognized as the private system that it is, then the issue of access for very poor people might be better addressed. If the problem were understood that there is *no* public health care system at the secondary and tertiary level that villagers can access, then the solution moves from asking, “How do we get villagers to come to public health care centres?” to, “How can we build public health care centres that villagers can come to?”

5. At the primary level, public health care does function in Lao PDR. Village health centres, are by far the most accessible form of public health care to poor and rural villagers who participated in this study. Village health centres, however, lack the capacity to identify and treat the complex and advanced health problems that villagers may present. Often, by the time a villager decides to seek help from a village health centre, the problem is far beyond what the health centre can identify or manage. Poor utilization of village health centres is exacerbated by the range of other options—in particular, the private pharmacy—that villagers can access to manage mild or early-stage health problems. In essence, the village health centre is in competition with the private pharmacy because of the many overlaps in services provided. Ideally, increased capacity of village health centres would help

increase utilization of these centres by poor and rural people. Alternatively, and perhaps more realistically, strategies to partner village health centres with private pharmacies might create opportunities for improved health services in rural areas. Pharmacies are discussed in greater detail below.

6. The role that pharmacies play in health care delivery in Lao PDR is seriously underestimated. In much of the developed world, pharmacies function as supports to the legitimate health care system. In Lao PDR, however, pharmacies are often the first point of access—and sometimes the only point of access—to Western-style health care for poor and rural villagers (Mayxay, 2007; Murakami, 2001; Nonaka, 2009; Paphassarang, 2002). The major role that pharmacies play in health care delivery in rural Lao PDR requires acknowledgement.

Despite worrisome procedural flaws, the health care system that *is* working in rural Lao PDR is the pharmacy system. Also worrying is the unexamined propensity for health care reform in Lao PDR to focus almost exclusively on enhancing the public health care system, which is poorly utilized, while the pharmacy system, which is used extensively, receives very little attention.

Reforms to the pharmacy system need to occur in tandem with programs that build the capacity of the public health care system and the skills of health care staff, and with at least as much intensity. In this study, private pharmacies were the most likely, and sometimes the only, Western-style health care option that

villagers utilized for early-stage illness episodes. With improved capacity, private pharmacies in rural Lao PDR have the potential to meaningfully impact health indicators and offer important primary health care through distributing appropriate doses and good quality medications for common and easily treated illnesses such as malaria, diarrheal disease and parasitic infections.

Private pharmacies have reached a critical mass of users necessary for large-scale uptake. Partnering private pharmacies with public health care facilities could improve the quality and regulatory control of these pharmacies, while also increasing the appeal of public health care facilities through association with a health care practice that has already garnered widespread community support.

7. Health care reform in Lao PDR has focused on training more doctors and nurses to increase the capacity within the system (Barenes, 2009). Until now, this strategy has been largely ineffective due to complex systemic problems, such as poor pay and undesirable living conditions, which cause highly educated people to refuse to work in rural areas. Research also suggests that the problem with health care reform in Lao PDR is not necessarily a problem with the number of trained doctors, nor perhaps even the quality of their training. The problem lies in the system itself, as indicated by the success of the private system, which is staffed largely by the same people who work in the public health care system. While the world view of health care workers envisions a field of practice dominated by

people who selflessly cure the ill to improve their communities, data available from poor countries, where health workers are paid impossibly low wages, indicate that those working in the curing profession, even in poor places, require compensation for their talents. More than anything, strategies need to be devised to compensate health care workers with living wages in exchange for their hard work and skills (Barber, 2004; Lagarde, 2008; McCoy, 2008; Merlin, 2011; Vujicic, 2009).

8. Donors are complicit in the failure to provide accessible public health care to poor and rural villagers in Lao PDR. Villagers understand that their poor health and lack of good health care are the result of major imbalances in the world. They also know that these imbalances exist for reasons that are out of their control. Usually, social uprisings require a critical mass of middle-class people who have the energy, education and resources to resist suppression (Morris, 1992). Rural Lao people have none of these. Donors have a responsibility to advocate for the people that they intend to serve.

Many of the problems with health care utilization in Lao PDR are well documented. Donors know what the problems are. They know about user fees, unofficial fees, indirect costs, complicated systems, ethnic intolerance and underpaid staff. They should know that their programs are not adequately addressing these problems. Donors have a responsibility to challenge the status

quo through the operation of their programs. If donors stood still, they might see, for example, that patients in hospitals are hungry, and that this is a problem that keeps people away from health facilities that are located far from their subsistence farms.

If donors grasped the theory of complexity, they might see that the solutions to many of the complex problems in Lao PDR are simple. Doctors who are paid poorly require a higher salary; patients who are bewildered by a system require social workers to help them navigate that system; unofficial fees require zero tolerance policies that are enforceable; and poor people who cannot afford health care need someone to pay for their health care.

Many of the solutions that donors support are far removed from the crux of the immediate problem. More trained doctors means more doctors who will set up a private practice so that they can survive. More village clinics that can only administer basic health care are not useful to villagers, who already have access to a cheaper, friendlier and closer pharmacy. Increasing the capacity of a health facility will not increase utilization of the facility if the users are unable to get there.

This thesis adds voice to recent calls that donors adjust their funding strategies to enable real solutions to real problems (Merlin, 2011; Vujicic, 2009). Projects that

run on the rhetoric of sustainability operate on a mistaken presumption of what are the immediate problems that halt progress toward development and improved health indicators amongst poor people. In his book *The White Man's Burden*, Easterly (2006) suggests that innovators who want to improve the lives of poor people go and find out what the problems are, and then solve those problems. Macro plans to change whole systems—as if these systems can ever be mapped or predicted—with lofty goals and funding that changes yearly, have failed to stand still long enough, or in the right places, to witness the on-the-ground struggles that villagers face in their daily lives.

Easterly's (2006) strategy to fix what obviously needs fixing pairs well with complexity theory. The only thing that is certain is that changing one part of a system will necessarily cause change in all the other parts, although the nature of that change can never be fully anticipated. The rhetoric of sustainability is stagnant, risk-averse, and inflated far beyond what it was ever meant to accomplish. It has become an excuse for apathy and a fall-back to justify comfortable ways of doing development. Donors need to decide to jump. They need to decide to pay salaries, hospital bills and taxis fares, and then see what happens. If they decide to do this, one thing is nearly certain: People will become healthier. Furthermore, almost certainly, there will be change within the rest of the system.

IMPLICATIONS FOR FUTURE RESEARCH

Research topics that could further expand the understanding of health seeking and public health care utilization in Lao PDR are:

1. The Lao Human Resources for Community Health Program (LHRCHP) is currently operating a project in Lao PDR that recruits students from rural areas and supports them through a seven-year medical training program. The goal of the program is to train doctors who will ideally be motivated to return to their rural communities and work as health professionals. As students begin to graduate from this program, research into the experiences of these students after graduation, the types of jobs they take, where they take them and why, would give valuable information about the success of this project, and whether similar projects could improve public health care capacity in rural Lao PDR.
2. Several research studies have examined the quality of services provided by private pharmacies. Much more needs to be understood about the situation of private pharmacies in Lao PDR. In particular:
 - Research that examines the contribution that private pharmacies make to health indicators in Lao PDR, and how these contributions, if any, could be built upon to improve pharmacy practice in Lao PDR.

- Research that examines pharmacy practice in rural Lao PDR, where many pharmacies are unregistered.
 - A pilot study that aims to increase pharmacy function in Lao PDR, with plans to ramp up the project in the short term once best practices are discovered.
3. Much of what is known about health care utilization and health seeking amongst ethnic minority people in Lao PDR is based on anecdotal data. While this project did collect data from ethnic minority people, the majority of the data were drawn from Phatang village, where villagers are mostly ethnic Lao. Research on ethnic minority populations is difficult to conduct due to the remote geographical location of most villages, as well as language and political barriers. Research on health seeking amongst ethnic minority people in Lao PDR, however, is essential so that the situation of these people can be better addressed. Other research specific to ethnic minority groups in Lao PDR could include:
- Research drawn from ethnic minority populations living in urban areas about their health seeking and health utilization experiences. As in other poor places, urban poverty in Lao PDR is in large part displaced rural poverty. Urban ethnic groups would be easier to access, and their stories about health seeking could enlighten researchers about the largely unknown experiences of very remote people.

- It is noteworthy that none of the articles reviewed for this study discussed the issue of language barriers in health seeking or health care utilization in Lao PDR. Given that up to 40% of the Lao population speak languages that are dissimilar to Lao language, it seems that language barriers must impact health seeking. Research into what these impacts are would inform public health care policy and practice in Lao PDR.

4. Clearly donors want to fund useful projects that solve pressing problems for poor people in Lao PDR. Research into the barriers and facilitators experienced by donors and NGOs operating in Lao PDR, and the ways in which they could work better, would be useful in improving the operation of projects in Lao PDR. In particular, this study identified several incidences in which sophisticated health care was delivered to very poor villagers free of charge, including girl who had a cleft lip repaired, a woman who received a mastectomy, a man who had a club foot repaired, and a child who was scheduled for heart surgery in the United States. Lao PDR is often a difficult place for NGOs to operate. An appreciative inquiry into how these NGOs have managed to operate successfully, along with data about the challenges they face, would help enlighten others who might also like to operate programs in Lao PDR.

DISCUSSION

This concluding chapter is a melding of close-up data gathered from poor and rural villagers in Lao PDR with global perspectives about what has been or could be done to improve health outcomes for poor populations. This chapter suggests novel viewpoints from which to understand health care utilization and delivery in Lao PDR, and what might be done to improve them. Ultimately, this chapter and the thesis that precedes it is a call for innovation based on understanding problems in all their complexity. In this thesis the problems of health care utilization and health seeking in Lao PDR are discussed broadly under three foci, namely the cost of health care, the influence of culture on health care seeking and the impact of bewilderment. These foci are emergent, changing and characterized by opaque boundaries. They are governed by internal and external rules of engagement that are not easily distilled or documented in ways that identify clear paths to resolutions.

Hopelessness is discussed in this thesis as a powerful consequence of complexity. Many villagers who participated in this study sought help for their health problem from a public health care facility in Lao PDR out of desperation and returned confused, demoralized, poorer and sometimes still sick or disabled. Data from this project indicates that the process of seeking health care from public health facilities in Lao PDR was epitomized by a discourse of hopelessness. Villagers who were rendered hopeless narrated their stories to other villagers. Altogether these stories, told one by one and year by year, create tacit

knowledge amongst poor and rural villagers that public health facilities in Lao PDR are inaccessible to poor people, they are prohibitively expensive, unwelcoming, far away, offensive and bewildering.

Paying close attention to stories and hopelessness has the potential to reduce complexity and see what might be done. In a world where health disparities are pressing and the urgency to do something *right now* is pervasive there is little time or patience for standing still long enough to grasp complexity. This project stood still and examined stories as a method of understanding how poor and rural Lao villagers who participated in this study responded to illness and disability. The stories also revealed processes that created hopelessness amongst informants. The study discovered that the cost of health care, the culture of how Western style health care is delivered and the bewilderment that emerged from current forms of public health care in Lao PDR are main problems but that the overarching consequences of these problems are pervasive stories of despair and exclusion and a resulting discourse of hopelessness.

Innovation in health care reform in Lao PDR requires that innovators look beyond solving immediate problems. While projects that address immediate problems *do* important things, such as immunize children, train health care workers or build clinics, they do not address higher-level barriers to improved utilization of health care and increased health outcomes for poor people. Higher-level barriers include the stories villagers relate amongst themselves about their experiences with public health care and their feelings of

exclusion from a system that is inhospitable to poor people. Change agents who are seeking innovation to health care reform in Lao PDR need to ask themselves, “Will my project (immunization children, training doctors, building health centers) cause villagers to talk hopefully amongst themselves in addition to meeting other immediate goals?” If the answer to this question is “no” then a farther reaching strategy is necessary.

Innovation requires that health project planners in Lao PDR reach up and include goals in their projects that will generate stories of acceptance amongst poor villagers and begin the process of creating a dialogue of hope.

Reaching beyond immediate problems requires understanding problems differently.

Understanding problems differently requires standing still long enough to make sense out of complexity. Moreover, doing something with new knowledge requires a conviction that change is possible and a willingness to venture into uncharted, and perhaps unconventional, ways of meeting the needs of poor and rural people. It might mean expanding the notion of partnership and who it is possible to partner with. It might mean engaging in so-called unsustainable practices such as paying wages to health care staff and giving food to poor people in hospitals. It might also mean accepting the priorities of poor and rural people. The eight key statements presented in this chapter result from standing still and examining problems through all their complexity. The suggestions embedded in these statements reach beyond immediate solutions to problems to include strategies that endeavor to change the dialogue of health care for poor and rural people in

Lao PDR. These suggestions are offered to encourage those who would take up the challenge to stand still and listen for stories with endings and stories of hope.

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APPENDIX A: VILLAGE LEVEL DATA COLLECTION SITES

For this study, village-level data were collected at Phatang village, Somsavat village, Namuang village, Phoxay village, Somsinxay village and Vang Vieng. Additional data were collected from villagers who attended the Phatang Health Centre from Keokuang village and Thin-On village. The following section offers additional information, as was available to me in 2007, about each of these data collection sites.

Phatang Village

Phatang village is located 18 kilometres north of Vang Vieng on a paved road. In addition to the local health centre, Phatang village had one licensed private pharmacy and one other informal “doctor” who sold medicines from his home. There was also one midwife and numerous traditional and religious healers. The village had a temple and several small shops that sold basic goods and sometimes a small selection of cooked food. The village had dirt lanes that became difficult to navigate during rainy weather. Phatang village had both an elementary and a secondary school. Most of the villagers in Phatang village practised Theravada Buddhism and most were ethnic Lao people.

Houses in Phatang village were mostly constructed from wood in the traditional stilt style common to ethnic Lao people. However, in 2007, many families had constructed or were in the process of constructing concrete walls around the bottom of their house, an indication of relative prosperity in the village. Electric supply in the village was

reasonably consistent, and cell phone coverage was good. Water supply, however, was problematic. Villagers who had a supply of water at their house usually directed the water from an underground spring through a hose. The high demand for water in the village, and the limited supply, especially during the dry season, made for water stoppages that could last several days. During the rainy season, the water supply was visibly tainted with silt and runoff. A truck drove through the village twice a week selling 30-litre containers of filtered water for 3,000 Kip (US\$0.30) each.⁵⁷

Almost all of the villagers in Phatang village were subsistence farmers. Many villagers also had small river gardens. Very few villagers had a job outside of farming except for those who had a small business within the village. There was a seamstress, a motorcycle repair shop, an ice shop, a Lao Lao⁵⁸ shop and a few other small businesses. A number of villagers owned a weaving loom, which they operated if they had yarn and a customer for their product. Villagers who had spare produce or eggs sometimes walked around the village offering these products for sale. A motorcycle drove through the village every day selling meat. Occasionally other trucks drove through the village selling fish, ice cream or sweet breads. Many villagers owned chicken and some had pigs or cows. Chickens and cows roamed the village freely, but pigs were penned. A small number of villagers in Phatang were landless and lived in houses constructed from woven bamboo

⁵⁷ The quality of this water is questionable, however. I became ill from this water, and villagers report that the quality of this water is very poor. Water specialists working in Vientiane further report that it is impossible to properly filter 30-litre water containers and sell them for only US\$0.30.

⁵⁸ Whisky

with dirt floors. These people were relocated to Phatang village as part of government relocation schemes.

Somsavat Village

Somsavat village is located 10 kilometres north of Phatang village (28 kilometres north of Vang Vieng) on a paved road. Villagers in Somsavat were relocated from three other remote villages, some of them up to 20 years earlier. In 2007, there were 184 households in Somsavat village. Most villagers in Somsavat lived in bungalow-style bamboo houses, built in the traditional style of the Yao ethnic minority group in Lao PDR. Houses in Somsavat village were mostly small and had dirt floors. Many villagers were landless and very poor. Some villagers travelled between 5 and 10 kilometres on foot each day to mountainside slash-and-burn fields that they cleared for growing rice. Somsavat village did not have a pharmacy although a local shop sold basic medicines. A trip to the nearest health centre (at Phatang village) from Somsavat village cost 20,000 Kip (US\$2) each way, likely more than the actual cost of visiting the health centre. Mobile health teams visited the village every three months, but services were limited to immunization and basic education programs. Most homes had no electricity, but water was available from a well located in the centre of the village. A local elementary school offered schooling up to Grade five, after which students were required to travel 10 kilometres to Phatang village, either on foot or by bicycle. Data were collected from villagers who lived in Somsavat and were entitled to free health care due to their poverty. Data were also

collected from friends and family of a student who attended our free English-language classes in Phatang village. Additional data were collected in Somsavat village in conjunction with a mobile immunization clinic conducted by staff from the Phatang Health Centre in March 2007, which I accompanied.

Namuang Village

Namuang village is located 10 kilometres east of Vang Vieng and 28 kilometres southeast of Phatang village. In 2007, there were 272 households in Namuang village. The road leading to the village was dirt and impassable during the rainy season. Namuang village was very poor, and most of the villagers were ethnic minority people. In 2007, there was a newly built health centre in Namuang village. The health centre had its own generator, which provided small amounts of electricity. There was a water well located on the grounds of the health centre. The village had no electricity, and villagers collected their water directly from a nearby river. There was no pharmacy in Namuang village. There was also no market. Villagers in Namuang survive on what they could grow themselves. Data for this project were collected primarily from the health centre and the Lao Human Resources for Community Health Program (LHRCHP) interns who were working there. Data were also collected in conjunction with a Canadian colleague from the LHRCHP, whom I accompanied when she conducted a one-day clinic at the Namuang Health Centre in February 2007.

Phoxay Village

Phoxay village is located halfway between Phatang village and Vang Vieng (about 9 kilometres south of Phatang). The village is located directly along the paved road. In 2007, there were 183 households in Phoxay village. There was a temple, several shops and a pharmacy. There was no local health centre. Most of the villagers in Phoxay were ethnic Lao people. Phoxay village is located within the service area of the Phatang Health Centre, although many Phoxay villagers who participated in this study stated that they preferred to utilize the district hospital in Vang Vieng because the distance was the same and they felt that the quality of care at the hospital was better. Phoxay villagers primarily practised Theravada Buddhism. Interestingly, Phoxay village had a rice bank, where villagers could get rations of rice if they did not have enough of their own. The village also had a community money fund from which villagers could borrow if they were desperate. The leader of Phoxay village kept detailed records of all of the people living there. Of particular interest to this study was a special record kept by the village leader that identified all of the disabled Phoxay villagers between the ages of 2 and 45 years. This record listed who the person was, his or her problem, and when it started. Handicapped International had previously operated a project in Phoxay village, which may account for the presence of this record. Data were collected from many of the people indicated on the disabled villagers record. Most of this data came from informal interviews. Data were also collected in conjunction with a mobile immunization clinic conducted by staff from the Phatang Health Centre, which I accompanied.

Somsinxay Village

Somsinxay village is located 4 kilometres south of Phatang village on the main paved road. The village is located directly on the road. In 2007, there were 285 households in Somsinxay village. Data for this project were collected from the local *moh mung* (bone healer), who lived in Somsinxay village. Informants from both Phatang village and Phoxay village used the *moh mung* to help with bone problems. In addition, at the time of interviews, the *moh mung* grandson had a broken bone. The *moh mung* demonstrated how he heals bones and the medicines he used in his practice. This *moh mung* was widely referred to during data collection, both by people from Somsinxay village and by people who lived in surrounding villages.

Vang Vieng

Vang Vieng is one of the larger centres in Lao PDR. It is located 18 kilometres south of Phatang village. In 2007, there was a newly constructed district hospital in Vang Vieng. Also at this time, considerable efforts were underway to improve the capacity of the hospital. For example, in 2007, the district hospital in Vang Vieng had just begun conducting Caesarean sections. It was also hoped that the hospital would soon have the capacity to administer blood transfusions. The town of Vang Vieng had many shops,

multiple pharmacies, restaurants, hotels and several tourist attractions, most notably eco-tourism attractions. There was also a good market in Vang Vieng that sold a wide variety of fruits, vegetables, clothing, electronics and other household goods. Data for this project were collected from families with whom I connected when I travelled through Vang Vieng. Data were also collected from the hospital, where I accompanied numerous villagers. Further data were collected from several staff members and administrators at the Vang Vieng District Hospital.

Keokuang Village and Thin-On Village

Data were collected from villagers who travelled to the Phatang Health Centre from Keokuang and Thin-On villages, although I did not visit these villages in person.

Villagers from Keokuang and Thin-On villages are ethnic minority people and most are very poor. These villages are very remote and difficult to access. I tried many times to visit these villages in person, but staff from the Phatang Health Centre were reluctant to take me along because the trip required several days of travel and they were concerned about my safety if I travelled into remote areas.