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A Comparative Analysis of Access to Reproductive Health Care in Laos and Southeast Asia

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LOYOLA UNIVERSITY CHICAGO

A COMPARATIVE ANALYSIS OF ACCESS TO REPRODUCTIVE HEALTH CARE
IN LAOS AND SOUTHEAST ASIA

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

PROGRAM IN WOMEN'S STUDIES AND GENDER STUDIES

BY

MALAKHONE SONETHAVONG

CHICAGO, IL

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LIST OF ACRONYMS

Acquired Immune Deficiency Syndrome	AIDS
Antiretroviral Therapy	ART
Association of Southeast Asian Nations	ASEAN
Cambodia, Laos, Myanmar, Vietnam	CLMV
Civil Servant Medical Benefit Scheme	CSMBS
Community-Based Health Insurance	CBHI
Compulsory Social Health Insurance	CSHI
Compulsory Social Scheme	CSS
Department of International Cooperation	DIC
Gross National Income	GNI
Gross Domestic Product	GDP
Health Equity Fund	HEF
Health Sector Development plan	HSD
Human Papilloma Virus	HPV
Human Immunodeficiency Virus	HIV
Medical Welfare Scheme	MWS
Millennium Development Goals	MDGs
Ministry of Health	MoH
Ministry of Public Health	MoPH

Ministry of Planning and Investment	MPI
Sexually Transmitted Diseases	STDs
Sexually Transmitted Infections	STIs
Socio-Economic Development Plan	NSED
Social Health Insurance for the poor	SHI
Social Security Organization	SSO
State Authority for Social Security	SASS
Total Health Expenditure per capita	THE
Voluntary Social Health Insurance	VSHI
Universal Health Coverage	UHC
United Nations	UN
United Nations Children's Fund	UNICEF
United Nations Development Program	UNDP
United Nations Population Fund	UNFPA
World Health Organization	WHO

ABSTRACT

This thesis research aims to unravel main barriers that prevent women from being able to access reproductive health care in Laos in comparison with other two Southeast Asia countries which are Thailand and Vietnam. The comparison of Laos, Thailand and Vietnam will be explored through an analysis of a literature review. This research explores the critical issues and on finding a mutual understanding between the role of the policy makers and the implementers of policies. At the end of the research, some recommendations on health care system improvement and personal perspective towards the rights of women on reproductive health and gender equality in Laos will be discussed.

CHAPTER ONE

INTRODUCTION

Purpose of the research

This thesis research aims to unravel main barriers that prevent women from being able to access reproductive health care in Laos in comparison with other two Southeast Asia countries, Thailand and Vietnam. These two countries, Thailand in particular, were selected to be included in this research because of demographic location, socio-economic status, culture and language similarity. The main objectives of this research are to:

1. Examine three social factors that affect women's rights and their lack of access to health care services. The three factors to be examined consist of poverty, gender inequality, and the national health care system.
2. To convey the importance of the health care situation to policy makers, health care donors, and project implementers.
3. To educate women on their basic rights regards to reproductive health care in rural areas, as well as their family members of the women who reside at the same house, particularly the spouse or male partner, local communities and health care professionals who have a direct influence on both their mental and physical.
4. Implement and propose effective and sustainable solutions for the human rights of women on reproductive health care.

The purpose of this research is to explore the critical issues and create a discussion with the goal of finding a mutual understanding between the role of the policy makers and the implementers of policies. It is essential that both parties share the same vision and understanding that policies might be inapplicable in certain situations. Thus, being aware of unpredictable factors will allow policy makers to create a network suitable for different areas of the populations.

Methodology and Data Resources

The methodology used in this study is a comparative framework by examining three social factors that prevent Lao women access to reproductive health care. The three factors to be examined are poverty, gender inequality and national health care system.

The above mentioned methodology will be broken down by the following details:

1. Literature review of health care in Southeast Asian countries (Laos, Thailand and Vietnam)
2. Perspective of women's human rights on reproductive health care
3. Health policies and implementation of policies
4. The role of communities and social media towards women's right advocacy

These analyses are inspired through the academic discourse where the western medicalization of women and women's health are interrelated and intersect with gender issues. For example, the medicalization of menopause of women in their middle age or older women. I believe the medicalization of menopause of women is essential because this will help them to live healthily. It is their rights to reproductive health that many should understand the changes of

physical and mental health of women's health through different stage of life, and then provide support, particularly the husbands or male partners.

The comparison of Laos, Thailand and Vietnam will be explored through an analysis of a literature review. Thailand and Vietnam were selected as a part of this study due to their three main similarities with Laos. First, Laos, Thailand and Vietnam are members of the Association of Southeast Asian Nations (ASEAN). Second, Laos has similar cultural practices and language to Thailand. Finally, Vietnam is also one of the CLMV countries. The CLMV countries consist of Cambodia, Laos, Myanmar and Vietnam. These countries are the developing countries within ASEAN (Lim and Nyunt 21). Therefore, these countries were chosen not because of their close proximity but because of their cultural similarities and current economical statuses.

Data to be used in this paper will be mainly derived from two main sources. The first sources are official online publications (including those published in Lao language which will be translated into English) of the World Health Organization and other UN agencies, ASEAN Secretariat official website and its publications, academic journals and databases from Loyola University Chicago Library. The second sources are information from specialists from various organizations.

In addition to this, the use of media in the area of reproductive health promotion in Laos will also be introduced in the research. To complete this research, further recommendations regarding potential transitional, regional, and continental collaboration, as well as funding mobilization will be discussed. The future recommendations will analyze health care situation in Laos to donors, some recommendation for health project implementers (Lao government officials for example), women's (reproductive health) rights advocacy approach strategies, and

good samples of how feminism in the U.S contributed to the society to fight for gender equality. The term feminist and understanding of feminism are considerably still a new field and concept. As a result, lessons learned from the U.S institution regarding women's studies and gender studies, will be able to contribute to a positive impact towards Lao society through women's reproductive rights.

Country Overview of Laos

Laos, or as it is officially named Laos People's Democratic Republic (Lao PDR), is a landlocked country in Southeast Asia. The country shares borders with five countries in the Greater Mekong (river) region namely China, Vietnam, Cambodia, Thailand and Myanmar (ASEAN Health Profile-Regional Priorities and Programs for 2011-2015 (Updated Version) 19). The capital city of Laos is Vientiane, the land area of the country is 236,800 sq km. The population resides densely among the valleys of the river, particular the Mekong River (Country Briefing Guide Lao PDR 2).

According to the report of the United Nations in Lao PDR (2015), the geography of Laos is hilly and mountainous which account for 80% of the whole country, only 25% of the land is cultivatable. The currency of Laos is Kip ("ASEAN Member States - ASEAN | ONE VISION ONE IDENTITY ONE COMMUNITY") and the official language is Lao. The demographics are categorized into three distinct categories. Each type of population is identified based on the location they resided in. The three categories of residents are lowland or lowland Lao (Lao loum), midland or midland Lao (Lao theung), and upland/highland or upland/highland Lao (Lao song) (Rigg 711). With regard to the three main categories of Lao population, it is known that the lowlanders occupy 56% of the total population (Country Analysis Report: Lao PDR 2).

The terminology lowland (Lao loum) refers to Lao populations who reside along valleys. Midland (Lao theung) is the population of the mountain slopes, and highland or upper land concerns with inhabitants of the mountain tops. These terms have been widely used since 1950s until now among academics and professionals (Pholsena 180).

Laos ranks 141 (out of 143 countries) as a medium human development index country (Jahan 214). Despite the fact that Laos is known as a poor country within economically vibrant Southeast Asia region, at the same time it is also a forgotten country within the region. In Southeast Asia studies, Laos would be invisible and unattractive to the eyes of many researchers and scholars. Due to political barriers and inconvenience of geographical access that almost impossible to travel to rural areas of the country. This sounds unfortunate for the country in terms of lack of research. Dating back to 1975, there was the first publication of a study grounded Lao rural society which the title of the book was Lao Peasants under Socialism by Grant Evans (Rigg 703). The publication was released during the year for Laos to become independent and officially established the country of Lao PDR. However, this book is out of date because it has already been more than two decades since its publication.

Even though Laos is recognized as a poor nation, its economy has constantly been improving over the last decades. According to the report from the World Bank in 2015, the Gross National Income (GNI) per capita of the country was \$1,740, with the Gross Domestic Product (GDP) growth per annual 7,4% as of 2015. People who were living with poverty and earning less than \$2 per day account for 16.72% of the total populations. This indicates that 2 million people within the country were poor and living with poverty within the country (“Poverty & Equity Data | Lao PDR | The World Bank”).

Demographic structure

In terms of the population, the number of people has increased over time and the nature of age group are varied, according to the Lao Statics Bureau, the housing and census conducted every 10 years. In 2015, the World Bank reported that the total population of Lao PDR has risen to 6,802,000 people (“Lao PDR Home”). The population has continually increased over time since the population census was first conducted in 1985. The population rose from 4,574,848 in 1995 to 5,621,982 people in 2005. Even though the population is continuously growing over the decades, Laos is still considered as one the smallest nations in Southeast Asia with the population slightly higher than Singapore, yet less than half of Cambodia (Results of Population and Housing Census 2015 21-23).

The average life expectancy of the Lao population at birth is 68.3 years and adult literacy rate is 73% (“About Lao PDR). The majority of Lao citizens are Buddhists which account 64% of the total populations, 31.4% identify as no religion, 1.7% are Christians, and 2.1% belong to a religion other than these. Lao population has the median age at 23.5 year-old, and the most dominant group is 16-64 years old which accounts for 63.7%. The age group from 0-14 constitutes 32% while senior population age 65 years and above is relatively small at just 4.2% of the total population (Result of Population and Housing Census 2015 33-37)

Health Status of the country

With regard to the population health and economic status quo compare to other ASEAN neighboring countries, Laos’s health care system is still behind many other ASEAN member countries. The country has a number of health care challenges that have been a dilemma for decades. Even though the government of Laos tried its best to reform public health system, it

remains as an uphill progress. The Lao government has developed a master plan on health care reform in and decree on health insurance to ensure every citizen receive quality health care.

The Ministry of Health (MoH) of Laos has developed a Five Years Health Sector Development Plan (HSD) with the hope to improve the health sector in Laos and to ensure Lao citizens have equally access to health care. The HSD plan will be updated every five years which it is created through the collaboration and guidance of the National Assembly and the resolution of identity. The new plan will be modified and updated from the outcomes, monitoring and evaluation of the previous five year plan. For instance, the 7th Five Years Health Sector Development Plan (HSD) (2011-2015) is developed based on the 6th HSD plan 2006-2010.

According to the 7th Five Years HSD plan (2011-2015), the government of Lao PDR aimed to achieve the specific task of the health sector and to complete the Millennium Development Goals (MDGs) which the United Nations (UN) had endorsed. The government acknowledges the importance of health of its citizen. Therefore, they government put its best effort to improve care system development and ensure to deliver quality health service for all (1).

In contrast, there are number of factors that hinder Laos from reaching quality health care service for its citizens. The report from Department of International Cooperation (DIC) of the Ministry of Planning and Investment (MPI) indicated that inputs to health sector in terms of health expenditure, health care coverage and health professionals remain low. Laos has the lowest expenditure on health care in the ASEAN countries. The Total Health Expenditure per capita (THE) was 33 US dollars while general expenditure on health care by the government achieved only 3.4%, which is the lowest in ASEAN countries. In terms of health insurance coverage, in 2015 the coverage was 32% and approximately 50% of the population at the end of

2016. The progress had been made due to the newly introduced National Health Insurance Scheme from the government. The number of health professionals in Laos is considerably low. For example, many health centers (two-third of the country) still do not have any midwives. Nationwide, only 36% of health centers have at least one midwife (Progress Report on Sector Working Groups 2016 41).

Status of Lao women

Women's position in Laos is still a challenging issue. Cultural beliefs and social norms about women's inferiority affect the life of Lao women in a number of forms, particularly ethnic minority women in poor rural areas. In Lao culture, men are considered leaders of the households. Men are representatives of family and have more power in decision making. Most of official meetings on village development programs involve men instead of women. Ethnic minority women, in particular, are less literate than men. As a result, they are under-qualified to participate in activities of their communities (Siliphong, Khampou and Mihyo 13).

According to Siliphong, Khampou and Mihyo, women's role in economic and agricultural areas is less valued and less visible than men's even though they provide the same input of work as men. For instance, women have great participation in agricultural work, where they play an important part in using natural resources, in addition to taking care of family members' food security. The roles of women are often unrecognized or invisible. Even if women and men would spend the same amount of time in agricultural work, men would spend more hours on income generating activities. However, in economic activities, Lao women own informal small business such as retail and textiles. With additional income from small business units and handicraft work, besides their farm work and household chores, women earn income to

support their families. However, there is also a limitation for women in working outside the home because traditionally women are expected to work close to their villages. Even though women have chances to work in formal sector, they then to be found working in low-skilled jobs, and it is rare to have women work in managerial positions (13).

Laos has a gender disparity in formal education, particularly for girls in rural areas and the poor. The Asian Development Bank and World Bank on Country Gender Assessment for Lao PDR indicated that in the rural areas of Laos fewer girls than boys are enrolled in secondary schools, and girls more than boys tend to drop out from schools. As a result of gender disparity in formal education, the dropout rate is still increasing even though the government has attempted to demolish gender gaps in school enrollment in the primary level. The higher the education level is also lower for female than male students (Country Gender Assessment for Lao PDR 22-23).

Poverty, distance from home to school, spendings, and traditional beliefs are likely to be main factors that prevent girls from being able attend schools. Most poor families fail to recognize the importance of formal education of girls in order to improve their living. With a lack of support by parents, children are discouraged from attending school, particularly ethnic minority groups whose linguistic barrier and cultural perspective of girls not to receive high education are strongly maintained. These notions sustain the cycle of low human resource development and poverty among the ethnic minority groups (Siliphong, Khampou and Mihyo 14).

Beyond educational disparity issues, gender inequalities on health in Laos come in a number of forms. Lao population in rural and poor areas have limitations to access clean and safe

water and sanitation. Water collection is a heavy burden for women, girls, elderly and ill persons. Women take roles as caregivers for family members' health and hygiene, women are more likely to suffer when safe drinking water and sanitation are difficult to access or unavailable. Girls are also unable to make time for studies due to water collection. It also affects their physical development since they are still young and have to carry water from sources back home (Country Gender Assessment for Lao PDR 29-30).

As discussed on the overall country review of Laos, it is understood that women's rights to reproductive health care services closely intersect with the country's circumstances of geography, demography, poor health care system and gender disparities. Barriers for most women's and girls' reproductive health are strongly related to location of where women reside, and the nature of the population on health seeking behaviors because of poor health system, and gender disparities on health reproductive health care. The following chapters will explore the health care system in Laos, Thailand and Vietnam to understand the mechanism of each country's health strategies. Finally, possible solutions will be addressed in order to encourage change to the impoverished health service in Laos and introduce new perspectives of gender issues in Laos.

CHAPTER TWO

HEALTH CARE IN SOUTHEAST ASIA

Prior to an exploration of health care in the Southeast Asia region, it is essential to identify the term Southeast Asia Region for this research. This is to ensure that the context of this study is specific, relevant and precise. The term Southeast Asia region for this paper refers to countries under Association of Southeast Asian Nations (ASEAN). The ASEAN consists of ten state members namely Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam (“ASEAN Member States - ASEAN | ONE VISION ONE IDENTITY ONE COMMUNITY”).

The ASEAN was officially established on August 8, 1967, in Bangkok, Thailand. Initially, there were four member states to sign the ASEAN Declaration (Bangkok Declaration), which are Indonesia, Malaysia, Philippines, Singapore and Thailand. The headquarters of the ASEAN are based in Jakarta, Indonesia. At a later stage, other countries within the region had joined the association. In 1984, Brunei Darussalam joined the association followed by Vietnam in 1995. Lao PDR and Myanmar joined in 1997, and Cambodia in 1999 (“About ASEAN - ASEAN | ONE VISION ONE IDENTITY ONE COMMUNITY”). Despite a strong solidarity among the nations, there are disparities among the member states among CLMV countries. The CLMV countries consist of Cambodia, Laos, Myanmar and Vietnam (and they are newer members of the ASEAN). These countries are as low-wage low-income countries where

infrastructure, education, governance, and trade regimes are needed to be improved to become more competitive (Mathai et al., 5).

Medical tourism in Southeast Asia

Medical tourism involves patients who travel to seek health care service in other countries (Chongsuvivat et al.). Guojinga and Zhiju indicated that medical tourism holds its own motives that meet the need of patients. Apart from the motives of medical tourism itself, medical tourists also have their own demands in medical tourism, which consists of five components. First, patients expect lower prices and good medical service. Second is time savings in treatment. Third, advancement or uniqueness of medical technology are important. Fourth, medical tourists look for unique or exotic tourism environments. Finally, medical tourism is a symbol of status (67-68).

Medical tourism has developed rapidly in Singapore, Thailand and Malaysia (Kanchanachitra et al., 770). According to Kanchanachitra, with the high demand on health workers within the region, the Philippines and Indonesia are known for human resources hub to export their health specialists to supply the demand of the region. This makes a trend of health care professionals migrations as well as migration from public to private hospitals to provide service to international patients, particularly for high skilled health experts. International patients travel from their home countries to seek health care treatment in Thailand, Singapore and Malaysia both regionally and internationally. For example, since medical tourism is very popular in Southeast Asia, many international patients from U.S, U.K and Germany fly to Thailand for health care treatment, while patients from the Middle East, Japan, and Australia would travel to either Singapore or Malaysia (773-775).

In Southeast Asia, Singapore, Thailand and Malaysia are the top destinations for medical tourism, in particular Thailand, which is the leader in medical tourism. Each year the country welcomes more than 1.5 million patients who seek medical care while Singapore and Malaysia are little bit behind (Acuin et.al., 534-535). Thailand also ranks as the second largest medical tourism country in Asia. In terms of tourism, Thailand is famous for its beautiful nature scenery and beaches. Patients who seek health treatment in Thailand bring hundreds of millions of dollars revenue to the country every year.

Malaysia is also known as one of the countries among Asian countries that developed medical tourism. Beyond this, its hospitals' medical equipment is recognized as the best in Asia. Singapore is also well recognized for first-class hospitals in Asia and is an English speaking nation. Most of its citizens have received secondary or higher education, and they speak English, which reduces language barriers with English-speaking westerners. The government of Singapore has recently been accelerating medical tourism. The country aims to attract at least one million foreign tourists to receive medical treatment each year (Guojinga and Zhiju 68).

For people from Laos, for example, as a country within Southeast Asia, the primary medical tourism destination would be Thailand. There are a number of factors that attract Lao patients to seek health care service in Thailand, particularly among well-off and urban citizens. There is a long history of Lao patients crossing to Thailand and get health care treatment. Due to a number of limitations of health care centers in Laos, there are inadequate qualified specialists to treat some types of severe illness as well as a lack of modern medical equipment. Therefore, many look for better medical service elsewhere. Discovering an accurate number of Lao patients seeking health care in Thailand seem to be very challenging since supporting data are very rare.

Notwithstanding, there is a research on health care seeking in Thailand. The research shows that Lao patients who decided to seek health service in Thailand must be equipped with good financial standing. This is because crossing to Thailand not only requires time, but also spending money to cross the border bridge between Laos and Thailand, medical visits and medications. In addition to this, Thai health care services are more attractive for many. Thailand and Laos share common cultural practices, religious beliefs (Theravad Buddhism), and linguistic background (Bochaton 365). Therefore, Thailand would describe itself as a big brother and Lao as a younger brother (country). Unfortunately, it is a considerably bittersweet truth that the two countries are often described as “enemy brothers” because, centuries ago, when the Siamese empire wanted to govern Lao Lanxang Country to become part of Thailand, there was a tremendous fighting between the two countries. That finally resulted an unimpressive historical event and legacy of war between Laos and Thailand.

Bochaton also explained that Lao patients had decided to cross to Thailand because of the country’s poor health care network in Laos (throughout the country), limited access to health centers, under-skilled doctors who might be misdiagnose patients, malfunctioning healthcare facilities, and, last but not least is good reputation Thai health service. For some patients, they might never consider seeking health service in Thailand. But due to worsening symptoms of their health condition and unavailable treatment in the Laos, they would seek advice from friends who had received health care in Thailand and have already recovered from illness. In addition to this, they also heard rumors of good health treatment in Thailand. They would finally seek health treatment in Thailand. As it is medical tourism, Lao patient cross to Thailand for health treatment

as well as take an opportunity to do shopping, exploring places, and even sometimes visiting family who reside in Thailand (366-369).

Chen and Flood suggest the migration of health professionals from public to private hospitals also causes income disparity among health workers and health care inequity for local citizens. Private health industry attracts health specialists with higher and promising income along with fewer workloads. In Thailand, for example, the remuneration of medical doctors in private health hospitals is between six and eleven times higher than public ones. Skilled health professionals in private health institutes effectively attract international patients, yet limit the accessibility for local citizens, particularly the poor. The migration of health specialists causes an uneven distribution of health professionals or, in other words, internal brain drain. As a result, health professionals' migration directly affects access to health care for the poor and locals who rely on public hospitals (290). Medical tourism in Southeast Asia mainly operates by private health institutes. In Thailand, for instance, there are four private hospital chains that are well known and welcome foreign patients. Those four hospitals are Bumrungrad, Bangkok, Thonburi, and Phyathai. In addition to this, with high-tech medical equipment added to health care, the cost for treatment is raised, and this contributes a burden for the poor of pricey health care payments (Chen and Flood 289).

Medical tourism within Southeast Asia is on the rise, particularly in Thailand, Singapore, and Malaysia. This results in health care workers' income disparities, and the effect of added modern health care equipment that lead to negative impacts on health care access, treatments, and costs for locals and the poor in Laos.

Medicalization and traditional medicine in Southeast Asia

Medicalization had been studied by sociologists since the late 1960s; the first study emphasized on the medicalization of deviance. Conrad addressed the term medicalization as “a process by which non-medical problems become defined and treated as medical problems, often in terms of illness and disorders.” The concept of medicalization was later perceived and applied to a broader range of human issues that involved medical jurisdiction. The definition of medicalization is a key to understanding what the term refers to: technically “medicalize” refers to “to make medical” (Conrad 4-5).

As addressed earlier in this research regarding health care in Southeast Asia, medical tourism is increasing Western style medicalization. Health care technology in the U.S and ASEAN countries are different which is compatible in terms of advancement of medical engineering and medicalization. For ASEAN countries, only some developed countries have advanced medical technologies while others still in a stage of improving basic health care system which a lack of necessary medical facilities. Some countries, particularly in poor rural areas, still rely on traditional medicines as basic medications. This is because of health care disparities among the neighboring countries as well as the rich and the poor within countries. For instance, Laos, Thailand and Vietnam, which are case studies for this research, still have health care disparities and differences in a number of factors. Even though these three countries are closely located to each other, particularly Laos and Thailand which language and culture are very similar, yet there are disparities on health care.

From my perspective I believe that medicalization might be useful for Laos in the future, but not for now. This is because Lao health care system is still in the stage of improvement and

human resources still a lack. The majority of Lao populations still have to spend out of pocket for health treatment. To some extent, I think medicalization is also a luxury health care for those who seek better health and well-being above the basic health issues, and it might help some people live the better and easier life.

In some parts of the globe, many are able to access to Western medicine while others are unable to access basic medications because of poverty. There are disparities in Western medicine, which is known as overmedicalization and undermedicalization. It is arguable that medicines from wealthy countries might not be as effective among patients in developing countries. This is due to the fact that those medications were manufactured to serve different health conditions for populations in wealthy nations, and this might be ineffective to cure populations in developing countries with different health circumstances. For instance, most developing countries encounter more pandemic disease, such as malaria and cholera, than developed ones. These types of disease are known as disease of poverty where they are preventable, yet the poor nations could not protect oneself from such diseases. In contrast, developed countries deal with more non-communicable diseases such as cholesterol and cancer (Bell and Figert 777).

From information discussed above, it is understood that certain medications and Western medicalization are more abundant in wealthy countries than less-wealthy ones. Even though some developing countries might lack equal access to medication and Western medicalization, alternative or traditional medicine still has the potential to save lives of the poor from illness and diseases.

The World Health Organization (WHO) has encouraged countries the use of good quality traditional medicine and be able to keep world population healthy. WHO has defined traditional medicines as “the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.” (“Traditional and Complementary Medicine”).

Alternatively, in some countries, the term alternative medicine or complementary medicine in the Western or Global North is the same term traditional medicine. Herbal medicines refer to medications that made from active ingredients of herbs or herbal elements either single or multiple plant materials (“Traditional Medicine: Definitions”). Traditional medicine is widely used around the world, and its use continues to grow. In some countries, traditional medicines are ineligible for health insurance coverage in Western countries. For some patients who could not afford to pay for health care expenditures and find difficulty seeking health care services, traditional medicines would be close to home which is more accessible medications (WHO Traditional Medicines Strategy, 16 & 36). A research reported that almost 90% of the population in developing countries has to pay for medications out of their own pockets. From that, paying for medicines becomes the second largest payment for the household after food. It is, therefore, understood that a large proportion of the world populations are unable to afford Western medicines, and this issue falls into the responsibility of the government expenditure (Camero et al., 240).

Traditional medicines are highly favored among women in Africa, Latin America and Asia. They use alternative medicines to improve menstrual disorders, and it is found that they

prefer traditional medicines over modern medications (Andel et al. 992). Similarly, traditional medicine is commonly used in Southeast Asia to promote women's reproductive health care treatment, particularly after childbirth. In Thailand, for example, traditional medicines is used to help postpartum women's overall health in order to fully recover after giving birth. Such practice calls "Yuu Fai" which means to lie down near a fire place.

This traditional medicine is to have postpartum women to lie by the fireplace. Such traditional medical practice is by skillful midwives. There are three steps to practice Yuu Fai. First is to massage all over the body to relieve muscle and body pain. Next, is to give hot compresses to promote uterine contraction, which will help protect postpartum from bleeding and bladder problems. Finally, is to have scented herbal steam to promote blood circulation, and to clear wastes from the body through open pores of skin (Phon-ngam, 1-5).

Likewise, in Laos, herbal medicines are used for women's postpartum treatment in rural areas, in this context by the Kry ethnic group. Traditional postpartum practices in other parts of country (similar to lie down near a fire place traditional medicine of Thailand) have almost been ignored because of the introduction of modern Western medicines and treatment. However, medicinal plants are prohibited for use during pregnancy; this means those plants are only to be used after giving birth. During the period of health treatment, the husband will be in charge of picking up the medical plants for his wife. In addition to this, each type of plant will have specific medical benefits. Plants could be used alone or in combination with others. Some medicinal plants are suitable to improve menstruation cycles while others are used to increase lactation for quality breast-feeding (Lamxay, de Boer and Björk, 3-4).

It seems clear that traditional medicines continue to play important roles on women's reproductive health care treatment in many parts of the world, including Laos. The challenges in improving the use of alternative medicines concern the quality of plants and passing local knowledge from generation to generation. It is important to have traditional medical practice recorded in writing since knowledge passed through oral communication, from one to another, is nearly forgotten with the introduction of Western medical practices.

From my perspective, both modern Western medicine and traditional medicine have different effectiveness, as a result, they should be used hand in hand to achieve the best health care. We should also consider what type of illness the person has, and whether modern or tradition medicine suits an individual's health issue. In addition, some certain types of disease, Western medicine might be more effective than traditional medicine as well. For instance, HIV/AIDS treatment. Patients who are living with HIV positive are advised to take ART medicine. The ART is known as a combination of HIV medicines taken to reduce and slow down the spread of HIV. With high multiplication of HIV infection, it will finally develops AIDS ("Overview Of HIV Treatments").

A study also found that traditional medicine might not be as effective as using modern medicine to treat a certain type of disease like as HIV/AIDS. The use of Moringa, for example, help boosts the immune system of the patients living with HIV/AIDS. Moringa is a plant natives to Sub-Himalayan areas, such as India and Pakistan. It is known that the leaves, fruits, roots and even flowers of Moringa benefit a number of health issues. For example, Moringa is good for joint pain treatment, it also helps to reduce high blood pressure, and increases immune system ("Moringa Overview Information"). However, it is less effective to use for HIV/AIDS treatment

because the natural elements from plants considered less effective than modern Western medicine (King 101-102).

Both modern Western and traditional medicines might be used interchangeably for some less severe type of diseases or illnesses. Nevertheless, traditional medicine might be less effective to cure some severe disease that require stronger chemical reaction to kill germs or infectious cells within human bodies compare to the modern medicines. Therefore, traditional medicine might not able to replace modern Western medicines.

Women's human rights on reproductive health care in Southeast Asia

Back in late 1990s, the health situation in Southeast Asia was near crisis. Many countries in this region encountered economic hardship caused by sudden economic collapse within the region. Economic crisis was not only affect the government system as a whole, but also directly affected the live of most citizens, particularly women and the poor. Since the ASEAN economic crisis in 1997, households lost income and government defunding caused life difficulties for many. At this stage of financial hardship, women and/or young girls with low education played their roles in supporting their families through entering the labor market, especially in the sex trade. Women's reproductive health was at risk in contracting Sexual Transmitted Diseases (STDs) and HIV/AIDS due to sexual exploitation, particularly for young impoverished girls (Bennett 374).

Bennett emphasized that due to the ASEAN economic crisis, this leads to the STDs and HIV/AIDS issues on the rise. The number of pregnancies among young girls in most countries was growing during this economic collapse. Health care risks in this region related to migration (both in and out migration), tourism, sex-trafficking, and military deployment, which accelerated

the spread of STDs. In addition this, due to uneven distribution of global resources, disparities created barriers to health improvement (375).

A study from the World Bank reported that women's reproductive health biological structure aligns with their lower socio-economic status, this places women at risk towards unsafe sex. Women are at higher risks of contracting sexually transmitted infections (STIs) and HIV than men because of women's bodies' biological factors. Additionally, symptoms of STIs are often unrecognizable in women until they are in an advanced stage with higher and more severe conditions. Human Papilloma Virus (HPV) infection causes genital cancer among women more than men. This is the most significant risk factor that causes cervical cancer as well as other forms of gynecological cancers, including breast, uterine, and ovarian cancer. An illness of reproductive health of women accounts for 27% in developing countries (Tinker, Finn and Epp 9-10).

According to Tinker, Fin and Epp, in developing countries, poverty underpins poor health where women represent a disproportionate rate of poverty. Women in the poorest economic status have higher fertility rates than wealthy women. In Vietnam, during the 1990s, fertility rates among the poorest women were 3.1 children per women, while the rates among more wealthy women were only 1.6 child per women. In contrast, in terms of reproductive health care access, wealthy women had better access to antenatal care and births attended by skilled physicians, at a rate of more than 90%, where the impoverished women could only access this kind of health care at approximately 49-50% (10-11).

Over the last decades, women's reproductive rights were almost unchanged due to cultural practices and beliefs, economics as well as other factors. Stronger support of

reproductive health care rights for women require from gender advocates, policy makers on women's right and program implementers of women's rights are needed to disseminate policies in educating citizens, particularly men, to understand and support women's health.

In this section, it is clear that the reproductive health of women is correlated with cultural beliefs and buying power for health service. Women in most Southeast Asia nations still lack power in making decisions and negotiations, especially with regard to reproductive health and their well-being. The rise in medical tourism within Southeast Asia also causes a huge burden towards the poor because they pay the same as the wealthy ones, and in some cases they can't afford to access the service and have to rely on traditional medication as an alternative health treatment solution.

CHAPTER THREE

HEALTH CARE OF THE THREE COUNTRIES IN SOUTHEAST ASIA: LAOS, THAILAND AND VIETNAM

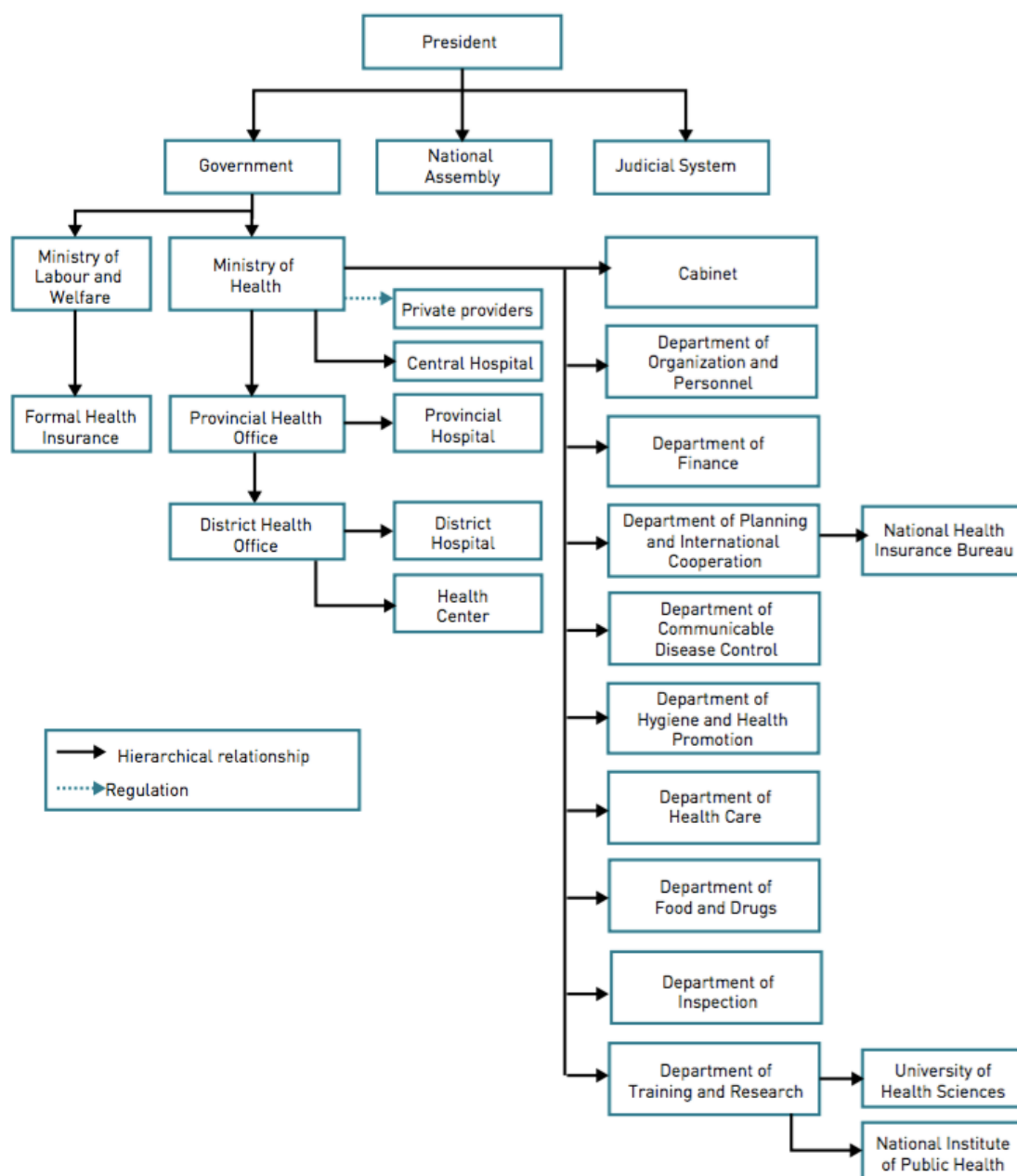
In this chapter, I will explore the health care systems and health policies of three countries (Laos, Thailand and Vietnam). I do this to demonstrate the distinctions between their structures of health systems and to understand public health improvement strategies for the government of each country in order to achieve health care coverage for all of its citizens.

Health policies and health system in Laos

The Ministry of Health (MoH) is a national health authority regarding the health sector that drafts and approves sectoral policies and implements health projects that aim to ameliorate the health of citizens (Akkhavong et al.21). The MoH has a national steering committee to follow all activities of its health projects. There are nine departments (excluding the Cabinet) within the MOH, of which three are newly established (Department of Communication and Disease Control, Dept. of Finance and Dept. of Training and Research).

The working system of MoH is a hierarchy divided into three levels which, the central level, provincial level and district level. Central level in this context refers to the Ministry of Health (Promoting Sustainable Strategies To Improve Access To Health Care In The Asian And Pacific Region 75).

Figure 1. Organizational Structure of Ministry of Health (MoH) and Health System



Source: *The Lao People's Democratic Republic Health System Review, 2014.*

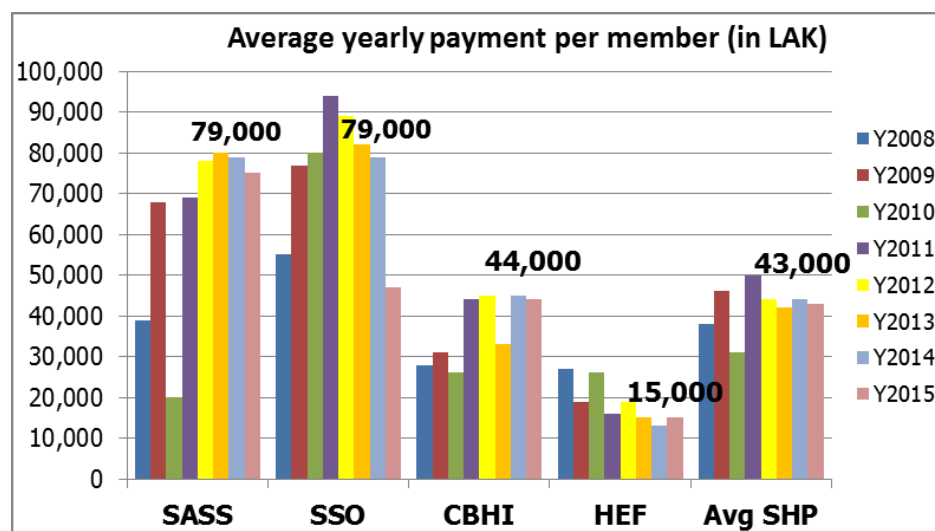
In the 2000s, the government set up four main social health protection schemes in order to ensure health care coverage fits the population in different sectors. The four health protection schemes of Laos include:

1. Social Security Organization (SSO)
2. State Authority for Social Security (SASS)
3. Community-Based Health Insurance (CBHI)
4. Health Equity Fund (HEF)

Each of health protection schemes was designed for different population groups that belong to a certain type of organization as well as an economic status. Akkaphong et al. explained that the SSO is designed for private employees, which is a basic social security and it is mandatory by law for the private companies to provide for their employees. The SASS serves civil servants, while the CBHI is for non-poor workers in the informal sector, and the HEF is a package particularly for the poor. Even though the government attempts to ensure that health care protection will cover its population, there are still economic and social disparities within the country that cause inequity in access and to good quality health service for all (22).

Even though each health protection yearly fee is relatively low and affordable for all, in practice, these social health protections are ineffective to some extent due to unwillingness in collaboration from companies, and knowledge of the population about these health protections is still low. The health protection among the poor is very low even though the fee is the lowest compared to the other types of health protection (Bounkham).

Figure 2. Average yearly payment per member in Lao Kip (LAK) (Bounkham 2017)



Source: Dr. Viengmany Bounkham, Department of Planning and International Cooperation, Ministry of Health, Laos

Note: The exchange rate US\$ 1 = 8,198 Kip ("Bank of The Lao P.D.R" as of May 3, 2017)

SSO 79,000 Kip approximately US\$ 9.64

SAS 79,000 Kip approximately US\$ 9.64

CHBI 44,000 Kip approximately US\$ 5.37

HEF 15,000 Kip approximately US\$ 1.83

Average SHP 43,000 Kip approx. US\$ 5.25

Some large private companies with labor-intensive on production have opposed making health care available for their employees. Some garment factories, for example, have a clinic within their company's facilities or might provide a health insurance plan for use in local hospitals. Unfortunately, there are some reports that these plans do not work since the service is poor, even below the normal service without health protection, and this causes a number of companies to avoid joining the health plan but instead provide some other forms of support in

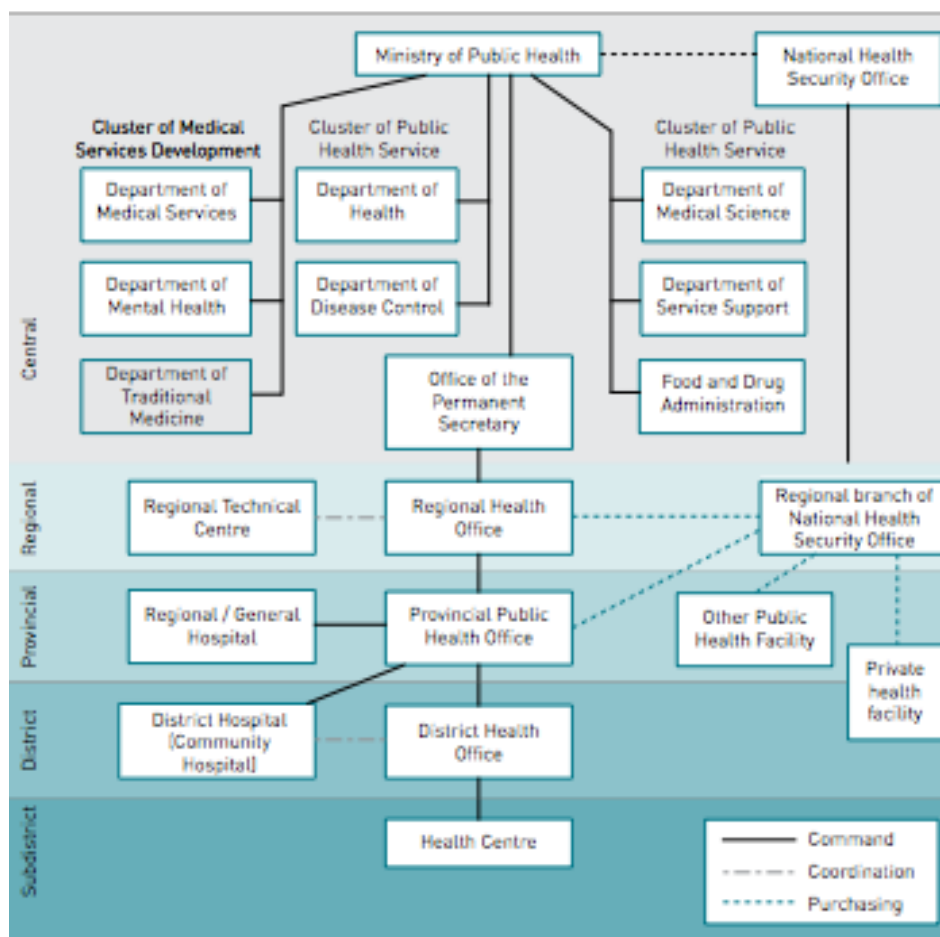
health cost instead, for instance, they cover giving birth or severe accident treatment costs. The majority of the Lao population still spends out of pocket for health care. In some cases, family members or relatives help patients to pay for health treatment expenditures (Southichack).

From the information introduced above in Figure 2, it is understandable that the government puts a great effort to provide equal health care for all citizens. In practice, there are numbers of hindrances to successfully implement such policies because there's a lack of collaboration of clients (companies and patients in general), and the basic health system (including health facilities and health workers) is still very poor.

Health policies and health system in Thailand

The national health authority of Thailand is the Ministry of Public Health (MOPH), which is in charge of formulating and implementing health policy. The MOHP administrative structure is divided into two levels, central and provincial. The central level consists of the Office of the Permanent Secretary and three clusters of technical departments including the Cluster of Medical Service Department, the Cluster of Public Health Department, and the Cluster of Public Health Service Support (Jongudomsuk et al. 17-23).

Figure 3. Organizational structure of Ministry of Public Health of Thailand



Source: *(The Kingdom of Thailand Health System Review 2015 23)*.

Prior to the introduction of UHC in 2002, Thailand had four main health insurance schemes, which each had its own purposes for serving different segments of the population. The four health insurance schemes consisted of:

1. Medical Welfare Scheme (MWS)
2. Civil Servant Medical Benefit Scheme (CSMBS)
3. Compulsory Social Scheme (CSS)
4. Voluntary Scheme

Thailand introduced Universal Health Coverage (UHC) to its health system in 2002. This health coverage dramatically transformed the life of the population. This means that out-of-pocket payments changed to funding by a mixture of tax-based deduction and insurance (“Thailand, Universal Health Care Eases The Impact of Diabetes”). The newly introduced Universal Coverage Scheme in 2002 was known as 30-Bath scheme (approximately \$0.90).

This 30-Bath scheme is a co-payment requirement for both in- and out-patient service, except for vulnerable citizens. Since the launching of UCS, the number of outpatient and inpatients admissions increased in designated facilities, particularly the low income patients. The overall out-of-pocket payment for treatment decreased, which provided positive impact towards household health care expenditures. The 30-Bath policy has faced financial issues, the service quality of health treatment, and accessibility to health facilities could not meet the needs of patients. Ultimately, this policy had to be eliminated due to a number of factors. For instance, long lines waiting to see doctors, inadequate health professionals and inadequate infrastructure to serve the patients as well as limitations for access (Paek, Meemon and Wan 1-3).

An implementation of the UCS 30-Bath scheme altered health service access patterns of the poor and the urban poor in particular. This scheme emphasized primary health care, helped to reduce treatment costs, and minimized poverty from health expenditures of the impoverished. The UCS benefitted the poor more than the rich with a comparison made before and after the implementation of the UCS. However, this health benefit package might be unable to cover every treatment, such as cosmetic surgery, because it is designed for basic health care (Yiengprugsawan et al. 24-26).

The Thai health care system and policies are well structured, and health policies made by the government were effectively implemented in a certain period of time. It was considered very effective at the beginning of the program, yet it is inefficient over time due to related complex issues, such as patients outnumbering health workers and hospitals. The lessons learned from Thailand can be used in Laos. It is important to learn how the government's system operates and puts policies into practice. Even though the program have failed and finally eliminated at least the policies made have been fully implemented. The currently Thailand's three main public health schemes are CSMBS, SHI and UCS (Tangcharoensathien, Patcharanarumol and Panichkriangkrai 4).

Health policies and health system in Vietnam

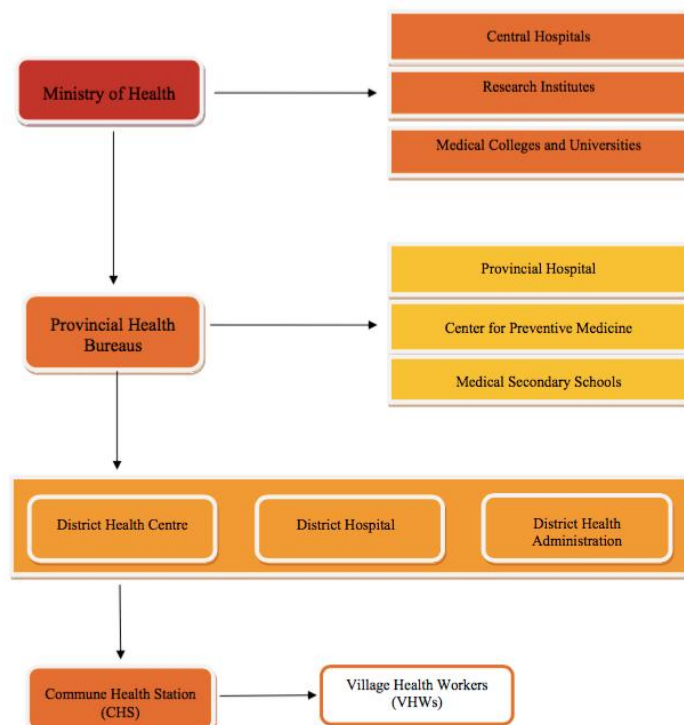
Vietnam has the third largest population country in Southeast Asia and thirteenth in the world (Tien et al 4). Asian Development Bank (ADB) reported that in 2017 the population of Vietnam reached 92 million people (Basic Statistic 2017 1).

The Ministry of Health (MoH) is the national authority in the health sector of Vietnam. The roles of MoH is to formulate and execute the health policy and programs in the country. The Vietnam health care administration is structured in a three-level system. As seen in Figure 4, the Ministry of Health (MoH) is at the tertiary level, the second level is provincial health bureaus and the last is primary level which includes basic health network, district health center, common health stations and village health workers (Tien et al. 4).

The government of Vietnam provided free health care and referral care service to all citizens prior to the country's economic crisis at the end of 1970s. In 1986, the government

launched the Doi Moi (renovation) reform of its economy, and this changed the pattern of health care in Vietnam.

Figure 4. Organizational Structure of Ministry of Health and Health System of Vietnam



Source: The Health Finance Review of Vietnam with a Focus on Social Health Insurance 2011

Four new health reforms were introduced in the health sector by the government after the economic collapse. In 1980s, four major health sector reforms included an introduction of user charge, health insurance, permission for private health care, and an open pharmacy market (Tien et al. 5). In 1989, the government introduced compulsory Social Health Insurance (SHI) to its country. The SHI consisted of three sub-schemes which are:

1. Compulsory Social Health Insurance (CSHI)
2. Voluntary Social Health Insurance (VSHI)
3. Social Health Insurance for the poor (SHI)

Tien et al. identified that the social health insurance for the poor has the same benefits as other compulsory participants. Even though this health policy benefits the poor and utilization of hospitals of the poor has been higher over time, the poor still have lower access and use the social health insurance lower than the compulsory ones. This is due to a number of reasons beyond user fee exemption and free health cards that provide the poor opportunities to access health service. First, they might lack an awareness of their SHI benefits package and their own barriers to access to health care, which include the cost of transportation, accommodation, and hospitalization fees they might suffer as extra expenditures. Another cause could be health facilities overloading where the capacity of the facilities to serve the patients could not meet the need of both eligible citizens as well as the poor. In a more severe scenario, there is a discrimination of hospital providers against the poor (and sometimes even against those who hold insurance cards) (7-8).

In 1994, the government of Vietnam issued health policies to improve health service accessibility for the poor and other vulnerable populations. The policies show in forms of health service exemption both user fee exemption, and cover them through health insurance. However, in practices, the government failed to provide explicit grant in implementation which caused health facilities lack extra funding and lost revenue (Tien et al.7).

The health systems and health policies of Vietnam demonstrate a strong commitment of the government to ensure all citizens receive quality health service. Nevertheless, in practice there are a lot of challenges to achieve such health policies. Basic health facilities are still of poor quality and fail to serve the needs of patients. In addition to this, the poor patients in particular are discriminated against when they receive the service even though they are exempt for the fees.

CHAPTER FOUR

FINDINGS

Barriers for Lao women to access reproductive health care service

This part of findings will discuss three social factors that affect women's rights and their lack of access to health care services, which are poverty, gender inequality, and national health care system that discourage women not to access health service, and will conclude with a comparison of health care in Laos, Thailand and Vietnam.

Poverty

The World Health Organization (WHO) defines poverty as an absolute term of income less than US\$ 2 per day. Poverty is connected with the undercutting of a range of human characteristic, including health. Poverty affects the poor in a number of forms. The vulnerable populations have less access to information and health care. They are less well nourished, which leads to greater risk of illness and disability (“WHO | Poverty”). In Laos, 23.2% of the total population lives below the national poverty line, which is the third highest percentage in the Southeast Asia region, after the Philippines with 25.2% and Myanmar with 25.6%. In addition this, those living below the poverty line in Laos is higher than Thailand, which has the share of population below national poverty line of 10.9% and Vietnam 8.4% (“Poverty In Lao PDR” 2016).

Poverty exacerbates issues related to the reproductive health of Lao women, particularly those who are ethnic minority. Due to the poverty of the majority of the population, it is almost

impossible for most poor households to gain access to health care. Going to a health center is very difficult for women in rural areas because those areas are poor in transportation. Women might have to travel for days and walk through water areas to a hospital in order to give birth. Giving birth at home is more convenient for women. However, once women encounter delivery complications, there is a risk for maternal health and this is a stage where decision making is delayed since it might be too late for mother to go to the hospital and other problems might occur during the transfer to health facilities. In addition to this, the strong custom of traditional medicines also influences the community to consult traditional healers prior to deciding to seek health care at a public health center, which is often perceived as a last option. And the most importantly, they have a lack of financial stability or in other words they are poor and have very low income. Many of the patients have to sell animals or even land in order to prepare money before seeking health care services (“Reproductive Healthcare Lags In Laos”).

Gender disparity

Marital practice in Lao is a monogamy in which women in particular are expected to be faithful to their husbands (but not vice versa). Lao women are conservative and hesitate to discuss sexual issues in the public (Ngonvonrath 5). These cultural beliefs lead to reproductive health issues for most women.

Gender disparity fundamentally has an impact towards the health care status of Lao women. Laos is a patriarchal society where men are more respected than women both inside households and in society. With such a disparity between men’s and women’s status, society even allows a loop hole for men to have multiple sex partners outside marriage as part the power

of masculinity power. If men fail to demonstrate the ability to have another woman outside their marriage, they will consider as not a real man.

Gender disparities lead to sexual health disparities. Women lack power of negotiation in sexual relationships, in terms of using condoms and refusing or accepting to have sex with men. In Laos, 87% of HIV transmission is through sexual contract of both heterosexuals and homo/bisexuals. HIV transmission is high because of low-educational levels, poverty, early sexual intercourse, cross-generational relationships, low utilization of male condoms and no use of female condoms, lack of HIV prevention and transmission knowledge, as well as unequal status in relationships. These factors also place married/partnered women at particular risk in Laos. Beyond this, due to poor understanding of gender equality in communities also highlight the challenge of achieving gender equality in the country (Lao PDR Country Report 34-35).

The World Health Organization also identified that social-cultural factors prevent women and girls from health service because of unequal power in relations between men and women ("Women's Health"). This identification is extremely accurate in Laos as discussed above. Gender inequality threatens the reproductive health of women, particularly women and girls from ethnic minorities because of traditional gender norms (and poverty) that place them in a vulnerable group. The Asian Development Bank reported that in underserved and rural areas of Laos, only few hospitals have obstetric emergency service available since there's a lack of skilled staff and medical equipment. Most women therefore give birth without skilled birth attendants support. A study also found that Lao women prefer female health care providers, of which there is a shortage of health workers in health sector ("Healthy Mothers And Babies In Lao People's Democratic Republic")

Comparison of health care in Laos, Thailand and Vietnam

The health system in Laos is quite similar to that of Vietnam, with an administration is divided into three levels - central, provincial and district. This type of health system structure provides a clear management direction. In reverse, it is complicated and less effective to some extent. This is because the power of negotiation and budget allocation mainly relies on the central level, while an implementation of health policies and activities falls into the responsibility of provincial and district levels, particularly in district levels and/or health centers in communities. For Thailand, there are only two main levels of health system management, which are central and provincial. Other than these two are health institutional organizations, which are under the supervision of the central level. From the information discussed in chapter three regarding health care system and policy, it is understood that even though health care systems are structured, and policies are clearly endorsed by the central level or Ministry of Health (Laos) and/or Ministry of Public Health (Vietnam), in practice, there are a number of challenges to achieve health services and health coverage towards target populations.

In Laos, even though a number of social health protections are established to serve specific populations, legal enforcement towards an implementation of health protections is still weak and only partially successful. This is because of the capacity of paying power of the population is low and a limitation of government's capacity on management of health service. The majority of the population are living with low income, underemployed, considerably poor and reside in rural areas. These components hinder health coverage expansion and cause Lao population lack health care coverage, particularly the poorest population. Finally, the government's capacity in implementing social protection assistance and contribution of revenue

are limited because only small amount of budge contribute to health expenditure. Such factors are evidence that health care coverage expansion will required further efforts to achieve social health support towards population, especially the poor (Leebouapao 360).

Regarding an introduction of Universal Health Coverage (UHC) and an implementation of UHC 30-Bath in Thailand, the 30-Bath scheme, or it is also known as 30-Bath treat all (all in this context refers to all diseases) scheme (Paitoonpong, Chawla and Akkarakul 265), was effective and provided great benefits to the poor in the first stage of implantation. Nonetheless, such a policy was unsustainable since the government encountered financial issues, inadequate facility supplies and lower numbers of health workers to serve patients. Ultimately, the 30-Bath scheme was abolished (Paek, Meemon and Wan 1-3).

Since the government of Vietnam introduced its new policies to the health sector in 1989, the new health protections are well categorized to meet eligible populations, particularly to support the poor. In fact, the implementation of such policies is varied. For example, annual payment of health protection is varied based on what type of a category participants fall into and the location of residential areas. Regarding health benefits of the poor, it is evident that the heath package still lacks full coverage. They had to pay hospitalization fees, accommodation fees, and, lastly, they were discriminated against because of their poverty. In terms of the government authority itself, with fee exemptions for the poor, the government could not provide expenditure and caused the loss of government income (Tien et al 7-8).

Even though the government of each country tried its best in developing health care protections to ensure all population are able to access health service, particularly the poor, it is obvious that the governments struggle with financial inabilities to run the programs, and often

times the poor are still the most vulnerable people in access to health care treatment. Finally, one point that I have learned from health system in each country is that, the government tries to priorities the poor to be able to receive equal health treatment, however, the way the government place prioritized the poor is different. For example, Thailand places the poor as the first priority where Laos and Vietnam place the poor category the last in the health coverage package category.

CHAPTER FIVE
HEALTH CARE POLICIES AND HEALTH PROJECT IMPLEMENTATION
ANALYSIS IN LAOS

This chapter will introduce some of the challenging issues related to health projects and health policies in Laos. This part is considered as important as other parts of this research since the topics to discuss below still remain unresolved or only partially successful. Therefore, the information discussed in this section will contribute some new perspectives for health policy makers, donors, academia and general interests.

The challenges of national health care reform in Laos

The challenges of national health care reform of Lao PDR are related to the administrative system of management and lack of human resources. Akkhavong et al. addressed that health workers' supplies in rural areas are still inadequate, particular in remote and ethnic communities (2014). Healthcare facilities are inadequate, for instance, numbers of beds available for incoming patients, which the national bed occupancy rate is 47.7% which lower than the standard 80%. In addition to this, the average length of stay in hospitals is 2.8 days only. In terms of human resources, the quality of service is poor due to poor staff motivation and under-qualification of health workers. There is an inequality of distribution of health workers between urban and rural areas since well-trained health personnel work at urban hospitals or at central or provincial administrative offices.

Finally, the government is ineffective in accounting and financial monitoring as well as accountability within the health system. For instance, there's a delay on the district level to submit final reports to the provincial level, and the provincial levels have to submit the final reports to the Ministry of Health, which is the central level (101-118).

Health system improvement might take time for Laos to achieve, due to a number of unsupportive factors that cause quality health care service to fail from time to time. Most importantly, health workers should remain responsible for their careers and have service minded to provide good health service towards all patients, especially towards to the poor and ethnic minority groups. This point is a sensitive fact that policy makers might fail to consider to some extent because the policies are implemented by persons. Strong human resources are more likely to perform well and put policies into practices well. With good and adequate human resources, health treatment service will be able to dramatically improve. This is because a good human resource would be more sustainable and able to pass over to new health workers comers. In case Lao government received medical equipment, it might be unattainable compare to providing technical support and on the job training to both existing and newhealth workers.

Improving health care in Laos, it is not only related to health service in general, but it is also related to political issue where the government of Laos has their own visions towards better health care service. In practice, such visions might require more cooperation and intervention from inter-agencies. Human resources development might be the most concerned case where basic infrastructures and equipment would be the second concerns.

The government of Laos received grants from multiple international agencies such as the United Nations agencies. Each year a new agreement will be modified and renewed. A renewal

of funding is based on common interests on certain areas. For example, WHO and UNPFA collaborate with Ministry of Health on public health. According to WHO Laos, the Minister of Health and the WHO, both parties have signed the fifth annual funding workplace 2017 in an amount of US\$ 2.1 (LAK 17.5 billion). This funding aims to support health reform in Laos and improve the health of the Lao population ("WHO Increases Cooperation For Health Reforms In Lao PDR").

In Laos, there are a number of international organizations, such as UN agencies and non-governmental organizations collaborate and provide both financial and technical assistance to the government of Laos. Those organizations are actively participating with the government of Laos to improve many areas of developments, for example public health or socio-economic development. Most often, funding information will be informed to the counterpart (specific ministry where the organization collaborates with) and also join their interested project with the projects of the government such as the collaboration between the WHO and MoH Laos.

In some cases, two or more organizations group together and join the development framework of the Lao government in specific areas of interest such as social-economic development. For instance, the UNDP, UNFPA, and UNICEF together join the project and commit to provide contribution to the government of Laos on the 8th National Socio-Economic Development Plan (NSEDP) and the Sustainable Development Goals (SDGs) ("UNFPA Lao People's Democratic Republic | Three UN Agencies Renew Their Commitment To The Development Of Lao PDR").

In terms of the contribution from international organizations, the form of contribution can both financial support and/or technical support. World Health Organization Lao PDR for example,

provides Direct Finance Cooperation (DFC) to the Ministry of Health Lao PDR. WHO explains DFC as “agreement payments are made by the Organization to cover the costs of items that would otherwise be borne by governments, in order to strengthen their health development capacity and ability to participate more effectively in, or to meet their commitments to, WHO technical cooperation at the country level. Such payments are normally made in local currency. DFC activities are subject to the same standards of health program accountability and evaluation in terms of relevance, efficiency, effectiveness and impact as any WHO technical cooperation program, project or activity at country level.” (“Grants: Direct Financial Cooperation”).

In this case, the WHO Laos provides funding for MoH Laos to implement health projects in both provincial and district levels. The funding request process such as fund request documentation and fund release will take (long) time. From my working experience as a program assistant for Program and Administration Office (PAO) of WHO on DFC, it was very tough to follow up some projects that already received funding but failed to implement the program.

In a worse case, once the project has already been implemented, the project implementer did not submit the project report on time, which caused another problem for the future fund request if the same implementer requests another financial assistance from WHO again. This type of situation is usually happen during my work at WHO.

Successes and failures of international assistance intervention on health care to Laos

Laos received a number of donations; however, there is also ineffectiveness in implemented projects. Each donor has specific requirements for the fund request documentation process and it strictly requires the Lao government to follow. To some extent, from personal working experience with the NGO and UN agencies on funding and policies, there are a number

of obstacles for Lao local authorities to implement the project on time as requested. This is because there were delays on missing supporting documents, particularly authorities in very rural areas where basic infrastructures are poor and low human resources capacity. In some serious cases, project implementers fail to submit finally reports on project implementation back to donors on time. This also leads to misunderstanding between the donors and implementers. Therefore, the future fund request form the same institution will be more difficult because they fail to follow the process in the first place.

CHAPTER SIX

DISCUSSIONS AND RECOMMENDATIONS

This chapter discusses concerned issues related poor health system within this research, some recommendations towards gender equality on health and the importance of media on reproductive health advocacy will be also discussed.

Reproductive health advocacy and the role of social media

Reproductive health advocacy in Laos is conducted in a number of forms. The most common practice is through outreach programs to communities, particularly to those who are in rural areas. Reproductive health programs will be implemented by Lao government where funding support is from donors or international agencies (Ngonvonrarath 7). For example, the United Nations Populations Fund (UNFPA) provides approximately 1 million U.S dollar per year in supporting mobile clinics, training health service providers and village health volunteers. Communities in rural areas benefits this program Benefit from this program despite lack of road access outreach where road access. For instance, in highlands communities, where the team of the mobile clinic could not access to the village, the team had to hike. The mobile clinic provided prenatal care, educated communities about family planning and HIV/AIDS prevention, and treated sexually transmitted diseases (Ryan).

There are multiple channels in health care advocacy. From my perspective, the role of social media is very important, in particular for those who are poor and reside in mountainous and rural areas.

Traveling to health facilities might be time consuming, and certainly transportation fees that might cause difficulty on health expenditure for many. The media such as T.V or radio, could spread the information to populations who are in remote areas. For the most poor in particular, who might be undereducated or uneducated, it would be effective to have the print out or flyers with photographs to convey important messages that are easy to understand more than formal documents printing with too much jargon.

Reproductive health campaigns in Laos are mostly funded by donors but they are also government run campaigns (Ngonvonrath 7). The figure below is an example of (partial) flyers on family planning for youth which were published in Lao language by the United Nations Population Fund (UNFPA) in Lao PDR.

Figure 5. Flyer of Family Planning for Youth published in Lao language by UNFPA



Source: Family Planning For Youth, UNFPA Laos 2016

The flyer displays cartoon characters that convey concerns related to adolescents' reproductive health. Not only printing is important to disseminate sexual education, but also the social media such as Facebook plays another important role. In Laos there are cyber cafes and computer available in the libraries of the most of universities and colleges where students in general interest could access to internets. In addition to this, some coffee shops or restaurants offer free internet connection or Wifi for customers to access the internet.

Reproductive health information can also be obtained through phone calls to health centers in case one prefers not to consult in persons. From my view, social media such as Facebook or even other media applications such as Twitter and YouTube are more accessible for many, for example, urban citizens and financially. However, they might not be accessible for the poor in rural areas who might lack an access to the internet connections (since it will require extra spending on data plans, internet gateways, electricity and other related costs). Therefore, printing media should go hand in hand with (online) social media, which is necessary to design the right media for the right audience.

Having the professional advocates going to the community to educate reproductive health might sound effective. However, from my perspective, having the person who the audience or targeted population could related to would be more suitable. This is because the clients might feel more comfortable to relate themselves to the speaker who might come from the same root as them. For instance, having the local villager who speaks dialects and understand the behavior of health seeking within the community trained to become local health workers, and provide the reasonable payment. This will not only a creation of local job for the villager, but also it is

another form of building human resources where funding is from the international agencies.

Once the project has ended, the knowledge will still remain with that person, she or he can then set up a small clinic in the village and make their own income.

Future challenges of reproductive health care of senior women in Laos

A number of reports and health projects will generally address reproductive health issues of Lao women during their reproductive years, such as maternal mortality and fertility. However, women's health changes once they enter menopause. Post-menopausal health of women is important because it is related to hormonal changes among women in their middle age or older. It is very rare to have specific health care centers for menopause patients because most places are for younger populations. Patients in their menopause will generally share knowledge of their experience by advising others on how to take care of their health as well as suggesting to buy certain types of medicines at the particular pharmacies.

It is important for Laos to invest in health care research for menopause patients in order to help them to understand their overall health, and to have specific health centers or departments for senior women. Most importantly, it is even more concerning for those who are in poor rural areas. Women from a young age should already learn about overall reproductive health and menopause in order to understand their reproductive health in the future. This will prepare (young) women to handle the changes to their physical and mental health in the right perspective without being panicked.

Recommendations

At this final section of my research, I have a few recommendations on gender disparity and reintroduce the perspective of the rights of women on reproductive health and potential health campaign for the poor and the disabled.

Health and well-being are fundamental for every human being. It is significant to understand the basic biological difference between men and women. Women's and men's illness symptoms might display differently, and the most important thing is that health is a basic human right for all, particularly women. Women have a number of burdens in life, such as education children and taking care of family members, besides professional life outside the home. Many still have misconceptions towards the reproductive rights of women. Many only understand the reproductive rights of women once they are pregnant and give birth. Actually, reproductive rights of women are more than just bearing a child. From my perspective women's reproductive rights are the right to fully own one's body, have the right to negotiate sexual relationships.

In addition to the body issue control of women, I would like to encourage Lao culture to be more open about sex education, and it should not be considered as rude or shameful when it comes to sexuality. In Laos, discussing about sex and sexuality are impolite, particularly among girls and women. I think this social norms prevent women to freely share and understand their reproductive health. Old generation populations are considered conservative, displaying affectionate such as kissing and physical contact between men and women in the public are perceived as inappropriate. Most often girls and women are told not to involve sexual intercourse before marriage, otherwise that person considered as not a good lady. However, this believe slowly dismisses since the new generation might no longer practice.

From my point of view, this is what I have learned in here in the U.S about women and the body issue. I am going share the lessons learned and educate in Lao culture because it might be completely right or wrong with women's body. I perceive this as the basic human right of women to control their bodies and make the decision on their own. However, it is important that girls and women are educated to learn their reproductive system, and how to protect their reproductive health which will reduce the risk of STDs infection, unwanted pregnancy, HIV/AIDS and other pandemic diseases.

Regarding women's body issue and reproductive health in Laos, I am more concerned about reproductive health of women than cultural beliefs or the taboo of having sex before marriage which I think it is the right of an individual. From my point of view, reproductive health for Lao women should be more available, accessible, and Lao women should be more knowledgeable about reproductive health. First reproductive health knowledge for girls should no longer considered a shameful topic to discuss in class, since educational institutions should be the first place where children and adolescent could absorb the trusted information from teachers. Outside classes, they can further discuss among peers base on what they learned in class and share information from their personal research. Second, more quality hospitals and health center should be more available and accessible for women in rural areas. In Laos, health centers are less accessible and available for most populations in rural and remote areas. In addition to this, quality health workers are inadequate to take care of the patients with serious illness.

Despite the fact that basic health and reproductive health treatment of Lao women in rural area might be an obstacle, traditional medicine could be the first aid for them to use and to shoot early stage symptoms of disease before they will transfer hospitals and nearby by health centers

to receive professional health service. For this issue, it would be best to have the locals provided education about the use of traditional medicines and planting herbs near their land or even turn into traditional medicines business. With this step, the government could provide technical support to villagers on how to plant, nurturing and using herbs the right ways. This will create local jobs, increase the use of traditional medicines and help to shoot and cure illness before going to the hospitals in the city where modern Western medicines might be more expensive and unavailable in remote areas.

I believe that gender issues on health care is interconnected with basic human rights of women (as well as men). Due to cultural beliefs, social norms place hardships on women in many areas of life. The disparity occurs since sex is identified and gender roles automatically rule the lives of girls and women. It is challenging to change traditional beliefs of gender equality. This might take another century (or so) or at least one decade (or more) to educate men and society regarding gender issues. Even though policies have been made and endorsed by the government, in practice it is an individual issue even the government itself might be unable to achieve the legal enforcement on women's right or gender equality.

For example, the National Assembly of Lao PDR considered a new draft of law. The National Assembly considered a new draft law on strengthening the role of women to promote gender equality. In that new law proposal, it emphasizes the appointment of women to higher positions within the governmental organization ("New Law on Lao Women's Union To Support Gender Equality"). In practice, a number of Lao women in high positions in the government office is still low, for example in the national parliament. In 1990, the percentage of Lao women

in the parliament was only 6% and reached 28% in 2016 (“Proportion Of Seats Held By Women In National Parliaments | Data”).

My recommendation is to add gender and reproductive health sessions into educational programs since the beginning in primary school. I believe this might be very effective to educate girls and boys since very young age. This is because children keep growing both physically and mentally. Once they reach their teens and adulthood, it will be helpful for them to take care of their health and respect one another on gender such as health and human rights equality. Beyond this, the health system in Laos is still in an improvement stage; this might help those who reside in rural areas. This is because many young girls in remote areas have fewer opportunities to finish secondary school. Therefore, I believe that gender and reproductive health education will help them to understand their basic human rights and be able to take care of their health once they reach adolescence and get married in a later stage of life.

Regarding the application of women’s studies and gender studies into reproductive right Laos, I think it might be challenging to apply Western culture and attitudes about reproductive health to Lao culture. Most girls are raised within extended families and where parents are closely monitor children. Girls are less independent even they turn 18 years old, they still stay in the same home with parents unlike in the U.S. In some cases, girls in rural areas get married in very young age. Most reproductive knowledge are rarely discuss among families. Most often girls discuss among close female friends and/or senior women who they could rely on. Discussing sexuality and sex are very limited and certainly rural girls and even girls in urban fail to access reproductive health information because of cultural sensitivity. Girls and women lack power to express one selves opinions because they have to listen to parents and cannot fully make their

own decisions compare to the U.S culture. Therefore, they are less expressive and rarely have to right to make decisions in most of cases.

Another recommendation for this research is the improvement of human resources. Since Lao have under-quality health care system, it is equivalently essential to improve health care workers' skills. As discussed on medical tourism regarding the migration of health professionals, health specialist migration causes health service disparities within the country. This issue causes an imbalance between urban and rural areas in the quality of health workers. It is important to sustain staff training in order maintain skillful physicians in every area of the country. This could be done by existing health experts in rural area to share and transfer knowledge to co-workers and new comers. Due to higher remunerations and better living conditions in the city, it is almost inevitable for skilled health professions to move into town and for better living conditions. By transferring knowledge this will help to reduce health service disparities between city and rural areas. Human resources improvement should be more sustainable and it shall be as effective as finical assistance and medical equipment support from donors.

The last suggestion for this study is to endorse a new policy on free health care for the poor and the disabled (born disabled and become disabled because of accidents or other related issues). It is known that a great proportion of the Lao population lives with poverty in mountainous rural areas. Some of them are disabled or later become disabled because of severe accidents from making a living or any other causes. It is almost impossible or extremely difficult for them to access health care centers or even bigger hospitals in urban areas where specific treatment for particular diseases is available.

Traveling to health facilities requires huge spending, not only spending for transportation and time traveling from home to hospital at a far distance, but also patients have to spend out of pocket. This suggestion might appear difficult, but I believe might turn into a real policy one day in the future. In case this might take time to achieve, another suggestion is to educate students in all level of education about the use of traditional medicines. Finally, the study of plants and herbs should be published and disseminate to nationwide. The research of plants and home medicines remedies should also be printed in dialect languages or in pictures since literacy rate is low in the rural areas.

At this end, I would like to emphasize that gender and reproductive health of women are still dilemmas for Laos as well as some other countries in the Southeast Asia region, and other parts of the world. It might take time to redirect the perception of people towards gender and health disparities. However, there is always a possible solution (or more) to cope with such issues with the right approach, the right time and the right person to solve these problems.

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