LIMITED DOSES:

HEALTH AND DEVELOPMENT IN LAOS, 1893-2000

KATHRYN DAWN SWEET

(*M.A. (Asian Studies), Australian National University;*

B.A. (Hons), University of Melbourne)

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DECLARATION

I hereby declare that the thesis is my original work and it has been written by me in its entirety. I have duly acknowledged all the sources of information which have been used in the thesis.

This thesis has not been submitted for any degree in any university previously.

K. Sweet

Kathryn Dawn Sweet

4 August 2015

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DEDICATION

To the memory of

my late grandmothers

Aileen May Richardson née Roberts (1912-2004)

and

Rose Dorothy Sweet née Parker (1916-2010);

and

to the future of Lao history

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SUMMARY

The study sets out to uncover reasons behind the Lao PDR's long-term low health indicators and poorly rated health system. It examines the development of the biomedical health services in Laos, within the academic frameworks of the history of medicine and international development. Combining archival research and interviews with health workers and technical advisors in five countries, the study reconstructs a history of efforts to provide healthcare over the period 1893-2000.

The study argues that a series of obstacles have limited consolidation and improvements within the Lao health sector: distance from the colonial metropole, decades of conflict, the promotion of doctrine in a trade-off with technical and management skills, and high levels of donor diversification. The cumulative impact of marginality and long-term dependence on diverse sources of external assistance has been the under-funded, under-developed and under-used patchwork of health facilities, staffing and service models apparent today.

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ABBREVIATIONS

ADB	Asian Development Bank
AMI	*Assistance médicale indigène*
AML	*Assistance médicale au Laos*
ANOM	*Archives nationales d'outre mer*
CCL	*Comité pour la coopération avec le Laos*
CIA	Central Intelligence Agency
CHC	Central Health Committee (*Khana Sathalanasouk Sounkang*)
CMEA	Council for Mutual Economic Assistance
DAC	Development Assistance Committee
DRV	Democratic Republic of Vietnam
EU	European Union
FBIS	Foreign Broadcasting Information Service
FSP	*Fonds de solidarité prioritaire*
GAO	Government Accounting Office
GDP	Gross Domestic Product
GNI	Gross National Income
GOL	Government of Laos/Lao PDR
IFMT	*Institut Francophone pour la Médecine Tropicale*
IMF	International Monetary Fund
KPL	*Khaosane Pathet Lao* (Lao News Agency)
Lao PDR	Lao People's Democratic Republic
LDC	Least Developed Country
LIC	Low Income Country
LNAD	Lao National Archives Department
LPRP	Lao People's Revolutionary Party

LSIS	Lao Social Indicator Survey
MAET	*Mission d'aide économique et technique*
MCH	Maternal and Child Health
MIC	Middle Income Country
NARA	National Archives and Records Administration
NEM	New Economic Mechanism
NGO	Non Government Organisation
NLHX	*Neo Lao Hak Xat* (Lao Patriotic Front)
OB	Operation Brotherhood
ODA	Overseas Development Assistance
OECD	Organization for Economic Cooperation and Development
PEM	*Programme d'enseignement médicale*
PGNU	Provisional Government of National Union
PHC	Primary Health Care
RLG	Royal Lao Government
SIDA	Swedish International Development Agency
UNFPA	United Nations Population Fund
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
USD	United States dollar
USOM	United States Operations Mission
VHP	Village Health Program
WHO	World Health Organization
WPRO	Western Pacific Regional Office

REFERENCING, TRANSLITERATION AND LAO NAMES

Referencing

The Lao National Archives Department (LNAD) has no established referencing system for sources, so I have devised a system as follows:

Location	Government or administration	Agency	Retrieval Code	Title of document	Date and page number
LNAD	RLG (Royal Lao Government)	MOH (Ministry of Health)			
	NLHX (Neo Lao Hak Xat)	CHC (Central Health Committee)			
	Lao PDR	MOH			

Transliteration

There is no standard method for transliteration of Lao into English. My transliteration relies closely on an unofficial but relatively predictable system used by the Lao Ministry of Foreign Affairs for rendering Lao names into Latin script in Lao passports.

Citation of authors with Lao names

I list the given name and surname of all Lao authors each time they are cited. This addresses the international custom of listing by surname, and the Lao custom of listing by given name. Lao names are listed in the bibliography alphabetically by surname.

CHAPTER 1

INTRODUCTION:

WHY STUDY THE HISTORY OF HEALTH AND DEVELOPMENT IN LAOS?

Our experience of the present very largely depends upon our knowledge of the past.[1]

Introduction

'Am' was short and tanned, with dark longish hair, a wispy beard, shining black eyes, and a smile that flashed across his face and left a lingering impression.[2] He was 25 years old when I met him in 2009, married, and from the ethnic group that lends its name to the district and town of Ta-Oy in Salavan province in southern Lao PDR.[3] He was a health volunteer, working at the lowest level of the government health network that cascades from the central-level Ministry of Health, down through provincial, district, sub-district levels to village communities. His basic literacy skills in Lao language, gained from a few years of rudimentary primary schooling, all but guaranteed his selection. There were few other 'educated' adults in his village. His role was to provide information to families in his village and three or four neighbouring villages about family planning methods, to supply contraceptives and refer

[1] Paul Connerton, *How Societies Remember*, (Cambridge: Cambridge University Press, 1989), p.2.
[2] I met 'Am' while conducting a project evaluation in 2009, before commencing my PhD studies. 'Am' is a pseudonym, but also a common prefix for men's names in Salavan province.
[3] I use the specific terms 'Lao People's Democratic Republic' or 'Lao PDR' only when referring to the government administration established on 2 December 1975. I use the term 'Laos' to refer to the country or nation prior to 1975, or in general references that span the pre- and post-1975 periods.

couples to the district health office when needed. He received a small stipend in return for his work and work-related travel.

Health volunteers like ‘Am’ are required to report to the district health office every month at their own expense. There was no bus service, and ‘Am’ may have baulked at the steep fare if one had existed. He had hitched a ride on the back of an old motorbike to reach the local district town, saving him a day’s walk of thirty or so kilometres along a rough, unpaved road which wound among forested mountains and through, not across, rivers – there were no bridges.

I met ‘Am’ in the course of my work as a development practitioner. I worked as a program manager in the fields of health, social and rural development for bilateral donors (ie: governments), multilateral development agencies, and occasionally, non-government organisations (NGOs) in the late 1990s and throughout the 2000s. While based predominantly in the capital, Vientiane, I had worked and travelled extensively throughout rural Laos. Speaking and reading Lao language had exposed me not only to the policies of international development agencies towards Laos, but also to the work of Lao government and party organisations, and enabled me to interact closely with officials and citizens, including health volunteers such as ‘Am.’

That day, ‘Am’ had submitted his monthly report on contraceptive use in the villages he served, as well as his regular request for re-supply of contraceptives. He had also submitted a short demographic report on the annual birth and death statistics in the cluster of villages, as Lao government workers do not collect such information themselves. Tragically, the statistics included the death of his own child, his third child to die in infancy in almost

as many years. He calmly assured me that his experience was not unusual, and that it was quite normal for babies to die in his village and the surrounding villages. My heart went out to him. Not one, but three children dead before their first birthday. My encounter highlighted a tragic irony within the Lao health system. While he walked from village to village, helping the district health service to extend its reach in remote, ethnic villages not otherwise served by the government's health network, that very network had failed him and his family on at least three occasions.

The current state of the Lao health sector

'Am's experience is not isolated. The Ministry of Health struggles to deliver basic healthcare services to much of the Lao PDR's rural population, which in 2014 comprised an estimated 65 percent of the nation's total population.[4] The rural population, made up of 49 officially recognised ethnic groups speaking different languages and adhering to diverse customs, live in small villages scattered in often remote mountainous areas, many of which have only seasonal road access, little or no public transport, and no connection to the national electricity grid.[5] Education and income levels are low. As such, Laos' rural population inhabits a marginal space within Laos and within the region which provides geographic, technical and cultural challenges for the provision of effective healthcare services.

Results of the most recent Lao Social Indicator Survey (LSIS) conducted in 2011-2012 show significant improvements in health indicators

[4] Information retrieved on 10 September 2014 from http://www.wpro.who.int/countries/lao/en/
[5] Successive Lao governments have attempted to entice the rural population into larger settlements. The Lao government has been implementing the most recent version of this policy, the 'Three builds' (*sam-sang*) policy, since 2010.

nationwide. Life expectancy at birth has risen from an estimated 42 years in 1977[6] to 64 years for men and 67 for women in recent years.[7] The infant mortality rate has decreased to 68/1,000;[8] and the maternal mortality rate is currently estimated to be around 357/100,000.[9] Moreover, 69.9 percent of the population are reported to have access to improved water sources in 2012.

Figure 1.1: Health indicators by country, 2012[10]

	Laos	Cambodia	Myanmar	Afghanistan	Chad
Urban population	35%	20%	33%	24%	22%
Life expectancy at birth	66	72	66	60	51
Infant/U5 mortality rate	68/72	--/40	--/52	--/99	--/150
Maternal mortality rate	220*	170	200	400	980
Improved water	c 70%	70+ %	80+%	60+%	c 50%
Stunting[11]	44.2%	c 40%	c 30+ %	c 60%	c 40%

*LSIS lists the maternal mortality rate as 357, significantly higher than the WHO estimate.

Other health indicators are proving harder to shift, such as the high rate of stunting in children (44.2 percent), linked to their nutritional intake and

[6] World Bank, *World Development Report 1979*, (New York: World Bank and Oxford University Press, 1979), p.126.
[7] Statistics for 2012 retrieved on 10 September 2014 from http://www.who.int/countries/lao/en/
[8] Ministry of Health *et al*, *Lao PDR Lao Social Indicator Survey (LSIS) 2011-12 (Multiple Indicator Cluster Survey/Demographic and Health Survey)*, (Vientiane: Ministry of Health and Lao Statistics Bureau, December 2012), p.III.
[9] Ibid., p.124.
[10] I include statistics from neighbouring low-income countries, and two other land-locked Least Developed Countries (LDCs) in Asia and Africa for comparison. Statistics for 2012 retrieved on 10 September 2014 from World Health Organization (WHO) country health profiles for Afghanistan, Cambodia, Chad, Lao PDR and Myanmar, listed at http://www.who.int/countries/en/
[11] Stunting (height for age) is one of three key measurements used in WHO's international child growth standards, along with wasting (weight for height) and malnutrition (weight for age). Stunting is defined as "having a height (or length)-for-age more than 2 SD [standard deviations] below the [Committee for Disease Control's] NCHS [National Centre for Health Statistics]/WHO international reference." See http://www.who.int/ceh/indicators/0_4stunting.pdf.

retention. However, the caveat remains that there are vast differences in the urban and rural statistics, which can mask the experience of families such as 'Am's' who live in remote and ethnically diverse localities.

Despite these improvements, international agencies such as the World Bank and the World Health Organization (WHO) frequently state that the Lao PDR has some of the lowest health indicators in the Western Pacific region and in Asia more generally.[12] The only other countries in Southeast and East Asia with similar health indicators are Cambodia and Myanmar.

In the light of such statistics, narratives concerning the Lao health sector are mixed. The Ministry of Health oscillates between bland assertions of continual progress for its domestic audience,[13] and pleas to the international community for assistance to plug the sector's ongoing shortages and short-comings by employing what Vatthana Pholsena has described as a "discourse of lack".[14] The narrative employed by international development assistance agencies is more consistent, centring on the short-comings within what emerges as a seemingly perpetual cycle of under-achievement when examined over an extended period of time. This particular narrative goes beyond the low health indicators to highlight the inadequate levels of health funding, the imbalance in health expenditure between urban and rural areas, and between curative and preventative services. International development assistance agencies also draw attention to the low number of health staff, the poor

[12] The Western Pacific Region is a geographical region of the WHO's member countries which includes a diverse group of high, mid and low-income countries, eg: Japan, South Korea, China, Mongolia, Vietnam, Cambodia, Lao PDR, Australia, New Zealand, Fiji and number of smaller Pacific island nations.
[13] The PHC policy document declares that "the health sector has, in general, made continual progress." See Ministry of Health, 'Policy on Primary Health Care', January 2000, p.2.
[14] Vatthana Pholsena, *Post-war Laos. The Politics of Culture, History and Identity*, (Singapore: ISEAS, 2006), p.213.

standard of health and medical education, the inconsistent quality of healthcare provision, and its low utilisation rates by the population. On occasion international donors couch the elements of under-achievement diplomatically by giving preliminary acknowledgement of progress, before identifying the sector's short-comings. The WHO's current Country Cooperation Strategy for the Lao PDR is a case in point. It states:

> In recent years the Ministry [of Health] has made significant progress in terms of health policy development and decentralization of health services to provincial, district and health centre levels. *However*, investment in health is still low … health service provision is strained by a lack of qualified, adequately distributed staff, adequate infrastructure and an affordable drug supply...[15] [my emphasis]

Similarly, a recent World Bank report summarises:

> *Despite* notable progress in health on some fronts, Lao PDR continues to have some of the worst maternal and child outcome indicators, both globally as well as in the East Asia and Pacific region … By international standards, government spending on health – at 1.1 per cent of GDP – is low and has been erratic over time, primarily due to [fluctuations in] external financing … there are large disparities in government health spending between central and sub-national levels …[16] [my emphasis]

Development practitioners in Laos become familiar with these narrative models and devices, in the course of contributing to strategies, plans and reports for bilateral and multilateral development assistance agencies. Employing this "discourse of lack" and highlighting the short-comings of the health sector is almost a requirement to secure international funding for future interventions. At other times, commentators have been less diplomatic; for example, the WHO refers in one document to the "strongly administrative"

[15] WHO and Ministry of Health, *Country Cooperation Strategy for the Lao People's Democratic Republic, 2012-2015*, (Vientiane: WHO, 2011), p.vii.
[16] World Bank, 'Government Spending on Health in Lao PDR: Evidence and issues,' Report no: 76229-LA, December 2012, p.2.

nature (a euphemism for 'bureaucratic') of the Lao PDR's Ministry of Health,[17] whereas political scientist Kristina Jönsson describes it bluntly as "malfunctioning."[18]More troublingly, the authors of a review of French NGO, Comité pour la Coopération avec le Laos' (CCL) development efforts state that they have observed no real improvements in the health sector over the organisation's quarter-century in the country. Instead, they claim that improvements in health status have derived from general economic and development improvements unrelated to the health services.[19]

The criticisms above are not without substance. I witnessed several health-related episodes in the field prior to undertaking this research which suggested the official policies of the Ministry of Health and its supporting international development assistance agencies have run far in advance of the capacity for actual implementation.[20] Government health services were not serving (and quite possibly were unable to serve) rural communities in the manner and to the extent to which the Lao government and donors intended, although it was less clear why this was so. Given the successive waves of grand plans to develop the Lao health sector, and an almost constant narrative of under-achievement, it is easy to wonder what meaningful progress, if any, the sector has made since its beginnings in Laos.

[17] WHO, 'Lao PDR. Country Cooperation Strategy at a Glance', May 2010.
[18] Kristina Jönsson, 'Policy making in transitional economies: poverty reduction and health care in Cambodia and Laos', *Studies in Health Service Organisations and Policy*, 23, 2008, p.174.
[19] Florence Strigler *et al*, 'La situation nutritionnelle et sanitaire et l'évolution du système de santé', in *Le Laos doux et amer. Vingt-cinq ans de pratiques d'une ONG*, edited by Dominique Gentil and Philippe Boumard, (Paris: CCL-Karthala, 2005), p.132.
[20] I use the terms 'international development assistance agencies' and 'international cooperation agencies' interchangeably throughout the thesis, and make no distinction between the two terms. I do not, however, use the more recent term 'development partners', which has gained currency in the 2010s.

Research question

The starting point for my research was to find explanations for why the Lao health sector had failed 'Am's' family, and others like his. I set out to uncover the sector's achievements, but also to understand the reasons contributing to the long-standing poor health indicators, the shortages, short-comings and under-achievements. In summary, my research question is: To what extent did five decades of heavy and highly diverse international development inputs, coupled with six decades of prior colonial efforts, benefit or hinder the Lao health sector? I aim to provide a more detailed explanation of prior efforts in the health sector and the development obstacles encountered in various decades, in order to promote greater understanding of the context in which Lao government officials and international development practitioners currently work, and to make sense of some of the challenges they currently face.

Why history?

Historian Pratik Chakrabarti suggests that studying the history of medicine can help us to understand the "deep problems that plague global health".[21] The examination of the relationship between past and present, and inversely between present and past, can create improved understanding of both past events and contemporary phenomena. In this vein, a study of the history of the Lao health sector could contribute to an understanding of the roots and dynamics of problems that currently encumber the sector and its future development.

[21] Pratik Chakrabarti, *Medicine and Empire, 1600-1960,* (Basingstoke: Palgrave Macmillan, 2014), p.vii.

A combination of theoretical and pragmatic factors influenced my decision to apply history to this study. History and development may seem at first to be at odds. While the discipline of history examines change over time, the international development sector attempts to plan and foster change with a focus that rests unashamedly on the future. As such, development is more often paired with the disciplines of anthropology or sociology, which are anchored more firmly in the present. The development sector has been criticised by anthropologist David Lewis, among others, for its a-historical and decontextualised approach which studiously avoids delving into the historical context in which governments, development agencies and communities operate, and the legacies they carry, allowing development efforts and practitioners to exist in a cycle of the "perpetual present".[22]

Historical sources, methodology and analysis can contribute to the policy and practice of both health and development in many ways. However, the use of history in the development field remains rare,[23] despite advocacy from scholars who support greater use of history in health policy.[24] Alison Bashford and Carolyn Strange argue that historians can offer useful perspectives to public health professionals, who may be interested in the past but have not been trained to think in a historical manner.

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[22] David Lewis, 'International development and the 'perpetual present': Anthropological approaches to the re-historicization of policy,' *European Journal of Development Research*, 21, 2009, pp.332-346.

[23] Virginia Berridge, 'History Matters? History's Role in Health Policy Making', *Medical History*, 52, 2008, pp.311-326; Virginia Berridge, 'Thinking in Time. Does Health Policy Need History as Evidence?' *The Lancet*, 6 March 2010, 375 (9717), pp. 798-799; and Michael Woolcock *et al*, 'How and Why Does History Matter for Development Policy?' *Journal of Development Studies*, 47(1), January 2011, p.71.

[24] Lewis, 'International development', pp.332-346; Alison Bashford and Carolyn Strange, 'Thinking Historically about Public Health', *Medical Humanities*, 33, 2007, pp.87-92; and Sally Sheard, 'History in Health and Health Services: Exploring the Possibilities', *Journal of Epidemiological Community Health*, August 2008, 62(8), pp.740-744.

> Historical mindedness … entails searching for differences as well as similarities between past and present, and not presupposing one or the other … If policy-makers look to historians for clear answers, they are likely to be disappointed. Alternatively, if they are receptive to information that may have been forgotten, and, more importantly, if they are receptive to the wide-framed thinking that historians bring to bear … historically informed analysis will prove its value.[25]

In a similar vein, the past decade has witnessed increased support from political scientists and applied anthropologists of development for the role of history in development studies, and for its potential to contribute to better policies, practices and outcomes.[26] Political scientist Rob Jenkins outlines three ways in which development ideas and practices can benefit from a historical perspective: a history of development ideas can be presented; historical parallels can be used to support development theory; and the impact of historical pathways on future development choices can be highlighted.[27] My approach coincides most closely with Jenkins' third option, showing how historical pathways and frameworks influenced subsequent development options or choices within the Lao health sector. However, I must emphasise that this study does not concern itself with the future of the sector, and therefore makes no recommendations for future action. Recommendations are the work of policy makers, health professionals and development practitioners, not historians.

Personally, a key motivation for this research was the desire to challenge the low profile of history in development studies, to be discussed in more detail in the following chapter. The decision to use archival sources and potential informants inside and outside Laos had a more pragmatic motivation,

[25] Bashford and Strange, 'Thinking Historically', pp.88, 91.
[26] Woolcock *et al*, 'How and why does history matter', p.71.
[27] Rob Jenkins, 'Where Development Meets History.' *Commonwealth and Comparative Politics*, 44(1), 2006, p.2.

as this allowed me to begin research in countries with faciliatory research environments while waiting for research approvals in the Lao PDR.[28] I calculated that in a worst case scenario, in which Lao government research approval were unforthcoming within university-imposed deadlines, I could conduct the entire project outside the Lao PDR. My concerns were warranted. Eleven months elapsed before I was granted research status at the University of Health Sciences in Vientiane, and 20 months before access to Laos' National Archives Department was forthcoming. Twelve months later, during writing up, the National Archives unexpectedly granted additional access to previously undisclosed sources.

Scarce and scattered sources

This study draws on archival research and oral history interviews to reconstruct an understanding of developments within the Lao health system. Archives in several countries provided written documents, maps, photographs and newspaper articles, which presented official views from the colonial administration, successive Lao governments, international donors and international NGOs. Interviews and discussions, on the other hand, provided an opportunity to seek out more individual views and importantly, Lao voices and experiences which were under-represented in official archival sources. Ultimately my research relies more on written than oral sources, in contrast to the bulk of contemporary Lao histories which prefer oral history.

[28] My request for research approval in the Lao PDR began at the National Institute of Public Health, but was referred to the Post-Graduate Department of the University of Health Sciences. From there it progressed slowly through the Ministry of Health to the Ministry of Foreign Affairs, and back again, three times. See the descriptions of the long and complicated processes of obtaining official permissions to conduct research in the social sciences and humanities in the one-party states of China, Vietnam and the Lao PDR. Sarah Turner, ed., *Red Stamps and Gold Stars: Fieldwork dilemmas in Upland Southeast Asia,* (Vancouver/Toronto: UBC Press, 2013).

It was necessary to cast the research net widely, due to the scarcity and *ad hoc* nature of secondary sources and the restricted status of some primary sources. Access to archival collections in the Lao PDR is strictly controlled, and some United States government sources dating from the 1960s and 1970s are yet to be declassified. The archives consulted are located in the Lao PDR, France, the United States of America, and the Philippines, and contain documents in Lao, French and English languages. While not exhaustive, these sources provide a substantive overview from which a history of the Lao health sector can be reconstructed. No Vietnamese or Russian language sources were consulted due to lack of familiarity with these languages. However, future examination of such sources would add important perspectives and a fuller understanding of health and development in Laos, especially from the mid-1950s onwards.

Rare access was granted to the collection of the Lao Department of National Archives (*Kom Samnao Ekasane Heng Xat*), hereafter referred to as the National Archives, located within the Ministry of Home Affairs (*Kasouang Phay Nay*),[29] and the photographic collection of the Lao News Agency (*Khaosane Pathet Lao*), within the Ministry of Information, Culture and Tourism (*Kasouang Taleng-khao Vatthanatham lae Thong-thieo*). Few scholars conduct historical research in the Lao PDR, and even fewer attempt to access archival collections.[30] I accessed the National Archives' collection after

[29] The Ministry of Home Affairs (*Kasouang phay-nay*) is a new ministry created in the 2000s, with departments and functions previously located in the Prime Minister's Office (*Samnak-ngane nayok*) and LPRP committees. This new ministry should not be confused with the Ministry of Public Security, formerly named the Ministry of Interior (also *Kasouang phay-nay* in Lao).

[30] Sarah Turner, 'Dilemmas and Detours. Fieldwork with Ethnic Minorities in Upland Southwest China, Vietnam and Laos', in *Red Stamps and Gold Stars: Fieldwork dilemmas in Upland Southeast Asia*, ed. Sarah Turner, p.3.

a lengthy research application process through the Lao Ministry of Health's University of Health Sciences. While archives staff were generally helpful, the cataloguing system is basic and likely incomplete. Most documentation available for consultation was clustered from 1966-1973, and after 1975. Archives staff disclosed additional holdings in a follow-up visit, which included selected colonial and Royal Lao Government (RLG) records, and information concerning the activities of the Central Health Committee (*Khana Sathalanasouk Sounkang*) of the resistance Neo Lao Hak Xat's (NLHX) Liberated Zone dating from 1966 to 1975.

The photographic collection of the Lao News Agency is primarily a collection of NLHX and Lao PDR images, catalogued in only the most rudimentary fashion. Captions are often absent, or contain revolutionary slogans rather than descriptions of the images. I used official photographs as an indication of the regime's publicity priorities during the various decades, as well as confirmation of oral and written records.

Data was also drawn from a selection of overseas archival collections in France, the Philippines and the United States of America. The Archives Nationales d'Outre-Mer (ANOM) in Aix-en-Provence, France provided an extensive collection of official materials from the colonial health service in Laos, and the individual health facilities that preceded its formation.[31] Unfortunately, Lao voices were muted at best; almost all documents were written by French doctors, with only occasional reports by Lao or Vietnamese auxiliary staff. The collection provides a surprisingly comprehensive insight into the operation of the Lao health service over a period of 55 years, despite

[31] ANOM was formerly named the Centre des Archives d'Outre Mer (CAOM). The health records for Laos are part of the collection of the Résidence Supérieure du Laos (RSL), Series S [Santé], boxes 1-12.

suffering from what Laurence Monnais describes as the historiographic "no man's land" during the Second World War: the collection held no documents for the period from 1941-1946.[32] Due to time constraints, health-related materials for Indochina as a whole were not examined, nor were financial or public works materials for Laos which could have provided more contextual information.

The collection at the WHO's Western Pacific Regional Office library in Manila, the Philippines, provides a useful complement to the RLG and Lao PDR documents in the National Archives. It contains annual and biennial reports of the WHO regional office from the early 1950s until the present day, which detail WHO assistance to the RLG and later the Lao PDR governments, as well as the governments of other member countries in the region. Occasional reports contain rare photographs of health activities in Laos in the 1960s and early 1970s. The WHO office library in Vientiane has a collection of more recent official strategies, plans and reports, with few predating the mid-1990s.

The National Archives and Records Administration (NARA) collection at College Park, Maryland, United States of America, provides archival evidence of American activities during the RLG period, although not all records have been declassified.[33] As expected, most United States records were in English, with the exception of Lao government announcements and the reports of French technical advisors, which were conveyed to Washington DC in their original French.

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[32] Monnais-Rousselot, *Médecine et colonisation*, p.83.

[33] Researcher Jonathon Clemente also found that many United States Government materials concerning medical assistance to Laos during the Second Indochina War remain classified. Email correspondence of 4 June 2012.

In addition to the NARA records, the USAID website contains a large and increasing number of digitised documents from the 1950s, 1960s and 1970s. The documentation provides information on USAID's Public Health Program, including the contract of NGO Operation Brotherhood (OB). I also thank the family of the late Dr Primo Guevara, a former OB doctor, for generously sharing documents from his personal archives.

Occasional Lao memoirs complement the archival materials. There are extremely few book-length memoirs by Lao health workers, but brief accounts exist.[34] Memoirs of foreigners who spent part of their working life in Laos and/or the Lao health sector are more numerous. A series of books by American doctor, Tom Dooley, penned in the late 1950s to raise funds for his medical work in rural Laos, offer a rich if sometimes dramatic description of health and medical conditions in selected rural towns.[35] The memoir of Dr Charles Weldon, the former head of USAID's Public Health Division in Laos from 1963-1974, describes his work during those years.[36] *Goodbye Vientiane*, a collection of reminiscences of former OB staff offers some light-hearted but nevertheless interesting commentary on the rural health network it operated from 1957 until 1975,[37] complementing Father Miguel Bernad's more formal

[34] Banyen Phimmasone-Lévy, 'Yesterday and today in Laos: a girl's autobiographical notes', in *Women in the New Asia: The Changing Roles of Men and Women in South and South-East Asia*, ed. Barbara E. Ward, (Amsterdam: UNESCO, 1963), pp.244-267; Fred Branfman, 'May the life of a former nurse from Xieng Khouang pass away without returning again,' in *Voices from the Plain of Jars. Life under an Air War*, (New York: Harper Colophon Books, 1972), pp.46-56; and Khammeung Volachit, *Nang Phet Pativat. Xivit tit-phanh kap hong-moh 101 viraxon* (Revolutionary female nurses: Life and the Heroic Hospital 101), (Vientiane: Manthoulath Press, 2012).

[35] Thomas A. Dooley, *Dr Tom Dooley's Three Great Books: Deliver Us from Evil, The Edge of Tomorrow[and] The Night They Burned the Mountain*, (New York: Farrar, Straus and Cudahy, 1960).

[36] Charles Weldon, *Tragedy in Paradise. A Country Doctor at War in Laos,* (Bangkok: Asia Books, 1999).

[37] Penelope Villarica Flores, *Goodbye Vientiane. Untold Stories of Filipinos in Laos,* (San Fransisco: Philippine American Writers and Artists Inc, 2005).

and praising account of OB's early operations in Laos.[38] Former British diplomat, Mervyn Brown touches on the work of British Colombo Plan doctors in the early 1960s, including their brief capture by the Pathet Lao,[39] while French medical advisor Didier Sicard and his wife provide insight into the conditions at the medical school in the early years of the new regime.[40] All sources provide interesting snapshots in time, but without an established historical framework the disparate and fragmentary accounts are unable to be placed into the broader context of the Lao health sector.

Interviews, discussions and ethics

Archival research was supplemented with interviews and in-depth discussions with former health workers, technical advisors and international development agency staff.[41] I interviewed 56 current or retired doctors, pharmacists, dentists, nurses, midwives, health administrators, and technical advisors, who are now resident in the Lao PDR, France, United States, the Philippines and Australia. Moreover, a seminar organised by the University of Health Sciences in Vientiane in June 2014 brought together 40 Lao health professionals, some of whom offered helpful advice and information.

Interviews took the form of discussions, and offered a more personalised aspect of the health sector than the formulaic structure and contents of official reports. However, the word 'interview' (*kane samphat*)

[38] Miguel A Bernad, *Filipinos in Laos, with "Postscripts" by J "Pete" Fuentecila*, (New York: Mekong Circle International, 2004).
[39] Mervyn Brown, *War in Shangri-La: A Memoir of Civil War in Laos*, (London: Radcliffe Press, 2001).
[40] Marie-Noële and Didier Sicard, *Au nom de Marx et de Bouddha: Révolution au Laos, un peuple, une culture disparaissent*, (Paris: Inter Editions, 1981).
[41] Ethics clearance for the interviews was obtained from the National University of Singapore (NUS) and the University of Health Sciences (UHS) in Vientiane.

proved highly formal and therefore fear-inducing for many of the Lao informants, and posed an initial barrier to the free flow of discussion. Outside the Lao PDR, most interviews were sound-recorded. Written notes were taken during or immediately after interviews that were not sound-recorded, and confidential transcripts of all interviews prepared. Most informants outside the Lao PDR agreed to be named in the research, whereas many inside the country requested anonymity.

Some potential informants in Laos appeared wary of my intentions and declined to be interviewed. Some replied that they were too old, others that their roles had been mundane and therefore they had nothing to contribute. Others passed away before I could interview them. Some ensured their responses did not deviate from current official policy, or recommended that I interview higher-ranking persons who would be more practiced at repeating the official line. Vatthana Pholsena encountered similar problems conducting oral history discussions in Laos, and reports that she was advised: "People may think you want to spy on their past and find flaws".[42]

I did not 'pursue' potential informants vigorously but let them gravitate towards me through friendships and personal contacts. To respect the numerous requests for anonymity, I rarely provide direct quotes from discussions in the thesis text. Instead, I use them as background information to inform my archival research.

The research stirred up mixed emotions for many Lao informants. One retired nurse smiled wistfully as she recited English-language slogans taught by a provincially-based Filipino medical team in the early 1970s. Another's

[42] Vatthana Pholsena, 'Shifting Visions of the Past: Ethnic Minorities and the 'Struggle for National Independence' in Laos' in *Contestations of Memory in Southeast Asia.* ed., Roxana Waterson and Kwok Kian-Woon, (Singapore: NUS Press, 2012), p.97.

eyes moistened as she recalled her carefree youth as a medical student in a beautiful Eastern European city in the 1970s and 1980s. However, one elderly man living in exile declined my email enquiry for an interview explaining, in impeccable English, that the past was too painful and so he had moved on.[43] Another exile wished me "Bonne chance".[44]

Thesis Outline

The study concerns the interlocking themes of health, development and history in modern Laos. It is the first historical research project to examine the development of the Lao health sector, and the history of medicine in the Lao context. It presents an account of the development of the Ministry of Health and its various forerunners, as well as a historical overview of the expansion of the health network, and the professional education and training of Lao health workers. On a broader level, the study seeks to explore the influence of colonization and decolonization, and the provision of high levels of diversely sourced international development assistance to the health sector over a period of more than a century.

The study provides an overview of developments in the Lao health sector from 1893 until 2000. It is a necessarily general study, at times sweeping, as it takes the first step in outlining the overall framework and context of the history of health and medicine in Laos before more analytical studies can be meaningfully conducted. The study begins with the French annexation of Laos, and closes as the Lao PDR's fourth Five-Year Socio-Economic Development Plan drew to an end. The year 1950 serves as a half-

[43] Email correspondence with former RLG official (anonymous), June 2012.
[44] Email correspondence with Dr Khamphaï Abhay, 10 October 2012.

way point. In that year, the French administration transferred management of the Lao health service to the RLG. As such, this study spans 57 years of colonial and 50 years of post-colonial health services.

Some informants encouraged me to extend my study until the present day, arguing that more impressive advancements have been made since the turn of the twenty-first century, and that by ending in 2000 my study would not capture them. My response has been that a large part of my intention is to reconstruct and highlight periods of history that have faded from memory or been discarded. The period after 2000 is well-known to many people currently working in the health sector, and information about those years is still relatively easy to access.

This study charts the establishment of a nationwide health service, including infrastructure, staffing and professional education and training, official policies and healthcare delivery within the limits of Laos' geographical, administrative and cultural marginality. Secondly, the research highlights the provision of international development assistance by donor agencies to the various Lao administrations. It explores the limitations inherent in the numerous but also highly diverse sources of such development assistance, and their impact on opportunities for consolidation or reform within the health sector. Finally, the study exposes the limited knowledge and awareness of the history of the health sector, and how this has led to the glossing over of sequential developments by official sources, buying into the international development sector's understanding of perpetual under-achievement, and denying contextual understanding for those currently working in the health sector.

Chapter Two examines the academic fields of the history of medicine, international development policy and practice, and Lao historiography which frame this study. The chapter advocates that histories of medicine must go beyond the study of biomedicine and colonialism, where they have traditionally clustered, to engage with the role of biomedicine in the post-colonial period, by examining its interplay with nation-building agendas and the international development sector. The chapter also discusses the latter's role in national development, and its often a-historical approach.

The following chapters provide a more detailed examination of the Lao health sector during four periods of the twentieth century. Chapter Three deals with establishment of a biomedical health service, *l'Assistance médicale au Laos*, in the colonial period (1893-1950). Chapter Four investigates its nationalisation and fragmentation in the post-colonial period under the administration of the RLG and in the 'Liberated Zone' of the resistance government of the NLHX, and its shaping during a period of extended war and conflict from 1950-1975. Chapter Five examines the changes and realignments within the health sector and the wider government sector in the socialist period of the early Lao PDR (1975-1990), while Chapter Six deals with the transitional period of new thinking and market economics in the decade from 1991-2000, ushered in after the fall of socialist governments in Eastern Europe and the Soviet Union, in the post-socialist period.

I conclude the study by summing up how Laos' multi-faceted marginality, combined with its long-term heavy dependence on diverse sources of external assistance, has influenced, and at times limited, development of Laos' biomedical health services. I conclude that the current

state of the health sector, and its often-cited poor performance, can be significantly explained by its historical development in the context of marginality and dependence on external assistance, with resultant disruptions, continuities and reconfigurations. And because the country's comparative economic and educational poverty has compounded the sector's slow development in the colonial, post-colonial, socialist and post-socialists periods, it is not possible to meaningfully examine Laos' health sector without also being mindful of parallel national development efforts.

Conclusion

The research aims to address the interests and requirements of international and Lao academics, and also to stimulate the curiosity of Lao health professionals about the history of their profession, the health sector, and wider history of the nation. It aims to provide deeper historical context about the Lao health sector for Lao government officials and also international development assistance agencies, which continue to provide funding and technical support to the sector.

The thesis uncovers and reconstructs the development trajectory of the Lao health sector over the period from 1893 to 2000. It acknowledges the achievements of the biomedical sector, while seeking to unravel the cycle of grand plans and seemingly perpetual under-achievement frequently invoked by successive Lao governments and international development assistance agencies. It presents historical explanations for the poor performance of the Lao Ministry of Health and the health sector more generally, arguing that it is bound up in the geographical, administrative and cultural marginality of Laos,

its long-term dependence on external assistance for the development of many of its technical and administrative services, and the resulting limitations that have manifested in the health sector.

CHAPTER 2

THE CONTEXT:

HISTORIES OF HEALTH, DEVELOPMENT AND MODERN LAOS

Introduction

The history of health and development in Laos spans a wide academic territory that is politically, economically, socially, culturally and ultimately geographically diverse. The research combines the history of medicine, the history of development policy and practice, and the historiography of modern Laos. This chapter outlines the academic framework provided by each of these fields. Histories of medicine have tended to focus on the colonial period, whereas studies of health and development are more commonly concerned with the post-colonial period. This research weaves these two related fields with historiography to examine the development of health networks, human resources and healthcare services from the onset of French colonisation until the turn of the twenty-first century. The timeframe covered by the research, significantly longer than most studies of the development sector, allows for a considered view of national and sectoral developments, and for questioning (without a definitive answering) of whether the internationally-funded development process has fostered improvements in the health sector, or a cycle of under-achievement and failure.

On a broader level, the study demonstrates the ways in which international political movements and events have impacted on Laos: a small, low-income, marginal nation; and the various dilemmas posed for Lao health

professionals, administrators and the population in general, and the options available to develop the health sector within these boundaries. This focus contrasts with much of the existing international literature in the fields of both the history of medicine and development studies, which focuses on the experience of larger and/or middle-income countries.

Histories of Medicine

In this section, I highlight some of the key themes emerging from the study of the history of medicine in the past 30 years. I pay particular attention to studies that explore the history of medicine in Southeast Asia and French Indochina, and conclude by summarising the critique of the contemporary state of health and medicine in developing countries, which argues that the foundations of unequal health are rooted in the imperial past and perpetuated by the current system of international development assistance.

Definitions of health, medicine, health systems and health services

The knowledge and practice of medicine has a long history in diverse societies throughout the world, resulting in different medical traditions, and concepts of health and ill health (or illness) that are both culturally and historically specific. The various medical traditions or conceptual health systems, for example, biomedicine, Ayurvedic and Traditional Chinese Medicine have mixed and exchanged ideas, practices and drugs over time, resulting in few clean-cut divisions between them. All conceptual health systems, however, aim to protect or improve human health. In the early twentieth century, the Rockefeller Foundation defined ‘health’ as the ability to

work.[1] The WHO, on its founding in 1948, adopted a more holistic definition: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[2]

This study deals primarily with the conceptual health system of biomedicine, as practised within a series of official health services in Laos. It engages with traditional Lao medicine only where it comes within the scope of the predominantly biomedical health services, despite traditional medicine offering a rich field of research.[3]

Academics use a wide range of terms to refer to biomedicine. In the history of medicine literature it is referred to alternatively as 'European medicine', 'Western medicine', and 'modern medicine'. I treat all these terms as having more or less the same meaning. The period-based terms, 'colonial medicine' and 'imperial medicine', also crop up frequently, alongside the more location-specific 'tropical medicine.' I prefer to use the term 'biomedicine', in part because biomedical education and practices were frequently transmitted to Laos via non-Western countries. I also prefer to avoid the problematic term 'modern medicine' because, as Hormoz Ebrahimnejad points out, biomedicine incorporates aspects of 'traditional'

[1] E. Richard Brown, 'Public Health in Imperialism: Early Rockefeller Programs at Home and Abroad,' *American Journal of Public Health*, 66(9), September 1976, p.900.
[2] World Health Organization, Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 22 July 1946 and entered into force on 7 April 1948.
[3] For more information on traditional Lao medicine, see Oudom Souvannavong, 'Some practices of Traditional Medicine', in *Kingdom of Laos. The land of the million elephants and the white parasol*, ed. René de Berval, (Saigon: France Asie, 1959 [1956]), pp.301-304; Joel M. Halpern, 'Traditional Medicine and the Role of the *Phi* in Laos', *The Eastern Anthropologist*, vol. XVI(3), 1963, pp.181-200; and Phou-gneun Souk Aloun, *Médecine traditionnelle bouddhique du Laos*, (Paris: L'Harmattan, 2001).

medicine, which is not static but continues to evolve, as does biomedicine.[4] In Lao, biomedicine is referred to as *phetsart*, the science or discipline of medicine, or sometimes *yah louang*, referring to drugs or pharmaceuticals, or literally mainstream, official medicine. The various branches of traditional medicine - botanical, animal and spiritual/magic medicine - are often grouped together under the category of *yah pheun-meuang*, literally 'indigenous medicine(s)'.

I avoid using the term 'health system', to reduce potential confusion generated by its dual meaning. While academics use the term to refer to conceptual systems of medicine, for example, as used at the beginning of this section, it also has a technical meaning favoured by the WHO to describe the organisation, people and actions which combine to provide healthcare services. In this case, I refer to specific health organisations, for example, the colonial health service or the Ministry of Health, as 'health services' rather than 'health systems', although I examine them according to the building blocks WHO states as being the necessary components of a health systems framework.[5] I use the term 'health network' to refer to the distribution of health facilities (hospitals and dispensaries), and 'healthcare services' to refer to specific practices or actions which treat disease or promote health.

Historiography of Colonial Medicine

The history of medicine does not confine itself to any particular medical system or tradition. However, the study of biomedicine in colonial

[4]Hormoz Ebrahimnejad, 'Introduction', in *The Development of Modern Medicine in Non-Western Countries. Historical Perspectives*, ed. Hormoz Ebrahimnejad, (London: Routledge, 2009), p.3.
[5] http://www.who.int/healthsystems/hss_glossary/en/index5.html, accessed on 19 November 2015.

settings has emerged as one of its most productive branches. Historians have critiqued the close links between biomedicine and empire in a range of colonial settings. Studies of the Indian sub-continent,[6] Africa[7] and Australia,[8] as well as Southeast Asia, including Malaya,[9] the Dutch East Indies,[10] the Philippines,[11] and Indochina[12] have contributed to the understanding not only of the development and application of biomedicine in various locations, but also of the processes of colonial ideology and policy in the development of health services. Historians have shown how biomedicine and colonialism developed in tandem,[13] how it was practiced by Christian missionaries, military forces and colonial administrations in non-European societies, and how its introduction and expansion in colonial settings became linked to what colonising nations perceived to be a responsibility to 'civilise' other societies. Early accounts of colonial medicine frequently referred to its role in a wider

[6] David Arnold, ed., *Imperial Medicine and Indigenous Societies*, (Manchester: Manchester University Press, 1988); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, (Berkeley: University of California Press, 1993); Mark Harrison, *Public Health in British India. Anglo-Indian Preventative Medicine 1859-1914*, (Cambridge: Cambridge University Press, 1994); and Biswamoy Pati and Mark Harrison, eds., *The Social History of Health and Medicine in Colonial India*, (London: Routledge, 2009).

[7] Megan Vaughan, *Curing Their Ills. Colonial Power and African Illness*, (Cambridge, UK: Polity Press, 1991).

[8] Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*, (New York: Palgrave Macmillan, 2004).

[9] Lenore Manderson, *Sickness and the State: Health and Illness in Colonial Malaya, 1870-1940*, (Cambridge: Cambridge University Press. 1996).

[10] G. M. van Heteren *et al*, eds., *Dutch Medicine in the Malay Archipelago, 1816-1942*, (Amsterdam: Rodopi, 1989).

[11] Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines*, (Durham: Duke University Press, 2006).

[12] Laurence Monnais-Rousselot, *Médecine et colonisation: L'aventure indochinoise, 1860-1939*, (Paris: Editions CNRS, 1999); Jan Ovesen and Ing-Britt Trankell, *Cambodians and their Doctors. A Medical Anthropology of Colonial and Post-Colonial Cambodia*, (Copenhagen: NIAS Press, 2010); Sokhieng Au, *Mixed Medicines. Health and Culture in French Colonial Cambodia*, (Chicago: Chicago University Press, 2011).

[13] Chakrabarti, *Medicine and Empire*, pp. xv, 141.

civilising mission, recounting how medicine was promoted as "the triumph of science and sewers over savagery and superstition".[14]

The late 1980s witnessed a critical approach to the study of the history of medicine and imperialism. Roy MacLeod and Milton Lewis argued that medical discourse "depoliticised" the problems of disease and illness in the colonial period by suggesting that all problems had technical or scientific solutions and neglecting their social and/or political aspects (for example, the unequal power relations between doctor (specialist) and patient; coloniser and colonised).[15] The new generation of scholars uncovered social and cultural discourses of medicine, climate and colonialism. They explored how such ideas contributed to the specialisation of tropical medicine, and the manner in which biomedical thinking conceptualised racial and gender differences.[16] Critical histories of biomedicine in India and Africa highlighted the oppressive power of colonial medicine through Foucauldian concepts of biopower and governmentality.[17] Consequently, Daniel Headrick's term, 'tool of empire' has been widely adopted to describe how industrial (and biomedical) technologies assisted imperial powers to advance their military, economic and cultural objectives. Headrick observes that the technologies proved far more enduring in former colonies than the ideology of imperialism itself.[18]

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[14] Shula Marks, 'What is Colonial about Colonial Medicine,' *The Society for the Social History of Medicine*, 1997, p.205.
[15] See Roy MacLeod and Milton Lewis, eds., *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, (London: Routledge, 1988), p.1; and Arnold, ed., *Imperial Medicine*.
[16] Marks, 'What is Colonial,' p.213.
[17] See Vaughan, *Curing Their Ills*; Arnold, *Colonizing the Body*; Harrison, *Public Health*; Mark Harrison, *Climates and Constitutions, Health, race, environment and British imperialism in India 1600-1850*, (New Delhi/New York: Oxford University Press, 1999); and Poonam Bala, ed., *Biomedicine as a Contested Site. Some revelations in imperial contexts*, (Lanham: Lexington Books, 2009).
[18] Daniel R. Headrick, *Tools of Empire. Technology and European imperialism in the nineteenth century*, (New York: Oxford University Press, 1981), p.4.

Colonisers were alleged to use biomedical healthcare and public health measures selectively, to protect the health of their administrators, settlers and occupying troops by creating sanitary buffers, and cynically promoting the health of colonised populations to increase their labour productivity.[19] In the tradition of subaltern studies, research has also highlighted the resistance of local communities to unpopular and culturally unfamiliar public health measures such as vaccination and quarantine.[20] Others have argued that the introduction of biomedicine into non-Western societies produced a site of contestation, in which colonised societies exercised a degree of agency, rejecting or selecting and reshaping the aspects of biomedicine that appealed to them.[21]

Biomedicine was also employed as a cultural tool, most notably in the period from 1890 to 1930 when colonialism reached its height. Scholars note that from the late 1800s biomedical care was extended to local communities in many European colonies. They argue that such actions were motivated by a growing humanitarian benevolence, albeit within discriminatory racial frameworks, but which also served to demonstrate colonial powers' belief in their own higher level of civilisation compared to the people they colonised.[22]

Researchers now appreciate that biomedicine was as much a product of empire as its tool. Colonial medical officers returned home with broader

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[19] Brown, 'Public Health in Imperialism', p.899.
[20] See Vineeta Sinha, *Colonial Encounters: Transplanting "western medicine", ousting "traditional healing"*, (Singapore: Department of Sociology, National University of Singapore, Working paper series, 1999); Au, *Mixed Medicines*; and Lenore Manderson, 'Political economy and the politics of gender: maternal and child health care in colonial Malaya', in *The political economy of primary health care in Southeast Asia,* ed. Paul T. Cohen and John T. Purcal, (Canberra: Australian Development Studies Network, 1989), p.81.
[21] Bala ed., *Biomedicine*; Ebrahminnejad, ed., *Development of Modern Medicine*; and Jonathan Saha, 'Uncivilised practitioners': medical subordinates, medico-legal evidence and misconduct in colonial Burma, 1875-1907,' *South East Asia Research*, 20(3), 2012, pp.423-443.
[22] Chakrabarti, *Medicine and Empire,* p.164.

knowledge and practices acquired in the colonies.[23] Additionally, scientific and medical researchers from the metropole benefited from the colonial expansion of the eighteenth and nineteenth centuries, as it enabled them access to study new climatic zones and diseases.[24] Rapid developments in European pharmacology were facilitated by earlier exchanges of therapeutic goods and practices, and the collection of a wide range of local medications by European traders and health professionals in colonised countries. The isolation of active elements in botanical, mineral and animal ingredients from the collected products allowed European researchers to proceed to manufacture pharmaceuticals.[25]

Others are less convinced by the 'exchange theory' of biomedicine in the Southeast Asian context. Paul Cohen and John Purcal argue: "There was hardly any cross-fertilisation of ideas from Southeast Asian traditions into 'imperial medicine'."[26] And Karine Delaye notes that scientific cooperation between empires in Southeast Asia was problematic as colonial science had trouble crossing borders in that region.[27] Regardless of the 'exchange theory', a tension remains between the allegation of colonial oppression through the imposition of unpopular biomedical practices, and the recognition of their ultimate health benefits. For example, quarantine measures were often unpopular but helped stem the spread of contagious diseases. Also, although

[23] Anderson, *Colonial Pathologies*, pp.7-8.
[24] Arnold, *Colonizing the Body*, p. 290; Monnais-Rousselot, *Médecine et colonisation*, pp. 14, 399.
[25] Chakrabarti, *Medicine and Empire*, p.34.
[26] Paul T. Cohen and John T. Purcal. 'The political economy of primary health care in Southeast Asia: problems and prospects', in *The political economy of primary health care in Southeast Asia.* ed. Paul T. Cohen and John T. Purcal, (Canberra: Australian Development Studies Network, 1989), p.6.
[27] Karine Delaye, 'Colonial cooperation and regional construction: Anglo-French medical and sanitary relations in South East Asia,' *Asia Europe Journal*, 2004(2), pp.461-471.

compulsory vaccination was unpopular in some places, it benefited large numbers of people.

No consensus about the effects of the introduction of biomedicine has been reached. David Arnold points out that colonial medicine has been accused of being a powerful, penetrating part of the colonising process, and at other times argued as having only superficial effects.[28] Others downplay the reach of biomedicine, stating:

> … there emerged a dualism in the delivery of health services, with a disproportionate share of the health budget allocated towards looking after the European community, while the paltry sum that was allocated for improvements of health of the indigenous population was grossly inadequate to extend the social benefits of modern medical care to the rural areas.[29]

There is a growing body of research dealing with the history of medicine in Vietnam, Cambodia and the French consular centres in south-western China.[30] Laurence Monnais-Rousselot's *Médecine et colonisation*, published in 1999, represents the most comprehensive academic study of biomedicine in French Indochina,[31] while more recent studies examine specific developments in the health sector. From these studies we learn that biomedicine was introduced to Indochina by Christian missionaries in the

[28] Arnold, *Colonizing the Body*, p.4.
[29] Norman Owen, ed., *Death and Disease in Southeast Asia. Explorations in Social, Medical and Demographic History*, (Singapore: Oxford University Press, 1987), p.14.
[30] Laurence Monnais (-Rousselot) is the leading historian researching the history of medicine in colonial French Indochina. See Monnais-Rousselot, *Médecine et colonisation*. Other notable historical studies of medicine in French Indochina include: Sokhieng Au, 'Indigenous Politics, Public Health and the Cambodian colonial state', *South East Asia Research*, 14(1), 2006, pp. 33-86; Au, *Mixed Medicines*; Ing-Britt Trankell and Jan Ovesen, 'French Colonial Medicine in Cambodia: Reflections of Governmentality', *Anthropology and Medicine*, 11(1), 2004, pp. 91-105; and Ovesen and Trankell, *Cambodians and Their Doctors*; Florence Bretelle-Establet, 'Resistance and Receptivity: French Colonial Medicine in Southwest China, 1898-1930', *Modern China*, 25(2) (April 1999), pp.171-203; and Thuy Linh Nguyen, 'The Medicalization of Childbirth in Colonial Vietnam, 1880-1944', PhD dissertation, University of Pennsylvania, 2009.
[31] Monnais-Rousselot, *Médecine et colonisation.*

seventeenth century, and was promoted and expanded under colonial rule. French colonisers perceived biomedicine as a peaceful and benevolent 'tool of empire'. Louis-Hubert Lyautey, a military official who served in Indochina in the late 1890s, is reported to have stated that medicine was "the ideal weapon of peaceful colonisation, because where the doctor has gone first, regiments can pass through without blood-letting".[32] He is quoted elsewhere as stating that "The doctor is the sole excuse for colonialism".[33] As in other colonial settings, France's civilising mission involved a practice of cultural imperialism in which French scientific knowledge and research, including biomedicine, was used to "radiate" French cultural values, and to assert "international hegemony or moral authority over the colony".[34] While education had the power to civilise the mind, biomedicine was employed to civilise the body, and to demonstrate the superiority of European knowledge over indigenous medical traditions or health systems.

Monnais portrays the introduction of biomedicine to French Indochina as a 'tool of empire', in line with historians of medicine in other colonial settings. She shows how French colonial authorities initially employed biomedicine for their own ends to create sanitary buffers between Europeans and local populations, and in accessible communities such as army barracks, prisons, and work gangs.[35] She also highlights later French attempts to expand

[32]Quoted in Eugène Teston and Maurice Percheron, *L'Indochine moderne. Encyclopédie administrative, touristique, artistique et économique,* (Paris: Librairie de France, 1931), p.210.
[33] Arnold, ed., *Imperial Medicine*, p.3.
[34] Lewis Pyenson, *Civilizing Mission. Exact Sciences and French Overseas Expansion, 1830-1940,* (Baltimore: Johns Hopkins University Press, 1993), p.57.
[35] Monnais-Rousselot, *Médecine et colonisation*, p.34.

the provision of healthcare into rural areas and the general population in the 1920s and 1930s.[36]

Biomedicine's use as a colonial 'tool of empire' was shown to have a dual nature, for cases such as vaccination proved to be a beneficial practice for both colonising and colonised populations. Imperial power provided French scientists with access to tropical climates and disempowered communities within which they could experiment with their vaccines.[37] The scientific discoveries of the Pasteur Institute, which had branches in French Indochina from the early 1890s, greatly expanded the ability of the colonial authorities to produce and distribute vaccines for smallpox, plague, cholera and tuberculosis. Local recognition of the benefits of vaccination is evidenced by the fact that researchers Louis Pasteur, Alexandre Yersin, and Albert Calmette are among the few Frenchmen whom today still have streets named in their honour by the communist government of Vietnam.[38]

Monnais, and anthropologists Jan Ovesen and Ing-Britt Trankell remark on the processes by which local communities and individuals in Vietnam and Cambodia consciously selected elements of biomedicine to adopt or reject.[39] Historian Sokhieng Au argues that local resistance stemmed the expansion of biomedicine in colonial Cambodia, As such, biomedicine not only showcased the power of French colonial science and knowledge in comparison to existing forms of traditional medicine, it simultaneously helped

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[36] Ibid., p.95.
[37] Anne Marcovich, 'French colonial medicine and colonial rule', in *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, ed. Roy MacLeod and Milton Lewis, (London: Routledge, 1988), p.112.
[38] Monnais-Rousselot, *Médecine et colonisation*, p.439.
[39] See Au, *Mixed Medicines*, pp.1-2, 183; Laurence Monnais, 'Rejected or Elected? Processes of Therapeutic Selection and Colonial Medicines in French Vietnam, 1905-1939' in Bala ed., *Biomedicine as a Contested Site*, pp.115-134; Ovesen and Trankell, *Cambodians and their Doctors*, p.23.

to improve the health and well-being of colonised people, and could therefore be used to evidence the benevolent intentions of colonial rule.[40]

Monnais' work, fleshed out in recent years to cover maternal and child health, pharmaceuticals and the hospital system, has laid the foundations for the study of biomedicine in Indochina. Her work is largely descriptive, testing but ultimately accepting the general theories generated within the wider field of the colonial history of medicine. It also shows a heavy bias towards the three Vietnamese territories of Tonkin, Annam and Cochinchina, possibly reflecting the nature of colonial sources.[41]

Two recent studies of the history of the Cambodian health sector take a more theoretical approach. Ovesen and Trankell's study, *Cambodians and Their Doctors*, draws on an eclectic collection of theories such as governmentality, biopower, globalisation and localisation.[42] Sokhieng Au's *Mixed Medicines* offers a more conventional history, confining itself to the years 1907 until 1940, and framed by her theory of 'cultural insolubility'. She argues that, despite the title of her book, in many respects the indigenous Cambodian medical tradition and French biomedicine did not mix. The two cultural ideologies, she argues, were so different that they did not and often could not mix, because they existed in separate "cultural thought worlds"

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[40] Monnais-Rousselot, *Médecine et colonisation*, p.62; Laurence Monnais, 'In the Shadow of the Colonial Hospital: Developing Health Care in Indochina, 1860-1939', in Gisele Bousquet and Pierre Brocheux eds., *Viet Nam Exposé: French Scholarship on Twentieth-Century Vietnamese Society*, (Ann Arbor: University of Michigan Press, 2002), p.147; and Frederick Quinn, *The French Overseas Empire*, (Westport, Conn: Praeger, 2000), p.6.

[41] See Laurence Monnais, 'La médicalisation de la mère et de son enfant: l'exemple du Vietnam sous domination française, 1860–1939', in *Children's Health Issues in Historical Perspective*, ed. Krasnick Warsh, Cheryl and Veronica Strong-Boag, (Waterloo, Ontario: Wilfried Laurier University Press, 2005), pp. 227-266; Laurence Monnais with N. Tousignant, 'The Colonial Life of Pharmaceuticals, Accessibility to Health Care, Consumption of Medicines and Medical Pluralism in French Vietnam, 1905-1945', *Journal of Vietnamese Studies*, 1(1-2), 2006, pp. 131-168; and Monnais, 'In the Shadow', pp.140-215.

[42] Ovesen and Trankell, *Cambodians and Their Doctors.*

which were "culturally insoluble."[43] The absence of Lao-specific studies means little is known about the introduction of biomedicine and the reaction of local communities' to it. Chapter Three explores the French colonial authorities' introduction of biomedicine to Laos, and argues that the Lao experience differed from that of Vietnam and Cambodia in significant ways, despite its inclusion within wider Indochinese health policy.

Post-colonial histories of health in developing countries

In the years following the end of the Second World War, many former colonies achieved independence. Historian of medicine Sunil Amrith argues that "perhaps the most fundamental shift" in thinking about healthcare services during this period was that health became widely accepted as a right of citizenship and the responsibility of governments. He observes: "In a very short space of time, to possess a health service had become a universal element of the functions of a state; any state".[44] Post-colonial studies of health and medicine are framed, for the most part, in terms of the political economy of health, rather than the history of science or the racial dimensions of power which characterise research on the colonial period.[45] They examine health and development, international health, and more recently, global health, often within the framework of international development policy and practice. For this reason, I take up the matter of specific health-related studies of the post-

[43] Au, *Mixed Medicines*, p.3.
[44] Sunil Amrith, *Decolonizing International Health. India and Southeast Asia, 1930-1965*, (London: Palgrave Macmillan, 2006), p.2.
[45] For example, Amrith, *Decolonizing International Health*; Monica Das Gupta *et al*, *Health, Poverty and Development in India*, (Delhi: Oxford University Press, 1996); and Peter Conrad and Eugene B. Gallagher, eds., *Health and Health Care in Developing Countries*, (Philadelphia: Temple University Press, 1993).

colonial period after first examining the general field of international development policy and practice.

Development policy and practice

Development policy and practice represents the second academic field of engagement for this study. Ideas about development have played a formative role in shaping the post-colonial Lao state, including its health sector. In this section, I provide an historical summary of the concept of development and the criticisms it has attracted, before moving to an examination of the position of health and development within the broader debate. The health sector has been included in global development policies, plans and funding programs for decades. And since the introduction of the concept of 'human development' in the 1990s, it has been accorded a more mainstream role. I also highlight the attempts of some academics to link research on the colonial and post-colonial periods, both in terms of the development sector and the health sector more specifically.

Definitions of 'Development'

The wide array of terminology employed to refer to development is bewildering. 'International development', 'assistance', 'cooperation', 'foreign aid', 'international aid', or simply 'aid' are all bandied about in discussions of international development assistance. Scholars and commentators seemingly use the terms interchangeably, but at other times accord them specific meanings. I use international assistance as the umbrella category, and separate it into three sub-categories: development assistance, emergency (or

humanitarian) assistance and military assistance. It should be noted that the definition of Official Development Assistance (ODA) used by the world's foremost development body, the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) currently excludes military assistance, as well as emergency or humanitarian assistance (which is provided on a short-term ad hoc basis in response to specific events or crises, eg: floods, droughts, refugee flows), although as development commentator Stephen Browne admits, there can often be a fine dividing line between development aid and the latter.[46] This thesis is predominantly interested in development assistance, and deals only fleetingly with emergency and military assistance in specific instances where health development assistance spills over into these sub-categories.

The concept of 'development' has proved difficult for scholars to define. This is perhaps because even when one uses the term 'development' in a way that is distinct from the umbrella category of 'aid', it can refer to the state of 'having been developed', the process of 'being developed', and the financial and/or technical inputs that contribute to both of these options. In terms of the state of development, Gilbert Rist observes that it could have been called 'civilisation' – a popular concept during the peak of the colonial period, 'modernisation', 'liberation', or even 'westernisation' given that its processes first emerged in the West.[47] Another scholar defines the state of development as: "the achievement of desirable economic and social progress,"[48] without entering into debate about what is 'desirable', or what represents 'progress', or

[46] Stephen Browne, *Foreign Aid in Practice*, (London: Pinter Reference, 1990), p.62.
[47] Gilbert Rist, *The History of Development. From Western Origins to Global Faith*, (London and New York: Zed Books, 2002), p.25.
[48] Guy Arnold, *Aid and the Third World. The North/South Divide*, (London: Robert Royce, 1985), p.28.

for whom. The World Bank picks up on this point, admitting that "different countries have different priorities in their development policies,"[49] suggesting that development means different things in different countries. The OECD's definition of ODA, current since 1972, focuses on the inputs to the development process. To qualify as ODA, financial and/or technical inputs are required to have as their primary objective the promotion of economic development and welfare of developing countries, and in the case of loans, to have a grant or concessional element of at least 25 percent (that is, a loan must be at least 25 percent below the market cost of borrowing the funds).[50]

Growth of the Development Sector

The early post-war period is commonly identified as the starting point of the international development sector, despite concepts of development and modernisation circulating since the Enlightenment of the 1700s, and the initiation of several development-related activities under colonial regimes.[51] Decolonisation, internationalisation and the beginnings of the Cold War helped shape the rise of development agencies, along with their assistance programs, and the deployment of technical advisors. Multilateral assistance organisations were formed to deal with relations in a changing world order, in what Amy Staples describes as an environment of optimism and

[49] Tatyana P. Soubbotina with Katherine A. Sheram, *Beyond Economic Growth. Meeting the Challenges of Global Development,* (Washington DC: World Bank, 2000), p.7.
[50] The DAC definition of ODA current since 1972, and accessed on 09 April 2013, is listed at http://www.oecd.org/dac/stats/officialdevelopmentassistancedefinitionandcoverage.htm.
[51] Stephen Browne, *Aid and Influence. Do Donors Help or Hinder?* (London: Earthscan, 2006), p.15; Carol Lancaster, *Foreign Aid. Diplomacy, Development, Domestic Policies*, (Chicago/London: University of Chicago Press, 2007), p.1; Viliam Phraxayavong, *History of Aid to Laos. Motivations and Impacts*, (Chiang Mai: Mekong Press, 2009), p.10.

internationalism and a belief that social and economic progress would reduce the risk of future world conflicts.[52]

In the 1950s the multilateral financial and technical agencies that addressed post-war reconstruction in Europe transformed themselves into agencies providing development assistance to newly independent nations categorised as Low and Middle Income Countries (LICs and MICs).[53] The International Monetary Fund (IMF) and the World Bank, established in 1944, provided financial policy and concessional loans to develop the infrastructure assumed to be required for economic growth. They were joined by regional institutions like the Asian Development Bank (ADB) in 1966, which loaned and granted funds for development purposes to member nations in a specific region. Technical agencies such as UNICEF, WHO, and the United Nations Population Fund (UNFPA) also joined the development effort, although their technical and coordinating roles spanned Highly Industrialised Countries as well as those in the developing world.[54]

The governments of the world's leading economies - the United States of America, the United Kingdom, France, Germany and Japan - were the major contributors to the multilateral financial and technical assistance agencies from the outset. These countries established their own bilateral development assistance agencies in the late 1950s and 1960s to plan and manage development programs, such as the United States Agency for

[52] Amy Staples, *The Birth of Development. How the World Bank, Food and Agriculture and World Health Organization Changed the World, 1945-1965*, (Kent, Ohio: Kent State University Press, 2007), p.34.
[53] In 2011 the World Bank defined MICs as countries with Gross National Income (GNI) per capita of USD 1,026 – 12,475; and LICs as countries with GNI per capita of USD 1,025 or less. The income cut-offs have fluctuated over the years based on the world economy. For details of the classification categories and its history, see: http://data.worldbank.org/about/country-classifications, accessed on 2 April 2013.
[54] Highly Industrialised Countries (HICs) have since been renamed High Income Countries, in recognition that some MICs have also industrialised.

International Development (USAID); the United Kingdom's Department for International Development (DfID); the Agence Française de Développement (AFD); and the Japanese International Cooperation Agency (JICA); and their respective forerunners. The OECD, a member organisation of the main high-income bilateral donors, monitored the development policies and aid volumes of its members through its DAC from 1961.

Given the Cold War environment, the development policies and activities of the socialist bloc were conducted separately to those of the OECD members. In the Soviet Union, the State Commission of Foreign Economic Relations (GKES) was responsible for assistance to low and middle-income developing nations, and the Soviet-directed Council for Mutual Economic Assistance (CMEA), also known as the Comecon, was formed in 1949 to coordinate development assistance from bloc members.[55]

The United States, France and Japan emerged as the twentieth century's largest international donors in terms of sheer volume of assistance provided to developing nations globally, whereas by the late 1990s the Scandinavian nations were contributing the highest percentage of their Gross National Product as ODA.[56] The contributions of the Soviet Union and other CMEA nations are harder to gauge and compare, as their aid was structured differently to that of the OECD nations. For example, a significant portion of Soviet assistance to Laos in the late 1970s and 1980s consisted of commodity shipments with "concessionary elements", although what that meant was not

[55] Browne, *Foreign Aid in Practice*, p.226.
[56] Peter Hjertholm and Howard White, 'Foreign aid in historical perspective. Background and trends', in *Foreign Aid and Development. Lessons Learnt and Directions for the Future*, ed. Finn Tarp, (London: Routledge, 2000), p.89.

clearly explained.[57] The difficult-to-estimate scale of Soviet and Eastern European development assistance has contributed to the downplaying or neglect of its significance by development scholars who tend to focus on OECD members.[58] This issue is of particular relevance in the case of Laos, because from 1960 it received international development assistance from both blocs.

Much of the academic research on development policies and programs concerns only the 'West' and ignores the development interests and influence of the Soviet Union and other CMEA nations, giving an unrealistic, one-sided view of the more complex reality, just as a focus on only socialist development policy would do. This is especially so, given that from the 1950s to the 1980s, development agencies from the 'West' and the socialist world effectively competed for influence, and implemented development programs side-by-side in many developing countries, including Laos.

It is important to note that development theories, priorities and methodologies have changed over the decades. The main aim of development programs in the 1950s and 1960s was to promote economic growth and industrial development for the developing world. Much of the scholarship dealing with 'Western-funded' development from that era focuses on economic policies and projects designed to stem the attraction of communism, the underlying assumption being that communism would not succeed in economically well-off societies. Soviet development policy appears to have placed a not dissimilar faith in the promotion of economic growth although in

[57] Viliam Phraxayavong, *History of Aid*, p.141.
[58] Colin W. Lawson, 'Soviet Economic Aid: Volume, Function and Importance', *Development Policy Review*, 5(1987), pp.257-276; and Quintin V. S. Bach, 'A Note on Soviet Statistics on Their Economic Aid', *Soviet Studies*, 37(2), April 1985, pp.269-275.

its case, it supported centrally planned economies and people's democracies modelled on the Soviet Union, which it hoped could provide it with needed commodities through barter-trade agreements.[59]

The 1970s experienced an expansion in lending from the multilateral agencies, especially the World Bank and IMF, and a focus on agriculture as well as industry and infrastructure. By the 1980s, however, several developing countries had accumulated large debts, leading to a trend in economic structural adjustment lending. The resultant austerity had severe economic and social impacts in many developing nations, perhaps contributing to the rise of NGOs which complemented and sometimes combated the state.[60]

Until the Eastern European overthrow of socialism in 1989 and the dissolution of the Soviet Union in 1991, the provision of international development assistance from both the OECD and CMEA nations was motivated as much by geopolitical agendas as by the development needs of recipient nations. The post-socialist period, however, ushered in a broader approach to development.[61] The United Nation's introduction of the concept of 'human development' in 1990 renewed focus on the importance of health within the broader development paradigm. Human development policies require investments in basic human capabilities: primary education, primary health care, food security, family planning and essential social and physical infrastructure.[62] Attention to poverty alleviation has risen in comparison to the

[59] Browne, *Aid and Influence*, p.25.
[60] Hjertholm and White, 'Foreign aid', p.81.
[61] It is recognised that while Europe has been post-socialist since the 1990s, one-party communist states maintain power in China, Vietnam, North Korea, Laos and Cuba. These remaining communist states have mostly discarded socialism in the economic sector, but socialist policy and practice is still evident in the political sector.
[62] State Planning Committee/National Statistics Centre and UNDP, *National Human Development Report 1998*, (Vientiane: State Planning Committee/National Statistics Centre, 1999), p.25.

pursuit of geopolitical allegiance, and the concept of human development has joined, although not displaced, the preoccupation with economic development.

While the development sector has realised that economic growth alone is not sufficient to trigger an improvement in livelihoods for the majority of people living in poverty, the 'policy diffusion/translation model' remains a preferred method to bring about change. In the early decades, it was assumed that LICs and MICs, regardless of their particular contexts, would be able to copy the economic development trajectory of the Highly Industrialised Countries, whether capitalist or socialist, after receiving a certain amount of development assistance. In this manner, it was assumed that "… the 'most developed' states could offer itself [sic] as a model for the 'less developed' states, urging the latter to engage in a form of mimicry".[63] Even as the development focus broadened from economic development to encompass human development, policy diffusion has proved to be a lasting popular model.

Critiques of Development

The process of development, and the international development sector that promotes it, has attracted criticism from many quarters. Despite its overarching humanitarian aims, the development sector has been accused of limiting the political sovereignty of developing nations, and trapping them in cycles of dependency and under-development. It has been critiqued as being self-interested, operating as an industry - a machine, even - and of being

[63] Immanuel Wallerstein, *World-Systems Analysis. An Introduction*. (Durham: Duke University Press, 2004), p.10.

driven by donor concerns rather than by recipients' needs.[64] In this section I sketch out some of the main political, economic, social, and historical criticisms of development, many of which are relevant to Laos, and some of the global responses to them.

International development work is frequently portrayed as apolitical and humanitarian in nature. However, many critics remark on the intensely political issues at stake for both donors and recipients. James Ferguson, in his anthropological study of a World Bank-funded project in Lesotho, observes that processes employed by the development sector depoliticise the highly political elements of a project and propagate state power, which is often complicit in a society's structural inequalities. He dubs development the "anti-politics machine," a term picked up by other scholars.[65] The repetition of failed development initiatives has been acceptable to elite groups in developing countries, he argues, because they benefit by consolidating their own power and personal financial gain. In such circumstances, there may be little incentive for governments to wean themselves and move beyond receiving international development assistance.

Bilateral development assistance organisations have been more overtly political than multilateral organisations. Bilateral donors have often directed their assistance to their former colonies; this is especially true of France and the United Kingdom.[66] During the Cold War, another frequent use of assistance was to sway developing nations that were undecided about whether

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[64] See Graham Hancock, *Lords of Poverty. The Free-wheeling lifestyles of power, prestige and corruption of the multi-billion dollar international aid business,* (London: Macmillan, 1989); and William Fisher, 'Doing Good. The Politics and Anti-Politics of NGO Practices,' *Annual Review of Anthropology*, 26, 1997, pp. 439-464.

[65] James Ferguson, *The Anti-politics Machine*: *"Development", Depoliticization and Bureaucratic Power in Lesotho*, (Minneapolis: University of Minnesota Press, 1994), p.284.

[66] Lancaster, *Foreign Aid*, p.143.

to follow a capitalist or socialist development path. The USA openly linked development assistance to its political objective of stemming what it considered to be communist expansion, while the Soviet Union professed to practice 'proletarian and socialist internationalism' by providing assistance to established socialist states in the developing world and to developing nations it considered to have a 'socialist orientation.'[67]

Even after the end of the Cold War, the provision and acceptance (or refusal) of development assistance continues to confer political influence. Critics argue that such assistance imposes overt and covert conditions which compromise national sovereignty. At the same time, it relies on and sometimes strengthens the national elites and state forces that create or maintain socio-economic and political inequality, limiting or obstructing poverty alleviation and social and economic development for disadvantaged groups.[68]

Criticism of economic development policy has been voluminous, in part because development has relied heavily on economics, and also because economics has often seemed to fail those it was designed to serve. The emergence of theories of dependency and under-development in 1950s and 1960s Latin America challenged the dominance of modernisation theory. While supporters of modernisation theory promoted the emulation of former colonial metropoles, dependency theorists argued that such a path was doomed to failure, due to the relations of unequal exchange existing between developed and developing nations.[69] The debt crises experienced by many developing countries in the 1970s and 1980s illustrated the point. Ferguson

[67] Thomas J. Zamostny, 'Moscow and the Third World: Recent Trends in Soviet Thinking, *Soviet Studies*, 36(2), April 1986, p.225.
[68] Lant Pritchett and Michael Woolcock, 'Solutions when the Solution is the Problem: Arraying the disarray in development,' *World Development*, 32(2), 2004, pp.191-212.
[69] Wallerstein, *World-Systems Analysis*, p.12.

argues that development is not an "anti-poverty machine," because it rarely reduces poverty.[70] Dependency theory had a significant moderating effect on approaches to development: the World Bank broadened its approach from purely promoting economic growth to include concern with equitable growth and distribution, and the United Nations unveiled the concept of human development, mentioned above, which involves economic and social aspects. The shift in development policy from a purely economic focus to a combination of social and economic factors coincided with the dismantling of the European socialist bloc, which meant both Western and former communist donors could focus on poverty reduction and social issues in the recipient countries rather than treating them as an arena for political and economic competition.

International development policy consequently promoted the health sector more strongly from the 1990s, although the predominance of economic thinking has meant that justifications for health policy and human development remain closely linked to economic measures in much of the development rhetoric. For example, the *World Development Report* for 1993 argues that health status not only indicates the degree of economic development of a society, it can actively contribute towards it.[71] More recently, the WHO's Commission for Macroeconomics and Health has argued that improved health of the poor contributes significantly to economic development and poverty reduction, through higher labour productivity, higher rates of domestic and foreign investment, improved human capital, higher

[70] Ferguson, *Anti-Politics Machine*, p.284.
[71] World Bank, *World Development Report 1993. Investing in Health*, (New York: World Bank and Oxford University Press, 1993), p.17.

rates of national savings, demographic changes (eg: lower fertility and mortality rates), and a reduction in the dependency ratio.[72]

The historical critique of international development is of a different nature to the political, economic and social critiques. In essence, it attacks the generalised, decontextualised and a-historical nature of the international development sector - in David Lewis's words, its grounding in a seemingly "perpetual present".[73] Through de-contextualisation and neglect, or misrepresentation, of history, it has been possible for international donors to repeatedly implement strategies, plans and projects … regardless of their appropriateness or success.[74] Rist bluntly questions why, when "promises are tirelessly repeated and experiments constantly reproduced … each failure leads to another reprieve?"[75]

Part of the answer lies in the fact that the international development sector is future-oriented. It has regularly minimized the achievements (and failures) of the past, basing itself firmly in the present and projecting its hopes onto the future. Moreover, international development staff often stay in a developing country for only a few years before moving on, and are therefore unwilling or ill-equipped to try a (new) approach.[76] They work either directly or indirectly with a pool of recipient government staff, often poorly paid, who

[72] OECD, *2002 Development Co-operation Report*, (Paris: OECD Publishing, 2003), p.166.
[73] See Lewis, 'International development', pp.32-46; Woolcock *et al*, 'How and Why Does History Matter', p.71; David Mosse, 'Introduction: The Anthropology of Expertise and Professionals in International Development', in *Adventures in Aidland*, ed. David Mosse and David Lewis, (New York: Berghahn Books, 2011), p. 7.
[74] William Easterly, *The White Man's Burden: Why the West's Efforts to Aid the Rest have done so much ill and so little good*, (London: Penguin Press, 2006).
[75] Rist, *History of Development*, p.23.
[76] Mosse, 'Introduction', pp. 1-32; and Dinah Rajak and Jock Stirrat, 'Parochial Cosmopolitanism and the Power of Nostalgia', in *Adventures in Aidland*, ed. Mosse and Lewis, pp. 161-176.

somewhat cynically can be willing to implement unsuccessful development approaches as many times as international donors are willing to fund them.

The language and vocabulary of development also contribute to the a-historicisation of the sector, repeatedly describing a landscape of lack, weakness, fragility and low capacity. Vatthana Pholsena, writing about her own fieldwork, refers to a "discourse of lack" employed by her counterparts from the Lao Front for National Construction, who spoke of "lack of means, projects and authority."[77] The recurrent discourse or rhetoric of lack, which is by no means limited to Laos, serves to perpetuate the a-historical approach and understanding of the development sector. Given the sector's simplistic trajectory of progress from poor to well-off, uneducated to educated, non-vaccinated to vaccinated and so on, it is easy for development practitioners to assume that the absence of funds, equipment or skills is a long-standing one that their inputs can rectify, or at a minimum improve. It is less common for development agencies or staff to delve deeper into the history of a nation or a development sector, to learn how resources have fluctuated or been reallocated over decades. As such, the development sector is prone to acknowledge little that existed or was achieved prior to a (new) development input, despite the sector's emphasis on change and progress. Lewis observes development practitioners "deliberately down-playing what went on before they arrived, as a way to demonstrate their own particular 'added value'".[78] This also happens at an agency level when a new project begins. By obscuring previous engagement in development issues, whether by government, international development agencies, the private sector or local communities, the 'rhetoric of

[77] Vatthana Pholsena, *Post-war Laos*, p.213.
[78] Lewis, 'International development', p.34.

lack' not only justifies the need for (new) engagement, it also wipes out any sense of a local history of development, thereby denying the opportunity to build on previous or existing structures, activities and achievements.

Ironically, the 'lessons learned' promoted by the development sector in the 1990s and 2000s, which might have encouraged historical awareness, seem instead to have been distributed laterally, across the geographical spaces of specific development sites or developing nations, rather than handed down through the decades within the same geographical space. As such, the lessons learned are unlikely to be utilised to construct historical context or an appreciation of development activity and approaches that have occurred in the same place. The result of regular appeal to the 'rhetoric of lack', and the a-historical approach to international development, is to deny past achievements and failures and to potentially obscure the main priorities for development assistance at national or sub-national level.

Health and development

Financial and technical support to the health sector was a standard feature of development assistance programs even prior to the 1950s. The health sector has attracted more attention, if not funding, since the 1990s. In some instances, health has been treated as an end in itself, while at other times it has been presented as a means to promote economic growth. For example, the WHO's Declaration of Alma Ata on Primary Health Care in 1978 linked the successful socio-economic development of developing nations to the provision of universal, accessible, affordable essential healthcare being

provided as close as possible to where people live or work.[79] In this manner, Cuba constructed a health network culminating in the mid-1980s Family Doctor Program which aimed to have a fully-trained doctor available on every urban block or in every rural village.[80] In a related approach, China launched its Barefoot Doctor Program in 1968, to place a trained health worker in each community.[81] These Primary Health Care (PHC) programs, and the Alma Ata declaration they inspired, were designed to ensure that the development of national health services was an essential element within national development plans, and did not risk being overlooked by governments or the international donors on which they relied for funding and support.

The research on health and development in the post-colonial period has been framed in terms of political economies of health, which explain the structural barriers to accessing modern healthcare services. The WHO, the OECD and the World Bank propose that health development is a litmus test for wider aid effectiveness.[82] Investing in the health of the poor has been a key strategy for organisations working for poverty reduction. As the *World Development Report 1993* explains:

> The adverse effects of ill health are greatest for poor people, mainly because they are ill more often, but partly because their income depends exclusively on physical labour and they have no savings to cushion the blow. They may therefore find it impossible to recover from an illness with their human and financial capital intact.[83]

[79] World Health Organization, Article III of *Declaration of Alma-Ata*, International Conference on Primary Health Care at Alma-Ata, USSR, 6-12 September 1978.
[80] Julie Feinsilver, *Healing the Masses. Cuban health politics at home and abroad*, (Berkeley: University of California Press, 1993), p.34.
[81] Xiaoping Fang, *Barefoot Doctors and Western Medicine in China*, (Rochester, NY: University of Rochester Press, 2012), pp.31-32.
[82] WHO *et al*, *Effective Aid, Better Health*, (Geneva: WHO Publishing, 2008), p.1.
[83] World Bank, *World Development Report 1993*, p.20.

Linking health status and poverty has gained gradual acceptance. From the 1950s, donors included public health activities and professional health and medical training in their international development cooperation programs. The WHO analysis has shown that the health sector globally received approximately five percent of all ODA in the 1980s and 1990s,[84] and that the percentages increased in the 2000s. A large share of health ODA is devoted to HIV/AIDS prevention and treatment at the expense of more "traditional" endemic diseases or basic health system strengthening. Health funding is often comprised of relatively small and fragmented donations, placing heavy management and coordination responsibilities on recipient governments, and a higher proportion of health sector funding compared to other development sectors is channeled through global and regional rather than national-level health projects. Such funding mechanisms reduce the control of developing nations over the aid process. In 2008, the WHO counseled that "high profile initiatives and programmes need to put more of their funding directly into countries' own health strategies and plans, and focus on making these funds as long-term and predictable as possible". The WHO reminded donors and recipients that "many health interventions require a long-term perspective".[85]

An OECD analysis of progress in the provision of development assistance to the health sector concludes that the effectiveness of such assistance risks being compromised by the complexity of aid architecture, and by the 'disconnect' between donor commitments and practices in terms of alignment with national health strategies, and harmonisation with other donors. While many donors agree with the wisdom of supporting country

[84] WHO *et al*, *Effective Aid*, p.7.
[85] Ibid., pp 1-2, 23.

strategies and national health plans, they insist on providing project aid rather than budget support. The analysis concludes that "there is strong evidence that project aid undermines aid effectiveness, distorts priorities and resource allocation, increases budgeting, reporting and audit demands, and weakens mutual and domestic accountability".[86]

In the nations of post-colonial Southeast Asia, healthcare has been frequently viewed by national governments and international development assistance agencies alike within the framework of national and economic development. The development of human resources for health has been a common strategy, although by 1970s there was more emphasis on meeting the basic needs of the poor.[87] However, the PHC approaches promoted in the 1970s and 1980s, exemplified by socialist nations such as China and Cuba, and attempted by Laos, did not differ markedly from the basic healthcare approaches implemented by other developing nations of Southeast Asia in the 1960s. Paul Cohen and John Purcal suggest this was no more than a case of old approaches repackaged with new rhetoric.[88]

Critiques of the health sector in developing countries

On the whole, research on health and medicine in the post-colonial period, and particularly the role of international involvement and cooperation in the health sectors of developing countries, has been less critical of the practice of biomedicine than studies which focus on the colonial period.[89] However, by the 1960s dependency theory was being applied to the health

[86] OECD, *Aid Effectiveness in the Health Sector: Progress and Lessons. Better Aid*, (Paris: OECD Publishing, 2012), p.13.
[87] Cohen and Purcal, 'Political economy', p.3.
[88] Ibid., p.9.
[89] Amrith, *Decolonizing International Health*, p.7.

sector, as underdevelopment of health in rural areas was increasingly acknowledged. Vicente Navarro has likened the poor state of the health sector in developing countries to the state of their economies.[90] In 1984, he foreshadowed Ferguson's criticism of the development sector more generally, criticising the WHO and Alma-Ata's approach to PHC for their failure to engage with inequitable power relations, locally, nationally and internationally. This failure included relations between multinational pharmaceutical companies and medical professionals and their patients; between members of communities; and between men and women.[91]

Linkages between Colonialism and International Development

Despite the emphasis on the international development sector's post-war origins, it is important to be mindful that there is considerable continuity with efforts and initiatives begun during the colonial period.[92] Donor nations are often former colonial powers and recipients their former colonies. As such, the colonial past has played a key role in shaping national and international development efforts if not specific ideologies in the post-colonial period, including those of the health sector. David Lewis and Uma Kothari recognise that the patterns of international development have their origins in the structure of empire and colonies, or metropole and periphery, despite what they lament as the seeming "inability of development theorists and practitioners to look back beyond the idea that development began after the

[90] See Vicente Navarro, 'The Nature of Imperialism and Its Implications in Health and Medicine,' and 'The Underdevelopment of Health or the Health of Underdevelopment: An Analysis of the Distribution of Human Health Resources in Latin America,' in *Imperialism, Health and Medicine*, ed. Vicente Navarro, (Farmingdale, New York: Baywood Publishing, 1979 [1974]), pp.5-9 and 15-36 respectively.
[91] Vicente Navarro quoted in Manderson, 'Political economy,' pp.82-83.
[92] Hjertholm and White, 'Foreign aid', p.82.

Second World War and engage with colonial histories".[93] Kothari argues that many of the practicalities and logistics of development assistance have a "colonial ancestry of ideas and practices,"[94] and that as such, decolonisation and the rise of international development have "led to a *reconfiguration* [emphasis in original] of people, ideas and spaces rather than a wholesale epochal transformation."[95] It could be argued that the multilateral and bilateral development organisations which dominate the sector today were part of the reconfiguration, as colonial power was restructured into the emerging multilateral organisations. For example, Michael Worboys, one of the first generation of history of medicine scholars, points out that tropical medicine formed the main scientific expression of Western medicine [his term] and health policy for the Third World over past 75 years.[96]

Despite the strong colonial linkages in the post-colonial world, few histories of medicine span both periods. Sunil Amrith's *Decolonizing International Health*, and the previously-mentioned *Cambodians and Their Doctors* are exceptions. Amrith provides an insightful exploration of the ways in which colonial health structures and biomedical practices survive in South and Southeast Asia. Although he focuses mainly on India, Singapore and Malaysia, his observations are of relevance to the former French Indochina.[97] Ovesen and Trankell make a similar point by emphasising the continuity of French influence in post-colonial Cambodia.

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[93] Uma Kothari quoted in Lewis, 'International Development', p.34.
[94] Uma Kothari, 'From Colonialism to Development: Reflections of Former Colonial Officers', *Commonwealth and Comparative Politics*, 44(1), March 2006, p.120.
[95] Uma Kothari, 'Spatial practices and imaginaries: Experiences of colonial officers and development professionals', *Singapore Journal of Tropical Geography*, 27, 2006, p.235.
[96] Michael Worboys quoted in Chakrabarti, *Medicine and Empire*, p.142.
[97] Amrith, *Decolonizing International Health*.

There is ongoing tension between the history of medicine's predilection for discourse analysis and narrative of colonial oppression, and health and development's preference for political economy and a focus on actual mortality and morbidity. The few studies that address both colonial and post-colonial histories of health and medicine perhaps exaggerate this difference of approach. Marks cautions historians of colonial medicine to avoid undue focus on medical discourse and texts, because at base the history of medicine should also be concerned with the history of actual morbidity and mortality.[98] This is useful advice, because it helps connect studies of the colonial period with more contemporary research on health and development.

The historiography of modern Laos

The historiography of Laos is modest in volume and range compared to that of other Southeast Asian nations, influenced by the country's marginality on both international and regional stages, its small population and economy, and the tight control exercised by the current one-party state over the production of history. Moreover, social, cultural and even economic themes such as health, medicine and development rarely find their way into the orbit of Lao history. As such, it is not surprising that few studies touch on, let alone focus on, the history of health or medicine in Laos.

In general, Lao and foreign language histories rarely stray from political and military themes, with the bulk of them centring on the thirty years of war and revolutionary struggle from 1945 to 1975. Official Lao-language histories, and even private autobiographies which pass the censor, often

[98] Marks, 'What is Colonial', p.215.

emphasise a familiar story of foreign aggression and heroic Lao resistance, while foreign-language histories are drawn into an exploration of how the intricacies of international foreign policy played out in Laos. The only rival to the narrative of war and revolution is that of national development, although it is more often found in the contemporary media than in the academic field of historical research.

Histories of modern Laos often begin with French annexation in 1893, highlighting that colonial rule, which spanned a period of sixty years until 1953, reunited the country.[99] Laos became the fifth colony of French Indochina, joining the Vietnamese territories of Cochinchina, Annam and Tonkin, and the Kingdom of Cambodia. Martin Stuart-Fox observes that throughout the colonial period, Laos was the least developed and most marginal of the Indochinese territories.[100] He argues that French efforts centred firmly on the Vietnamese territories, and that interest in Laos was based on its potential as an alternate road to China, a stepping stone to Siam and an extension of Vietnam rather than on any real potential found within the territory itself.[101] At the same time, Søren Ivarsson, suggests that French colonisation created a cultural barrier between Laos and Siam (now

[99] Historians do not agree on the exact date of Lao independence, whether it should be measured from the date of the post-World War II *modus vivendi* with France of 1946, the Franco-Lao General Convention of 1949, the Franco-Lao Treaty of Friendship and Association of 1953, or the 1954 French defeat at Dien Bien Phu which precipitated the end of French Indochina as a colony. Some present-day official Lao historians reject all of these dates, claiming that true Lao independence was only achieved on 2 December 1975 with the establishment of the Lao PDR and the abolition of the "neo-colonial" RLG. I prefer the view shared by Martin Stuart-Fox, Grant Evans and Viliam Phraxayavong that Laos achieved independence with the signature of the Franco-Lao Treaty of Friendship and Association on 22 October 1953. See Martin Stuart-Fox, *A History of Laos*, (Cambridge: Cambridge University Press, 1997), p.83; Grant Evans, *A Short History of Laos. The Land In Between*, (Chiang Mai: Silkworm Books, 2002), p.92; and Viliam Phraxayavong, *History of Aid*, p.53.
[100] Martin Stuart-Fox, 'The French in Laos, 1887-1945', *Modern Asian Studies*, 29(1), February 1995, p.111.
[101] Ibid., p.112.

Thailand).[102] Despite all efforts, Laos' small and ethnically diverse population (estimated to number between one and two million inhabitants during the colonial period), its tiny economy, and difficult communications, led to it being repeatedly described as a "colonial backwater".[103] Grant Evans notes that Laos was an economic burden for the entire sixty years of colonisation. He argues that its colonisation should be understood as motivated by French nationalism rather than economic exploitation.[104] Attempts to establish a modern bureaucracy, including health and education services, were severely constrained by the meagre supply of human resources. As Frenchmen posted to Laos were few, the colonial administration encouraged the migration of Vietnamese administrators, small traders and workers.

State-sanctioned communist and nationalist histories chronicle a politically-inspired narrative of colonial abuses and local communities' resistance, presented in the current day as evidence of the Lao people's innate revolutionary spirit of resistance and struggle. The state-produced *Pavatsat Lao* is the prime example of this genre of history, highlighting the exploitation of the colonial taxation system and railing against the lack of social services provided, despite such services not existing before colonisation and requiring taxes to fund their development.[105] In comparison, foreign language histories

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[102] Søren Ivarsson, *Creating Laos. The making a space between Indochina and Siam, 1860-1945*, (Copenhagen: NIAS Press, 2008), p.94.
[103] Alfred W. McCoy, 'French Colonialism in Laos, 1893-1945' in *Laos. War and Revolution*, ed. Nina S. Adams and Alfred W. McCoy, (New York: Harper Colophon Books, 1970), p.67; Stuart-Fox, 'French in Laos' p.121; Evans, *Short History*, p.39; Geoffrey Gunn, *Rebellion in Laos. Peasant and Politics in a Colonial Backwater*, (Bangkok: White Lotus, 2003); and Ivarsson, *Creating Laos*, p. 93.
[104] Evans, *Short History*, p.42.
[105] Ministry of Information and Culture, *Pavatsat Lao*. *Deukdambanh – pachouban*, (Lao History – from its origins to the present), (Vientiane: Ministry of Information and Culture, 2000), pp.535-546. Written by Souneth Photisane, with a PhD from the University of Queensland, and Nousay Phoummachan, the text was closely monitored by a party-government committee. See also Bruce Lockhart's review, which focuses on the pre-colonial

argue that French colonialism had no more than a light touch on Laos, and was generally ineffectual in terms of economic and/or social development.[106]

The period of post-colonial independence is one of the most politically confused periods of Lao history. The newly independent Laos entered the 1950s with minimal trained personnel capable of leading, administering and developing a modern, bureaucratic state. The country was heavily dependent on international development assistance, much of it initially provided by France. The RLG struggled with the imbalance between its political independence and its financial and technical dependence on donor nations, as well as a growing insurgency supported by communist forces from the neighboring DRV. Laos' economic dependence intensified during the First and Second Indochina wars, as the socialist-inspired Neo Lao Hak Xat (NLHX, more commonly known in English language publications as the Pathet Lao) struggled with the RLG for control of Laos. Again, significant levels of external influence were at play: the United States and its allies (including France, but also Thailand, South Vietnam and the Philippines) supporting the RLG; and the DRV, China and the Soviet Union supporting the NLHX resistance in the mountainous areas of rural Laos. The lengthy conflict heightened economic dependence on external sources, and opened the way for the international development sector to establish a strong presence in Laos.

The overwhelming focus of histories in this period is the Second Indochina War and its effects on Laos. While foreign studies focus on the domestic and foreign policy aspects of all sides of the conflict, Lao-produced histories rarely acknowledge or explore the structures, activities and/or

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sections of the book. Bruce Lockhart, 'Pavatsat Lao; Constructing a National History,' *Southeast Asia Research*, 14(3), 2006, pp.361-386.

[106] Stuart-Fox, *History of Laos*, p.44; and Evans, *Short History*, pp.49-50, 53.

achievements of the RLG regime, creating what Evans describes as "a huge silence" concerning the RLG and its period in office.[107] It is rendered invisible: irrelevant or simply absent from the official narrative of Lao history. The previously-mentioned government-sponsored history perfectly demonstrates this point in its treatment of the health sector. It provides some decontextualised information about healthcare services in the colonial period, before skipping almost the entire RLG period, and resuming its health-related narrative in the late 1970s.[108]

The post-1975 national narrative is one of peace, solidarity and national construction, in which the Lao People's Revolutionary Party (LPRP) and its 'correct' policies assume centre stage. International donors, and the financial and/or technical assistance they provide, have a key role in this history, but rarely feature in the nationalist narrative. There is some irony in this point, as the potted histories that international donors and development assistance agencies are prone to present often commence on 2 December 1975, the date of establishment of the current political regime.

Despite the vital role played by international development assistance in modern Laos, surprisingly little historical research has been conducted on the development sector itself, with the exception of Viliam Phraxayavong's *History of Aid to Laos*, and Timothy Castle's study of American military assistance to the RLG.[109] The sector has consistently portrayed Laos as

[107] Evans, *Short History*, p. 280.
[108] See Ministry of Information and Culture, *Pavatsat Lao*. Health and medical services in the French colonial period are addressed at pp.571-574, while health and medicine in the Lao PDR period are discussed at pp. 1112-1113. However, the section dealing with the period from 1954-1975 makes no comment of social or cultural matters such as health. It is consumed exclusively with political and military affairs, at pp.803-1,009.
[109] See Viliam Phraxayavong, *History of Aid*; and Timothy N. Castle, *At War in the Shadow of Vietnam. US military aid to the Royal Lao Government, 1955-1975*, (New York: Columbia University Press, 1993).

Southeast Asia's laggard in terms of socio-economic development, lacking both financial and human resources, and therefore in need of long-term assistance. The colonial administration observed that Laos would require significant assistance, and even Vietnamese immigration, to catch up with what it considered to be the 'vigour' and go-ahead nature of its Vietnamese territories. Lao statesman Outhong Souvannavong expressed concern that Laos was not ready for independence in the late 1940s because, in his view, it could not survive without French aid,[110] and United States cables confirmed in 1954 that "the development program … can be realized only through foreign financing".[111] The Head of the United States Operations Mission in 1959 stated bluntly: "Laos is the most remote and primitive and least organized of the free [non-communist] nations in Southeast Asia".[112] He went on to outline his government's view of Laos:

> The Royal Kingdom of Laos is not a country of factories, highways, power dams or large structures. It is a low-income nation with a largely self-sufficing agricultural economy and undeveloped in nearly all respects. Emphasis is on bare essentials, be it in terms of the food that is eaten, the implements used, the goods exchanged, or the shelters of most of the population. Practically the whole country is in its unchanged natural state. It is the least developed in the region, lacking proven material resources, physical and institutional development, and most classes of even semi-skilled workers and entrepreneurial leadership. The difficulties of the situation are further aggravated by recurring political instability. Despite all this, the Lao continues to live unaffected and unruffled – and undeveloped, quite removed from 20th century ways of life.[113]

[110] Jean Deuve, *Le royaume du Laos, 1949-1965. Histoire événementielle de l'indépendance à la guerre américaine*, (Paris: L'Harmattan, 1984), p.3.
[111] NARA, RG 59, Box 5005, 'Economic situation in Laos 1954', 15 November 1954.
[112] Daly Lavergne, 'American Cooperation with Laos. A Vital Link in the Chain of Mutual Security,' (Vientiane: USOM, 1 July 1959), p.3.
[113] Ibid., p.4.

Senior Lao government officials accepted the nation's need for external assistance, given the rudimentary level of its own financial and human resources and its aspirations to be a modern nation on a par with other nations in the region. Fifty years after independence, Somsavat Lengsavad, a senior Lao PDR minister responsible for economic affairs, acknowledged the government's continued heavy reliance on international assistance. He stated: "It is the Government's firm commitment to gradually lessen the Lao PDR's high dependency on official development assistance (ODA)," but added "This will happen progressively … over time".[114]

Expanding the boundaries for social and cultural history

In terms of Lao history, Grant Evans provides perhaps the most comprehensive overview of social and cultural issues, which he weaves into the general political narrative of his *Short History of Laos*.[115] Mayoury Ngaosyvathn's scholarship on gender history,[116] Vatthana Pholsena's work on upland minority people in the Second Indochina War and its aftermath,[117] and Simon Creak's recent study on the history of sport and attitudes concerning the human body also expand our knowledge of social and cultural history in the Lao context.[118]

The very few secondary sources which touch on the health sector have contributed to a sketchy, *ad hoc* understanding of its place in Lao society. The light colonial presence in Laos has supported an assumption that French

[114] Somsavat Lengsavad, Preface in the Government of Lao PDR, 'National Growth and Poverty Eradication Strategy', (Vientiane: Government of Lao PDR, January 2004).
[115] Evans, *Short History.*
[116] Mayoury Ngaosyvathn, *Lao Women, Yesterday and Today*, (Vientiane: State Printing Enterprise, 1995).
[117] Vatthana Pholsena, *Post-war Laos*.
[118] Simon Creak, *Embodied Nation. Sport, Masculinity and the Making of Modern Laos,* (Honolulu, University of Hawaii Press, 2015).

authorities neglected the development of the health sector, along with a host of other technical and administrative services.[119] Lao-language histories make more frequent references to the health sector than does English scholarship. *Pavatsat Lao* devotes approximately seven of its 1,310 pages to health matters, quoting statistics from the French colonial period, as well as from different years of the Lao PDR, but offers no comparison or explanation of the fluctuations in those statistics.[120] Nor does it make any mention of the years from 1940-1980 when international development assistance to the RLG made a significant impact to the development of health services in the most highly populated areas of the country. The official history of the Lao People's Army conveniently sums up the general attitude and amount of information provided about the topic: "The health sector did not receive much attention. Rural areas had no health facilities at all, epidemics spread throughout the entire society, and the incidence of disease among children was high".[121]

Among international historians, Stuart-Fox makes only short reference to health matters in *A History of Laos*. He quotes *ad hoc* health statistics, and repeatedly makes the point that qualified health staff were in short supply, whereas Evans makes no mention whatsoever of health or medical issues.[122] Several of the scholars who do mention health matters make claims not supported by examination of the colonial archives. Stuart-Fox contends, for example, that medicine in colonial Laos rarely expanded outside the major

[119] Lao People's Army, *Pavatsat Kongthap Paxaxon Lao, 1945-1995* (The History of the Lao People's Army, 1945-1995), (Vientiane: Army Printing House, 1998), p.9; McCoy, 'French Colonialism' p.82; and Hesketh Bell, *Foreign Colonial Administration in the Far East*, (London: Edward Arnold and Co., 1928), p.285.
[120] Ministry of Information and Culture, *Pavatsat Lao*, pp.571-574; 1093; 1112-1113; 1117; and 1131-1132.
[121] Lao People's Army, *Pavatsat Kongthap*, p.9.
[122] Stuart-Fox, *History of Laos*, pp. 44, 66, 69, 75, 77, 83, 100-101, 141, 154, 178, 193, 196.

towns, and was initially provided only to Europeans, a line repeated by other scholars until it has assumed the status of fact.[123] *Pavatsat Lao* claims that French medicine was intended mainly for French people and local elites, as do Phongsavath Boupha, Kristina Jönsson and an entry in the *Encyclopedia of Global Health.*[124] Souneth *et al* accuses the colonial authorities of indifference to health issues, claiming that only one hospital existed in 1900, and that it was located in Vientiane, a statement incorrect on both counts. He goes on to allege French refusal to expand the health network or increase the number of medical staff despite a request from Prince Bounkhong of Luang Prabang. As he recounts the incident, the prince:

> … requested there be hospitals in the provinces, for the people's health and to allow them to avoid illness, because every day there were more deaths than births. The French government of Indochina forgot that Laos is a small country. (128/146) [sic] After this request, the French imperialists did not build more hospitals or increase the number of medical staff at all. They thought that illness was a natural matter, so they left the Lao people to treat their own illnesses at home, in the villages, using spirit doctors (*moh phi*), traditional healers (*moh yao*) and mediums (*nang thiam*).[125]

The above-mentioned claims are consistent with the general tendency of histories of medicine produced in the 1980s and 1990s to argue that colonial health services operated for the benefit of the colonisers and to the detriment of colonised people. However, while scholarship has progressed to a more nuanced appreciation of the complex interrelationship between biomedicine,

[123] Ibid., p.44.
[124] Phongsavath Boupha, *The Evolution of the Lao State*, p.16, and the similar – but not identical - Lao language version, Phongsavath Boupha, *Kane kha-ngay toua khong lat lao* (The Evolution of the Lao State), (Vientiane: Nakhone Luang Printing Press, 1996), p.31; Kristina Jönsson *et al*, 'Health policy evolution in Lao People's Democratic Republic: Context, processes and agency', *Health Policy and Planning*, 2014, p.4; and Justin Corfield, 'Laos' in *Encyclopedia of Global Health*, ed. Yawei Zhang, (Thousand Oaks, CA: SAGE, 2008), pp.995-996.
[125] Ministry of Information and Culture, *Pavatsat Lao*, p.571.

colonial power and local populations, analysis of the Lao experience has remained relatively static and superficial.

Several recent studies that address health or other social issues suggest a lack of historical data. For example, a French study refers to the 'heritage' of the Lao health system,[126] and an article by Jönsson *et al* mentions the "layers of influence" on the health system, but neither the heritage nor the layers prior to 1975 are investigated, presumably due to limited access to sources.[127] Recent health-related PhD theses skip over the awkward matter of the sector's history, again presumably due to the lack of accessible sources.[128] This state of affairs has resulted in rumours, misunderstandings, and simplifications of what may or may not have taken place in the Lao health sector.

The challenge of doing historical research in Laos, in a suspicious official environment, is compounded by a general disinterest in research. As Jönsson and colleagues point out in a 2007 article on health systems research, even applied research occupies an awkward space in the Lao PDR:

> Research [in Laos] … does not have the positive connotations that it has in most high-income countries. Medical staff is accustomed to working by routine, and tends to be suspicious of research ... There is no real appreciation of research in Lao PDR, no tradition among medical staff to follow international professional journals, and limited incentives to publish internationally … Among some policymakers, according to our interviewees, research was seen as expensive and as a waste of scarce resources. Besides, policymakers claim to know the situation in their own country … They do not always see the usefulness of research findings, and sometimes deny or do not want to

[126] Strigler *et al*, 'Situation nutritionnelle', p.121.
[127] Jönsson *et al*, 'Health Policy Evolution', p.4.
[128] Kristin Lundberg, 'Women, Weaving, Wellbeing. The Social Reproduction of Health in Laos', PhD dissertation, University of Kansas, 2008; Audrey Bochaton, 'Pai Thaï, Pai fang nan. Construction d'un espace sanitaire transfrontaliere: le recours aux soins des Laotiens en Thaïlande', PhD dissertation, Université Paris Ouest Nanterre, 2009; and Denise Buchner, 'Stories without endings. A narrative of illness and disability in rural Laos', PhD dissertation, University of Calgary, 2011.

> acknowledge findings that may be inconvenient either for their ideology or their career.[129]

Lao historiography provides valuable context to a history of health and development, by locating it within the existing albeit modest body of work within the field. The marginality of Laos, the dominance of political and military themes over social and cultural themes, and the strong policing by the Lao authorities of what is acceptable and unacceptable history means that many subjects remain unexplored. According to Stuart-Fox, the close policing has the effect of "impoverishing" the comprehensiveness and richness of Lao scholarship.[130] However, while state-sanctioned revolutionary history presents a clear progression from exploitation, resistance and struggle to victory, the history of national development, and more specifically the health sector, is more problematic. To date, the Lao development sector oscillates between narratives of continual progress and perpetual under-achievement, which generate an ambiguity in the overall narrative.

Conclusion

A history of health and development, and the development of the Lao health sector in particular, brings together the academic fields of the history of medicine, the history of development policy and practice and the historiography of modern Laos. It raises issues of the use of biomedicine as a tool and/or product of empire, and the degree to which it was imposed or voluntarily adopted by the Lao population. It questions the role of biomedicine

[129] Kristina Jönsson *et al*, 'Health Systems Research in Lao PDR: Capacity development for getting research into policy and practice', *Health Research Policy and Systems*, 5 (11), 2007. Note: the pdf version has pages stating "page number not for citation purposes".
[130] Martin Stuart-Fox, 'Serendipity, or Discovering Lao History,' in *Historians and their Discipline. The Call of Southeast Asian History*, ed. Nicholas Tarling, (Selangor: The Malaysian Branch of the Royal Asiatic Society, 2007), p.130.

in post-colonial Laos, as the growing international development sector used the health status of the population as a measure of the nation's poverty, and traces how support of national health services became a core sector of international development programs in Laos since the 1950s. The following chapter examines the introduction of biomedicine to Laos by the French colonial administration, and its expansion nationwide, which provided a platform for development assistance in subsequent periods.

CHAPTER 3

THE TYRANNY OF DISTANCE:

THE COLONIAL *ASSISTANCE MÉDICALE AU LAOS*

(1893-1950)

The French interest in Laos was always in relation to somewhere else.[1]

Vientiane governs Laos with its eyes fixed on Hanoi,
and its back to the territory [Laos].[2]

Introduction

The health sector of present-day Laos rests on the foundations of the health service established by French colonial authorities more than one hundred years ago. Laos' geographical, administrative and cultural distance from the decision-making metropoles of Hanoi and Paris made it unlikely that its needs and realities would be fully appreciated and considered in the formulation of Indochinese health policy. As such, the Lao Health Service (*Assistance médicale au Laos*) or AML was shaped by policies and practices designed for and implemented in the Vietnamese territories and transferred to Laos (and Cambodia). Laos' insufficient budgets and the premature introduction of health policies caused considerable frustration for French doctors in Laos, and were exacerbated by the territory's status as the smallest, poorest and last territory to be annexed to French Indochina. Examination of health sector developments in the colonial period reveals that Laos' multi-

[1] Stuart-Fox, *History of Laos*, p.20.
[2] Charles Rochet, *Pays Lao. Le Laos dans la tormente 1939-1945*, (Paris: Jean Vigneau, 1946), p.65.

faceted marginality, and its dependence on external funding and staffing were defining characteristics.

This chapter explores health developments in Laos during the French colonial period from 1893 to 1950. The chapter closes three years prior to Lao independence in 1953, because in 1950 France transferred responsibility for the health service to the semi-autonomous Royal Lao Government (RLG).[3]

French authorities consolidated a modest healthcare service in the early decades of the twentieth century. They built a network of health facilities in urban and rural locations staffed with French doctors, provided training for Lao health staff, and delivered biomedical healthcare to the local (*indigène*) community, contrary to the claims of several contemporary historians that the locations were primarily urban, subaltern staff mainly Vietnamese, and patients French or members of the local elite.[4]

All Indochinese territories struggled with fluctuating and inadequate health budgets. Laos, however, was burdened by the additional challenges of having fewer trained health staff, and lengthier and more costly supply chains, limitations compounded by its marginal status within French Indochina. It was difficult to attract and retain sufficient European and Vietnamese medical officers to work in Laos throughout the colonial period, and only a limited number of Lao completed health and/or medical training. Moreover, local communities were unfamiliar with biomedicine and seemingly reluctant to use

[3] Responsibility for the health service was transferred to the Royal Lao Government (RLG) in April 1950, in accordance with the Franco-Lao Treaty of 19 July 1949. See ANOM, RSL, Series S, Box 12: 'Rapport annuel de 1950 de l'Assistance médicale au Laos', p.15. All RSL documents cited in this chapter are from this series and will henceforth be cited by box number only.

[4] Stuart-Fox, *History of Laos*, p.44; Phongsavath Boupha, *Kane Kha-ngay Toua Khong Lat Lao*, p.31; Jönsson *et al*., 'Health policy evolution', p.4; and Corfield, 'Laos' in *Encyclopedia of Global Health*, pp.995-996.

it. Therefore, while Lao staff were trained, and Lao patients accessed biomedical care, many health workers throughout the colonial period were of Vietnamese origin, as were a disproportionate number of patients.

Transferring biomedicine to Laos: a symbolic 'tool of empire'

The transferral and expansion of biomedicine to the colonies formed part of France's *mission civilisatrice*. There was a particularly strong link between biomedicine and colonialism in Laos because, unlike in other Indochinese territories, biomedical services were provided almost exclusively by colonial medical officers, many of whom were seconded from the military. In other territories, Christian missionaries and private physicians participated in the expansion of biomedicine, but these groups had only peripheral involvement in colonial Laos. Missionaries provided first-aid and nursing care in occasional villages, and a private sector of doctors and pharmacists emerged only after decolonisation.[5]

Biomedicine was transferred as a branch of technical knowledge and skills that could potentially help France, its officials and the communities it had colonised.[6] However, it would be incorrect to argue that biomedicine in Laos facilitated the kind of economic exploitation alleged to have occurred in colonial settings elsewhere. For a start, there was very little economy to exploit. Laos operated at a rudimentary level of economic productivity, and required annual financial subsidies to cover its basic administrative and

[5] This research uncovered no evidence of private biomedical practice in colonial Laos. The annual AML report for 1937 specifically states there were no "*médecins civils libres*", although there were a handful of private pharmacy shops in the main centres by the early 1930s. See RSL, Box 4: 'Rapport annuel 1937', p.4. Oudom Souvannavong advises in 1949 that there was still no sign of private medical practice in Laos. Oudom Souvannavong, 'Une étude du problème medico-social au Laos', Thesis, Doctorat en médecine, University of Paris, 1949, cited in Monnais-Rousselot, *Médecine et colonisation*, p.218.
[6] Ibid., pp.21-63.

technical expenses. The introduction and expansion of biomedicine did, however, demonstrate the reach and power of the colonial administration, and its ability to apply European science to health problems for those who came in contact with its expanding but far from universal network. Biomedicine was provided by doctor-officials who were unquestionably 'agents of empire', although their activities were dominated not by the care of colonial staff and troops, or the economic exploitation of the population as in other locations, but by the care for local (mainly Lao and Vietnamese) patients and the training of local health staff. As such, biomedicine in the Lao context could be seen as a symbolic 'tool of empire' with strong links to empire, despite its weak effect on the population of Laos.

Biomedicine appears not to have reached land-locked Laos until the late 1800s when French explorers, several of them military and naval doctors, made forays into Lao territory from Vietnam, Cambodia and Siam. (Christian missionaries were largely absent from Laos at the time of French annexation).[7] Elements of biomedicine may have filtered into Lao territory through occupying Siamese forces in the early to mid-1800s, as Siam hosted Western doctors at this time, but no evidence was uncovered in this research.[8] Medical doctors involved in France's exploration missions in the mid to late 1800s, such as Jules Harmand and Paul Neis, make no mention of local communities'

[7] Christian missionaries were the initial conveyers of biomedicine in neighbouring Southeast Asian countries, opening small dispensaries and orphanages. A Catholic vicarate of Nong Seng was established in 1899 at Outhène, on the Mekong opposite Pak Hinboun, and a small Protestant mission station opened at Songkhone, Savannakhet province, in central Laos in 1902. In addition, Catholic missionaries from neighbouring Annam were active in north-eastern Laos from the 1880s. See www.mepasie.org/rubriques/haut/pays-de-mission/la-thaïlande-et-le-laos/, p.11; Jean Decorvet and Georges Rochat, *L'Appel du Laos*, (Yverdon: Imprimerie Henri Cornaz, 1946); and personal email correspondence with Oliver Tappe, 5 December 2014.

[8] Medical researcher Dr Mayfong Mayxay raised this question in a seminar at the University of Health Sciences, Vientiane, on 26 June 2014. This is unlikely, but a possibility yet to be explored by historians of Thailand.

pre-existing familiarity with biomedicine.[9] It is therefore highly probable that biomedicine was introduced by the French administrators and military doctors who followed the explorers.

The French authorities progressively set in place a network of health infrastructure and biomedical healthcare services. At first, the military established basic medical posts and storage points at irregular intervals along the Mekong. These posts dispensed first-aid and basic biomedical services to the few French civil servants, the 'native' colonial troops (*garde indigène)* recruited mainly from Vietnam, and the occasional, experimental member of the local Lao community.

The initial sites of Laos' biomedical network were established prior to the formation of formal health services for Indochina or Laos. The first health facility was established in April 1895 in Luang Prabang in northern Laos,[10] followed in 1896 with a second at Khong in southern Laos. At the time, colonial Laos was divided into Upper Laos and Lower Laos, administered from these two fore-mentioned towns. Long distances and poor travel conditions separated the two health facilities, a point emphasised by a French tourist in 1897, who stated, "One should not become ill in Vientiane, nor in Savannakhet, because it is twenty-five to thirty days to the Luang Prabang hospital [upstream], and a minimum of fifteen days to the one in Khong

[9] See Jules Harmand, *Explorations coloniales au Laos*, (Paris: Soukha Editions, 2010 [1878-1879]); and Paul Neis, *Travels in Upper Laos and Siam, with an Account of the Chinese Haw Invasion and Puan Resistance*, (Bangkok: White Lotus, 1997 [1884]).
[10] RSL, Box 1, Governor-General's Decree No.662 of 30 April 1895.

[downstream]".[11] A third facility opened on the Mekong at Pak Hinboun in what is now Khammouane province in 1898.[12]

Not until 1903 was a health facility established in Vientiane. The town became the administrative capital of Laos in 1900, following the merging of Upper and Lower Laos into one administrative entity, but it took some time for the various branches of the colonial authorities to relocate there. In May 1903 the Resident Superior, the highest ranking colonial official in Laos, ordered the closure of the Pak Hinboun health facility and the relocation of its staff and services to Vientiane the following month.[13] The *Ambulance de Vientiane*, later named the *Hôpital principal de Vientiane*, was established on the present site of Mahosot hospital.[14] Another facility had opened in Xieng Khouang in north-eastern Laos in May 1903, bringing the initial colonial facilities to a total of four.[15]

This timeframe placed Laos decades behind the rest of Indochina, as military hospitals in Saigon and Phnom Penh and a civilian hospital in Choquan had operated since the early 1860s.[16] Similarly, American Protestant

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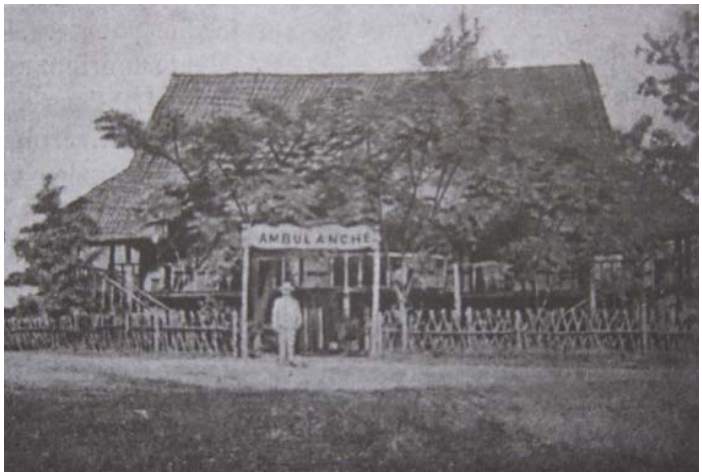
[11] Isabelle Massieu, *Le Laos*, (Paris: Magellan and Cie, 2005 [1900]), p.71.
[12] Documents dating from November 1896 refer to the Khong facility, and from February 1898 to the one at Pak Hinboun. See RSL, Box 2.
[13] *Journal Officiel de l'Indochine Française*, (Hanoi: Imprimerie F.-H. Schneider, 1903), pp.1011-1012. See also Sophie Clément-Charpentier, 'Les débuts de Vientiane, capital coloniale', in *Recherches nouvelles sur le Laos. New Research on Laos*, ed. Yves Goudineau and Michel Lorrillard, (Vientiane and Paris: École française d'Extrême-Orient, 2008), p.312. Lucien de Reinach's 1901 report created some confusion when he stated that Laos' three *ambulances* included Vientiane and not Pak Hinboun, as this information is not supported by the primary sources at ANOM but has been repeated by some scholars. See Lucien de Reinach, *Le Laos*, (Paris: A. Charles Librairie-Editeur, 1901), cited in Marion Fromentin Libouthet, *L'Image du Laos au temps de la colonisation française (1861-1914)*, (Paris: L'Harmattan, 2012), p.182; and Ministry of Information and Culture, *Pavatsat Lao*, p.571.
[14] 'Mahosot' translates loosely as 'large pharmacy'. Mathurin and Fontan claim the name 'Mahosot' was applied to the Vientiane hospital from 1948, but AML monthly and annual reports continue to refer to the 'Hôpital de Vientiane' until 1950. See L. Mathurin and R. Fontan, 'La médecine au Laos', *Médecine tropicale*, vol 33(6), November-December 1973, p.645; and RSL, Box 12: 'Rapport annuel de 1950 de l'Assistance médicale au Laos', pp.5, 76.
[15] RSL, Box 2: Governor-General's Decree dated 8 April 1903.
[16] Monnais, 'In the Shadow', pp.145-146.

missionaries in the neighbouring kingdom of Siam had begun medical activities in the northern centre of Chiang Mai in 1872,[17] and a biomedical hospital, Sirirat, had opened in Bangkok in 1888.[18]

Figure 3.1 Pak Hinboun *ambulance*, 1900[19]



The early health facilities of Laos were variously referred to as medical posts, hospitals and *ambulances*. The term '*ambulance*' derives from the mobile field hospitals used by the military in their conquest of Indochina. Over time these facilities became stationary, serving civilian as well as military patients, but the term continued in official usage, becoming the preferred term for the main health facilities from the early 1900s.[20] The larger sites possessed consultation rooms, pharmacies, male and female wards, and basic surgical capability, as well as kitchens, laundries, bathrooms, and staff accommodation.

[17] Daniel McGilvary, *A Half Century Among the Siamese and the Lao. An Autobiography*, (Bangkok: White Lotus, 2002 [1912]), p.96.
[18] Chatichai Muksong and Komatra Chuengsatiansup, 'Medicine and Public Health in Thai Historiography: From an Elitist View to Counter-Hegemonic Discourse, in *Global Movements, Local Concerns. Medicine and Health in Southeast Asia*, edited by Laurence Monnais and Harold J. Cook, (Singapore: NUS Press, 2012), p.232.
[19] Alfred Raquez, *Around Laos in 1900. A Photographer's Adventures. Volume 2: The 288 Photographs*, (Bangkok: White Lotus, 2013), p.9.
[20] Monnais, 'In the Shadow', p.147.

Such facilities were typically staffed by a European (French) doctor, and assisted by a small team of Vietnamese male nurses, most of whom learned their nursing skills in the *garde indigène*. Lao health staff were trained as the colonial period progressed.

Grand plans: Health policy and financing

In the early twentieth century, the colonial authorities of French Indochina laid plans to create a quality biomedical health service that could expand services to the *indigène* community in urban and rural areas in each territory of the Union. Healthcare was to be standardised and institutionalised, and delivered by qualified doctors and trained paramedical staff. Little attempt was made to regulate the practice of indigenous or traditional medicine which co-existed alongside biomedicine. A concerted effort was made to increase the number of health facilities in rural areas in the 1920s and 1930s, and the Social Assistance program of the 1930s encouraged women to seek maternal health care and to deliver in maternity clinics. Healthcare to the local community was intended to be free for the poor, following the policy model of the Free Medical Service (*Assistance médicale gratuite*, or AMG) introduced in France in 1893, but with space for some local flexibility.[21]

Administrative and financial infrastructure was created to implement colonial health policy. The *Inspection-Général de la Santé* for French Indochina was established in 1897. Health budgets were drawn in part from the Indochina-wide general budget, and in part from the local budget of each territory. Under this system of financial redistribution, colonial programs in

[21] Monnais-Rousselot, *Médecine et colonisation*, p.30.

Laos and Annam were effectively subsidised by Cochinchina, Tonkin and Cambodia.[22] Monnais notes that the general budget rarely allocated more than one percent of its funds to the health sector, and that while 10-15 percent of local budgets tended to be allocated for health, those budgets were considerably smaller. She also notes that despite the generally limited size of health funds, there was an incremental increase in budget allocations throughout Indochina in the first three decades of the twentieth century.[23]

Colonial authorities created health administrations in each Indochinese territory in the early 1900s and opened a School of Medicine in Hanoi in 1902 to train local auxiliary doctors (*médecins auxiliaires*), pharmacists, midwives and nurses.[24] A practical school of medicine opened in Saigon in 1904, presumably for those students reluctant to travel north for professional training. Nursing and midwifery schools later opened in the major Indochinese centres, including Vientiane, to support the work of higher-level medical staff.

A British colonial official visiting French Indochina in 1928 noted the "ambitious scale" on which the French made plans for their territories.[25] The development plans for the establishment of a Lao health service and the training of Lao staff proved to be extremely ambitious, given the absence of even rudimentary existing services and the modest funding and human resources available. When French staff and funding decreased in the mid-1930s, a process which seems likely to have continued throughout the years of World War II, the colonial health service and many of its facilities slid into neglect and disrepair.

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[22] Libouthet, *L'Image du Laos*, p.172.
[23] Monnais-Rousselot. *Médecine et colonisation*, pp.82, 460.
[24] Ibid., p.277.
[25] Bell, *Foreign Colonial Administration*, p.191.

The *Assistance médicale au Laos* (AML)

The Lao Health Service, or *Assistance médicale au Laos* (AML), was the smallest and most remote of Indochina's colonial health services. Though established on paper in May 1904, its actual organisation into a centralised technical service seems to have followed the establishment of the Indochina-wide Native Medical Service (*Assistance médicale indigène*) or AMI in 1905.[26] The AMI demonstrated the explicit colonial intention to provide healthcare services to non-Europeans. It had three main objectives: medical treatment, disease prevention, and medical training.[27] Its creation also signalled a transfer in overall responsibility for healthcare from the military to the civilian administration, although considerable military influence remained in its management and oversight.[28] The service recruited its own corps of European and *indigène* health staff to provide basic, affordable healthcare, free to the poorest. It provided medical consultations, hospitalisation, surgery, pharmacy and laboratory diagnosis, as well as maternal and child healthcare, vaccinations, and quinine supply for the non-European population throughout Indochina.[29]

In the larger and more established territories, the creation of the AMI marked a split from the existing military health service and the General Service for colonial civilian staff.[30] In Laos, these distinctions were absent, as there were no exclusively military or European health services. The modest existing health facilities treated military and civilian officials and local people

[26] RSL, Box 2, Dr Rouffiandis to Resident-Superior, 25 April 1905.
[27] Ovesen and Trankell, *Cambodians and Their Doctors*, p.28.
[28] Ibid., and Monnais-Rousselot, *Médecine et colonisation*, p.68.
[29] On the mandate of the Indochina-wide AMI, see Monnais-Rousselot, *Médecine et colonisation*, p.69; Au, *Mixed Medicines*, discusses its work in Cambodia.
[30] Monnais, 'In the Shadow', p.151.

under the same roof, if not in the same room. Following the establishment of the AMI, all medical staff in Laos were AMI staff, regardless of whether they were civilian or seconded military officers, and all patients attended the same health facilities and consulted the same doctors.

The AML was one of the first technical services established in Laos and therefore medical officers were some of the earliest colonial officials posted there. Vincent Rouffiandis, the head doctor (*médecin-chef*) of the Vientiane *ambulance*, was appointed the inaugural head of the AML, titled *Chef de service local* rather than *Directeur locale de la Santé* as in the other territories. In addition to curative medical services, which formed the bulk of its work, the AML was responsible for preventative health services, para-professional education and training, and the management of scientific institutions. A territory-wide Local Hygiene Committee, attached to the AML, managed preventative or public health services from 1905 and provincial committees from 1907.[31] Vaccine stations operated in Xieng Khouang from 1905, and Luang Prabang and Houayxay from the 1920s, and a Vaccine Institute in Vientiane supervised the provincial stations from 1922.[32] The stations produced vaccines for use locally, because the distances and travel times from Saigon and Hanoi made their shipment to Laos impractical. Other institutions were also established. A nursing school opened at the *Ambulance de Vientiane* from 1915. A central pharmacy was created in 1923, and a small bacteriology laboratory and a midwifery school opened in Vientiane the following year. AML reports also regularly list the existence of two "leprosaria", located outside the towns of Pakse and Luang Prabang, although

[31] RSL, Box 3: 'Rapport médical annuel (Année 1908)', p.2.
[32] RSL, Box 3: 'Rapport annuel de 1923 de l'AML', p.1; and 'Rapport annuel de 1926 sur l'Assistance médicale au Laos', p.21.

it is unlikely that they were anything more than agricultural villages in which leprosy sufferers had been instructed to reside.[33]

The full complement of health services was not established in Laos, possibly due to its small population, its remote location and its limited administrative budget. Laos did not require a Maritime Sanitary Police for the health and quarantine inspection of visiting ships due to its landlocked location. However, it did not receive a separate rural health service as in the Vietnamese territories, presumably because the AML already had a relatively rural focus. There were no maternity clinics outside of the main hospitals, no ophthalmology institute, no asylum for the mentally ill, no sanatorium for tuberculosis patients, and no dental services, although such services existed in other Indochinese territories. Patients were required to travel to those territories, or to Siam, to access these services. Nor was there a private medical sector in Laos, presumably due to the limited number of potential paying customers.

Traditional healers (Buddhist monks, spirit doctors and shamans) continued to provide health-related services, but they remained in the informal sphere, unregulated and unlicensed by the colonial authorities. Colonial records provide little if any evidence of formal cooperation between imported

[33] AML reports indicate no leprosy institutions apart from the two 'leprosy villages', which first appear in the1908 AML report. Their combined population was reported as around 200 over many years, but had declined to 62 in 1950. Leprosy-sufferers may have been gathered into villages in other regions of Laos, but AML reports mention them only rarely and never in detail. There is no mention of leprosy villages established or supported by Christian missionaries. For a rare account of the leprosy village near Pakse in the 1920s, see Decorvet and Rochat, *L'Appel du Laos*, p.104.

biomedicine and local traditional medicine, or even Sino-Vietnamese medical services which existed in the major towns.[34]

The AML initially organised its activities into four medical *circonscriptions*, or districts: Luang Prabang, Khong, Vientiane and Xieng Khouang. [35] A fifth *circonscription*, Savannakhet, was added when a dispensary opened there in 1913.[36] The head of each *ambulance* was tasked with supervising outlying dispensaries and medicine depots within the *circonscription,* and conducting both curative and preventative healthcare, including vaccination rounds in the surrounding rural areas, with or without the support of a designated mobile doctor-vaccinator. The *circonscriptions* stretched over several provinces, making effective coverage of the population extremely unrealistic. Dr Vivie, the AML Head in 1909, attempted to explain the challenges to his superiors in Hanoi:

> … Laos covers an area of 267,000 square kilometers, which is half the size of France. The medical *circonscription* [district] of Vien-Tiane alone covers an area almost the size of Tonkin, and larger than that of Cochinchina. The borders cover a wide expanse: they touch on southern China, Burma, Siam, Cambodia, Annam and Tonkin; and all the conditions for the incubation and spread of epidemic diseases are present, on one or the other side of the border. Moreover, the Lao races live in complete ignorance of even the most basic rules of hygiene and treatment; they are decimated by disease, epidemics, infant mortality, opium. Most of the country has never seen a European [French] doctor. Not even 1/10 of the population has benefited from our methods [of biomedicine]. Epidemics begin, spread and subside without anything that can be done to combat them, except, after receiving fairly specific information by telegraph [from the afflicted areas], to send instructions which arrive after everything is over. The [medical coverage] for European officials is also compromised. The posts in the main provincial towns of Ban-Houei-Sai, Saravan, Attopeu, and Sam Neua

[34] For a description of traditional medicine in use in Laos at the turn of the twentieth century, see Charles Spire, *Les Laotiens: coutumes, hygiène, pratiques médicales*, (Paris: Challamel, 1907).
[35] The medical *circonscriptions* in Laos should not be confused with the administrative *circonscriptions*, a term that was used interchangeably with 'province'.
[36] RSL, Box 3: 'Rapport annuel médical d'ensemble de l'année 1913', p.1.

> have seen a doctor only once in 14 years, the towns of Muong Sing and Muong Ou never have. The influence of the Lao Medical Service [AML], centred around 4 small circles on the map, extends along a few kilometers' radius from each ambulance and along a few rare and short straight lines which represent the route covered by a doctor-vaccinator.[37]

Given the overwhelming challenge posed by geographical distances, it is not surprising that colonial authorities chose to expand the health network as financial and human resources gradually became available. They established small dispensaries and medical posts in the small rural towns of Laos, rather than attempting to serve the countryside from a few urban bases only.

Development of the Colonial Health Network

Health facilities in Laos rose from the initial four *ambulances* at the time of the AML's establishment in 1904 to 76 facilities of varying levels at handover of the health service to the RLG in 1950.[38] The number of facilities increased rapidly in the 1920s as public works budgets became available for the upgrading of hospitals and the construction of new infirmaries and rural dispensaries. These were augmented by dispensaries constructed by village communities themselves. The number of facilities peaked at 65 in 1933,[39] before declining presumably due to shortages in funding and staffing brought on by the Depression and the outbreak of World War II in Europe. Facilities increased again in the late 1940s, approaching the levels recorded in the early 1930s.

The developing colonial health service created a hierarchy of facilities, organised into three main categories. They were, in descending order of level

[37] RSL, Box 3: 'Rapport médical pour le Laos (Année 1908)', pp.10-11.
[38] RSL, Box 12: 'Rapport annuel de1950', p.7.
[39] RSL, Box 4: 'AML Rapport annuel 1933', p.8-bis.

of care provided: hospitals, *ambulances*/infirmaries (essentially small hospitals), and dispensaries/medical posts. Below this hierarchy were medicine depots, stock-piles of basic medications often attached to army encampments and rarely staffed with medically-trained personnel. *Ambulances* established in the six main towns of Luang Prabang, Vientiane, Xieng Khouang, Pakse, Savannakhet and Thakhek were re-classified as hospitals in 1923. They were staffed with one or more fully qualified French doctors, one or more local assistant doctors (*médecins auxiliaires*), a small team of locally trained nurses, and in rare instances an assistant pharmacist and/or a registered midwife. The remaining *ambulances*, later renamed *infirmeries*, were essentially secondary hospitals providing mid-level care in the smaller towns. They were staffed sometimes by a doctor, but more commonly by an auxiliary doctor and some nurses. At the lowest level, dispensaries or medical posts operated in large villages, providing the most basic level of care and receiving technical supervision and supplies from the nearest *ambulance*. Such facilities were often managed by a male nurse with no more than six months' training in a nearby hospital.

No expansion of the AML took place in its first decade of existence. There was rapid expansion into rural areas in the following decade, though, as *ambulances* and/or dispensaries were added throughout Laos: Attapeu and Xepone in 1917, and Xam Neua, Phongsaly, Meuang Sing and Houayxay in 1919.[40] By 1926, the basic infrastructure of the health network was in place. The six hospitals mentioned previously formed the network's core. Eight *ambulances-infirmeries* located in the smaller provincial and district towns

[40] RSL, Box 3: 'Rapport annuel de l'Assistance au Laos (1917)', p.1; and 'Assistance Médicale, rapport annuel 1919', pp.3-4.

mentioned above, with the addition of Paklay, provided secondary healthcare. In addition, 38 dispensaries had been constructed in rural villages. They functioned as medicine distributors and referral points for the higher-level medical facilities.[41]

Figure 3.2: Colonial health facilities in Laos, 1895-1950[42]

Year	Hospitals	*Ambulances*/infirmaries (small hospitals)	Medical posts/dispensaries (heath centres/*souksala*)
1895	-	1	-
1900	-	3	-
1905	-	4	-
1910	-	4	-
1915	-	4	1
1920	-	5	10
1925	6	4	30
1930	6	8	n/a
1935	6	8	36
1940	6	8	39
1947	6	6	31
1950	6	6	65

While the number of hospitals and *ambulances* remained steady through 1950, the number of dispensaries fluctuated. They peaked at 51 in the early 1930s, but had dropped significantly to 36 in 1935, signalling the rapid expansion of facilities had outpaced the supply of health staff and operating budgets and was therefore not sustainable. Only 31 dispensaries were operating in 1947 according to the AML's annual report.[43] The number jumped to 65 in 1950, suggesting a last-minute scramble on the part of French

[41] RSL, Box 3: 'Rapport annuel de 1926 sur l'Assistance médicale au Laos', p.21.
[42]The statistics in Figure 3.2 have been compiled from AML reports from 1895-1950, held in RSL, Boxes 1-12. The statistics have been supplemented with additional AML annual reports for 1939 and 1947, missing from the ANOM holdings but reproduced in Oudom Souvannavong, 'Une étude du problème'.
[43] Oudom Souvannavong, 'Une étude du problème', Table 1, unpaginated.

medical officers to re-expand the health network before handover to the RLG.[44]

The early medical facilities were of the most basic construction. The original *ambulance* in Luang Prabang was built of bamboo and thatch, and described by Dr Lefèvre as a "large shed … steaming in summer, freezing in winter."[45] Budgets for the construction of brick and tile structures became available by 1908, but proved to be inadequate, causing construction to proceed slowly. Permanent buildings and facilities were added, upgraded or repaired over the next decade as funds allowed at each *ambulance*. A construction boom took place in the 1920s, as more sizable budgets became available. Several permanent structures were erected in the main centres of Vientiane, Pakse, Savannakhet and Thakhek in 1923-1924. A timber prototype for rural dispensaries was developed in 1926, and funds allocated to the Public Works service for their construction at locations throughout Laos.[46] A certain degree of public interest seems to have been generated by the construction program, because from the mid-1920s village communities began constructing their own dispensaries, in addition to those constructed by the Public Works service. By 1928, 26 rural dispensaries had been built by the authorities, and another 29 by local communities.[47] Sokhieng Au suggests that such behaviour in Cambodia was prompted by the popularity of pharmaceuticals and the hope of obtaining them at rural dispensaries, even if the presence of foreign (French and increasingly Vietnamese) medical staff was less popular.[48] However, the

[44] RSL, Box 12: 'Rapport annuel de 1950', pp.19-21.
[45] RSL, Box 1: Monthly report of Dr Lefèvre at Luang Prabang *ambulance*, 5 November 1897, unpaginated.
[46] RSL, Box 3: 'Rapport annuel de 1926 sur l'Assistance médicale au Laos', p.19-bis.
[47] RSL, Box 4: 'Rapport annuel de 1929 sur l'Assistance médicale du Laos', p.32.
[48] Au, *Mixed Medicines*, p.80.

increase in rural dispensaries overstretched the AML's capacity to staff and equip them, a problem flagged in the AML's 1926 and 1929 annual reports.[49] The network ceased expansion in the mid-1930s and contracted in the 1940s as funds dried up.

Colonial Staffing and Professional Training

Staffing proved to be a major challenge for the AML throughout the colonial period, both in terms of training sufficient numbers of Lao staff, and attracting sufficient numbers of French and Vietnamese staff to manage the health service and fill the professional gaps. Problems with the supply of foreign staff were compounded by the high rate of turnover with few willing to spend more than a few years in the remote outpost of Laos. Positions within the AML, in accordance with the wider AMI, were designated by race, profession and level. Racial classifications were simply 'European' and '*indigène*' (native), where European usually referred to someone of French birth, whereas *indigène* encompassed Lao, Vietnamese, Cambodian and even Chinese staff. The professions ranged from doctor and auxiliary doctor, later revised to Indochinese doctor (*médecin indochinois*) and the higher-ranking *docteur indochinois*, pharmacist and auxiliary pharmacist, midwife and auxiliary midwife, and nurse. Levels (*classes*) designated seniority within each profession. New graduates entered at the intern or probationer (*stagiaire*) level, and proceeded through five levels. When nurses reached level one, they could

[49] RSL, Box 4: 'Rapport annuel de 1929', p.11.

be promoted to senior nurse (*infirmier major*).[50] Promotions in Laos occurred approximately every two years.

Nearly all French staff serving in the AML were male doctors, many of whom were seconded from the military. The colonial records reveal, however, that the racial categories of European and native were sometimes blurred. The presence of a European civilian doctor in Xieng Khouang in 1914 named Le Quang Trinh demonstrates that naturalised French citizens (in this case a presumably Vietnamese-born doctor) could hold a European-designated position, regardless of ethnicity.[51] Similarly, two men with European names but who may well have been of mixed race, Emile Schutz and Maurice Philippe, moved between the AML's racial categories. Both began as native *médecins auxiliaires* but transferred to the European staff-roll as head nurses by the early 1930s in Vientiane and Luang Prabang respectively.[52] Their move is likely to have been motivated by the higher salaries and associated social benefits for European nurses than native auxiliary doctors. Schutz subsequently re-transferred into the ranks of native doctors, and in 1950 was listed as a *médecin indochinois* in Salavan province.[53]

European (French) staffing

Laos was not a popular posting for ambitious French doctors, and colonial authorities had difficulty attracting them. Doctors considered

[50] RSL, Box 3: 'Rapport annuel de l'Assistance au Laos, 1916', p.5.
[51] RSL, Box 3: 'Rapport médical ensemble de 1914 du Chef du Service de l'Assistance médicale au Laos', p.5.
[52] Schutz transferred to the European staff-roll in 1928, Philippe in 1931. See RSL, Box 4: 'Rapport annuel de 1928', p.3; and 'Rapport annuel de 1931', p.7.
[53] RSL, Box 12: 'Rapport annuel de 1950', p.17.

Cambodia and Laos as "frontier societies" and preferred to work in Vietnam.[54] French doctors working in Laos numbered only four from 1916-1918, reached 13 in 1929, and peaked at 14 in 1950,[55] but averaged only eight during the years from 1913 to 1933. (Paradoxically, more French medical staff worked in Laos under the RLG administration than during the colonial period.) A bonus was discussed in 1929 as a possible lure to resolve the staffing "crisis".[56]

Certainly, a posting to Laos offered few urban comforts, nor any of the after-hours, private consultation opportunities available in Indochina's larger, wealthier urban centres, which helps explain why so many of the doctors in Laos were seconded from the military. In 1910, for example, six of the seven French doctors posted to Laos were in this category. In 1930 four of eight French doctors were military, and by 1950 all 14 were.[57] The high proportion of military doctors had a marked impact on the operations of the AML during both World Wars, as it appears many were recalled to Europe, leaving Laos with only a skeleton staff.

Numerous AML heads railed at the insufficient staffing allocations and requested increases in the number of doctor-positions, due to the time-consuming nature of travel throughout Laos' large medical *circonscriptions* and the expansion of the health network. The service totalled a modest 14 positions in 1906. Five were French doctors: a *médecin-chef* at each of the four *ambulances*, and a mobile doctor-vaccinator based in Vientiane, and the remaining nine were 'native' male nurses: two at each *ambulance*, and one to

[54] Au, *Mixed Medicines*, p.68; and RSL, Box 4: 'Rapport annuel de 1929', p.7.
[55] RSL, Box 12: 'Rapport annuel de 1950', p.14.
[56] RSL, Box 4: 'Rapport annuel de 1929', p.128.
[57] RSL, Box 3: Assistance Médicale au Laos: Rapport médical d'ensemble pour l'année 1910, unpaginated; Box 4: 'Rapport annuel de 1930', p.6; and Box 12: 'Rapport annuel de 1950', p.4.

accompany the doctor-vaccinator.[58] Limited staffing required the *médecin-chef* of the Vientiane *ambulance* to double as the Head of the AML until the 1920s. The AML head in 1913 protested that the complement of doctors was "completely insufficient", and that 16 were required to adequately serve the size of the Lao territory rather than the current ten.[59] His proposal appears to have fallen on deaf ears as colonial Laos never reached that level of European staffing.

Another problem was the high rate of vacancies within the official allocations. Positions were difficult to fill, and European staff had a propensity to remain on extended overseas leave. From the mid-1910s to the early 1920s, there were often only four, sometimes five, doctors working in Laos despite an allocation of 10 positions. Some managers despondently gave up requesting additional staff positions, and asked instead that the authorities merely furnish the number of doctors funded in the budget.[60] By the 1930s, health managers appeared resigned to chronic understaffing.[61]

The AML also struggled with high staff turnover. Rarely did French doctors stay for more than a few years, and those who proved unable to adapt departed even faster. To minimise the risk of premature departure, Dr Henric recommended in 1912 that mobile doctor-vaccinators should ideally be "young, active, strong, familiar with horse-riding and physical exercise".[62] In 1929, Dr Le Nestour made the following recommendations:

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[58]The position of *médecin-chef* was a combined technical/administrative role. Originally, each *ambulance* was headed by a *médecin-chef.* Later, during the RLG period, a *médecin-chef* was appointed as Head of the Health service in each province.

[59] RSL, Box 3: 'Rapport annuel [1913] médical d'ensemble du Chef du Service de l'Assistance médicale au Laos', pp.4, 26.

[60] RSL, Box 3: 'AML Rapport médical ensemble pour l'année 1910', unpaginated.

[61] RSL, Box 4: 'AML Rapport annuel de 1932', p.3-bis.

[62] RSL, Box 3: 'Assistance médicale' - apparently an AML draft report for July 1911-June 1912, unpaginated.

> In the general interests of the [Lao] Medical Service, it is desirable for doctors to serve several placements, or even their entire careers here. In this country, very different from the other countries in the [Indochinese] Union, one needs in order to succeed more than just technical knowledge but also knowledge of the 'natives', their language, their morals [customs], as well as the desire and tenacious motivation to be of use to our cause.[63]

Dr Francière was a rare example. Posted to Luang Prabang hospital as a young, civilian *stagiaire* (intern) doctor in 1910, he worked in Laos for more than two decades, rising to become a doctor of the first class, and eventually Head of the AML in 1926.[64] His long experience and obvious affection for Laos, and fluency in Lao, benefited the AML. The majority of colonial medical staff, however, remained only a few years at most which was insufficient to understand the social and cultural setting and develop functionality in Lao. Most French doctors could not communicate directly with patients, and relied on Lao nurses to interpret. Some of the Vietnamese assistant doctors and nurses were in a similar situation.[65]

Native (indigène) Staffing and Professional Education

By the early 1920s, the colonial health administration acknowledged that a cadre of Lao health staff was needed to help address the difficulty of attracting and retaining French doctors and reduce the cost of expanding the health network. The approach also supported greater sustainability of the health service. In 1921, the AML head stated, "the whole future of the

[63] RSL, Box 4: 'Rapport annuel de 1929 sur l'Assistance médicale du Laos'.
[64] RSL, Box 3: 'Rapport annuel de 1926 sur l'Assistance médicale au Laos', p.4.
[65] Only three French doctors and one Vietnamese *médecin auxiliaire* are on record as learning Lao. See RSL, Box 2: *Ambulance* de Hinboun, Dr Gravot to Resident Superior, 5 May 1903; Box 5: AML monthly report for September 1913, unpaginated; and Box 3: 'Rapport annuel de 1925 de l'Assistance médicale du Laos', pp.7-8.

Assistance Médicale in this county is linked to this essential question: to have a [health] service in Laos [staffed] with *médecins auxiliaires* of Lao origin".[66]

At least ten Lao students qualified mainly as *médecins auxiliaires*, mainly in Hanoi. No Lao students are known to have completed the higher-level *docteur indochinois* qualification, offered in Hanoi from 1923, which was equivalent to medical training in France but licensed graduates to practise medicine only in Indochina.[67] By the close of the colonial period Oudom Souvannavong was the only Lao to have qualified as a *docteur en médecine*, graduating from the University of Paris in 1949.[68]

The *École de médecine de l'Indochine* in Hanoi, opened in 1902, offered training to natives in auxiliary medicine, pharmacy, midwifery and nursing. The school's minimum entry requirement was completion of lower-secondary school (*collège*), but identifying Lao candidates with sufficient education and French-language ability proved challenging. Secondary education in Laos was the least developed of all territories in French Indochina, and while the Collège Pavie had opened in Vientiane in 1921, few of its graduates chose to leave Laos to study medicine.[69]

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[66] RSL, Box 3: 'Rapport annuel de 1921 de l'Assistance médicale au Laos', p.41.
[67] Teston and Percheron, *L'Indochine moderne*, pp.192-193.
[68] Oudom Souvannavong's thesis focused on the future needs of the Lao health system to ensure improved health for mothers and their infants. See Oudom Souvannavong, 'Une étude du problème'.
[69] The *Collège Pavie* building, constructed in the early 1920s, subsequently became the the dormitory for the Royal School of Medicine (*École Royale de Médecine*) when it opened in late 1957. See Himmakone Manotham, *Nakhone louang vieng chanh samay lao pen ananikom khong falang* (Vientiane in the French colonial period), (Vientiane: Sisavath Press, 2010), p.20; and Oun Sananikone, *Lao Issara. The Memoirs of Oun Sananikone.* translated by John B. Murdoch and 3264, Data paper No. 100, Cornell Southeast Asia Program, (Ithaca, NY: June 1975), p.29.

Figure 3.3: Number of AML medical staff, 1904-1950[70]

Year	Doctors (French)	Médecins auxiliaires, Médecins indochinois (Lao/Vietnamese/Chinese)	Midwives (Lao/Vietnamese)	Nurses (Lao/Vietnamese)
1904	5	0	0	?
1906	5	0	0	9
1910	7	0	0	14
1913	7	0	0	29 (25 Vietnamese)
1915	5	0	0	35 (29 Vietnamese)
1920	4	5	0	77 (61 Vietnamese)
1925	12	12 (6 Vietnamese)	0	97
1930	8	13 (5 Vietnamese, 1 Chinese)	5	156 (approx. 40% Lao)
1935	n/a	17 (9 Vietnamese)	11	170
1939	5	15	17	180
1945	n/a	n/a	n/a	n/a
1950	14	23 (1 possibly Vietnamese)	16	220

The first Lao *médecin auxiliaire*, Tiao Katignarath, graduated from Hanoi in 1916. Early Lao graduates included at least another three princes, Tiao Singkham (1918), Tiao Singkeo (1920) and Tiao Khamphay (1925). Records suggest that several of the Lao students enrolled in medical studies did not graduate. In 1927 the medical school introduced a special section of the *médecins auxiliaires* course especially for Lao students, on the assumption that a course specifically tailored for their needs would increase both enrolment and completion rates. However, only five of the seven first-year students progressed to the second year and all students reportedly failed the exams the following year, sparking fears that the section would be short-

[70] The statistics in Figure 3.3 have been compiled from annual and monthly AML reports from 1906-1950, held in the RSL, Boxes 1-12. They have been supplemented with AML annual reports for 1939 and 1947, absent from the ANOM holdings but reproduced in Oudom Souvannavong's thesis. There is no breakdown by gender, but narrative reporting indicates that male nurses predominated for the entire period.

lived.[71] Such fears appear to have been well-founded because no further mention is made of the special section and only one Lao, Khamko, is mentioned in later AML annual reports as having graduated in the 1930s.

A second medical faculty opened in Saigon in 1941, and "six or seven" Lao students are reported to have transferred there from Hanoi.[72] A third medical school opened in Phnom Penh in 1946. It offered training for assistant doctors, now termed *médecins assistants*. Nine Lao students, all male, were studying there in 1950, which reportedly included all those who had been in Saigon and had opted to transfer their studies to Phnom Penh.[73] The reason for the transfer is unclear, although one source suggests it was because Lao people had a "strong dislike for things Vietnamese".[74] The AML received a sudden influx of ten newly graduated *médecins assistants* in 1950. The Lao records do not indicate where these staff trained, who appear to have been treated as subordinate to the *médecins indochinois*, but it is highly probable that most had graduated from Phnom Penh.[75]

Because the production of Lao *médecins auxiliaires* proceeded slowly, Vietnamese were posted to Laos from 1922 to supplement their ranks. These staff typically arrived in Laos as interns and returned to Vietnam soon after they were promoted. Trinh Van Dam, the first such intern, was assigned to provide medical care to the mainly Vietnamese labourers engaged in building

[71] RSL, Box 4: 'Rapport annuel de 1929 sur l'Assistance médicale du Laos', p.9.
[72] Khamsone Sassady states that Lao medical students continued their studies throughout World War II in both Hanoi and Saigon, and Mathurin and Fontan suggest that six or seven Lao *médecins assistants* trained in Saigon, but they cite no source for their information. See Khamsone Sassady, 'Contribution à l'étude de la médecine laotienne', Thesis, doctorat en médecine, University of Paris, 1962, p.112; and Mathurin and Fontan, 'La médecine au Laos', p.646.
[73] This information is mentioned in the Lao-language text but not in the French-language text of *Laos 1950*. See also Ovesen and Trankell, *Cambodians and their Doctors*, p.78.
[74] Frank LeBar and Adrienne Suddard, eds., *Laos. Its people, its society, its culture*, (New Haven: HRAF Press, 1967 revised edition [1960]), p.186.
[75] RSL, Box 12: 'Rapport annuel de 1950', p.17.

Colonial Route 4.[76] The contingent of Vietnamese auxiliary doctors rose to eight by 1932, and presumably remained at that level until the 1940s.[77] Their numbers were augmented by occasional Chinese auxiliary doctors, also graduates from Hanoi.

While the centralised medical administration sent Vietnamese staff to serve Lao, Khmer and ethnic minority communities, colonial authorities in Laos were mindful to prevent Lao doctors being outnumbered by Vietnamese colleagues, a point that appears not to have been sufficiently respected in Cambodia.[78] The AML boasted an unusual professional hierarchy for both Indochina and Laos. While French doctors occupied the senior technical and administrative positions, experienced Lao *médecins auxiliaires* with increasing seniority formed the middle ranks, and newly graduated, junior Vietnamese auxiliary doctors occupied the lowest rungs of the hierarchy. For the most part, recently arrived Vietnamese staff opted to depart Laos quickly - maybe because their position differed from other administrative or technical services, where French-educated Vietnamese often supervised lower-level Lao officials. Only one Vietnamese doctor remained on the AML staff in 1950, employed as a *médecin indochinois* in Xayabouly. It is not possible to ascertain whether he was posted from Vietnam, or Lao-born to Vietnamese parents.[79]

As with the *médecins auxiliaires*/*médecins indochinois*, the cadre of Lao nurses and midwives was slow to take shape. The Governor-General of Indochina created a cadre of civilian nurses for the AML in 1906, but the

[76] RSL, Box 3: 'Rapport annuel de 1922 de l'Assistance médicale au Laos', p.4.
[77] RSL, Box 4: 'Rapport annuel de 1932 de l'Assistance médicale au Laos', pp.3a-3b.
[78] Au, *Mixed Medicines*, p.74.
[79] RSL, Box 12: 'Rapport annuel de 1950', p.17. Xayabouly would be an unusual posting for a Vietnamese doctor, as few Vietnamese immigrants or labourers resided there. It is therefore more probable that the doctor was Lao-born.

budget was insufficient for their recruitment.[80] Initially Laos relied upon Vietnamese nurses recruited from the *garde indigène* or from the local community with varying success. The AML records remain largely silent about the turnover rates among nurses in the early years, treating them as marginal characters. However, some Vietnamese nurses stayed in Laos long-term, learnt the language, and made significant contributions. Nurse Nguyen Van Noc, who worked in southern Laos for three decades from the 1890s, first at Khong and later Pakse, is worthy of special mention. On his death in 1921, the Pakse *médecin-chef* paid tribute to him:

> After having served at various health facilities in Cochinchina, he came to Laos at the beginning of the [French] occupation, participating in the difficult military campaigns, and was a valuable aid to the doctors who created the first medical organisations in often difficult conditions in this new country. Remarkable for his demeanour, his devotion, his loyalty, and his professional knowledge, he received numerous awards and the highest assessments from all of his supervisors…even in his last days, he was the most punctual and the most zealous of the nurses. His blameless life was a constant example to his young colleagues who venerated him like an ancestor, and upon whom he exercised the most positive influence. Servants [of colonial France] such as this are too rare, and as such, their passing must be noted.[81]

Recruiting Lao nurses proved to be a hit-and-miss endeavour. More systematic recruitment of nurses began from 1908, and in 1909 two Lao had been employed as nurse interns (*infirmiers stagiaires*).[82] From 1912, an informal practical nursing school is reported to have operated at the Vientiane *ambulance*. The AML annual report states that a group of volunteers worked in the hospital without salary and learnt on the job. Nine volunteers, eight of them Vietnamese, were employed as nurse interns in 1913 after passing an

[80] RSL, Box 3: 'Rapport annuel 1907 de l'Assistance médicale du Laos', unpaginated.
[81] RSL, Box 6: Monthly report of Pakse *ambulance* for December 1921, unpaginated.
[82] RSL, Box 3: 'Médical annuel ensemble, Année 1909', unpaginated.

exam.[83] That year the AML's nursing cadre comprised 29 nurses: 25 Vietnamese, four Lao, and all male.[84] Not until 1917 does a female nurse appear, employed in Pakse.[85]

The Vientiane nursing school was officially opened by the Resident Superior in March 1915.[86] Prospective students were required to have completed primary education, and to have some basic familiarity with French language. Over the following years the nursing school struggled to find Lao students with a sufficient educational background, and most students were drawn from the immigrant Vietnamese community.[87] Given the low student numbers, the school closed from 1920 until 1922, but re-opened in 1923 under the supervision of Tiao Katignarath, recently transferred from Savannakhet hospital to Vientiane.[88] Student numbers hovered around 14 per year throughout the 1920s.[89] However, concern about the predominance of Vietnamese students prompted the adoption of pro-Lao affirmative action, by requiring a Lao language test in the late 1920s. The strategy backfired: rather than increasing the number of Lao, enrolment data suggests the test encouraged Vietnamese students to brush up their language skills.

The number of nurses employed by the AML gradually climbed, as did the proportion of Lao compared to Vietnamese. By 1930 approximately 40 percent of nurses were Lao, compared to 29.5 the previous year.[90] In later

[83] RSL, Box 3: 'Assistance médicale: Rapport annuel médical de l'année 1912 pour l'Ambulance de Vientiane', p.6.
[84] RSL, Box 3: 'Rapport annuel médical d'ensemble de 1913', p.7.
[85] RSL, Box 3: 'Rapport annuel de l'Assistance au Laos (1917)', p.3.
[86] RSL, Box 3: 'Rapport annuel médical d'ensemble de 1916', p.5.
[87] RSL, Box 3: 'Rapport annuel de 1920', unpaginated.
[88] Tiao Katignarath directed the nursing school at the Vientiane hospital until his premature death in the early 1930s. Dr Jaisvasd Visoutthiphong, interviewed in Torcy, France, 2 December 2012.
[89] RSL, Box 4: 'Rapport annuel de 1929 sur l'Assistance médicale du Laos', p.10.
[90] RSL, Box 4: 'AML Rapport annuel de 1930', p.10.

years, the AML annual reports no longer distinguished between Lao and Vietnamese, so it is not possible to observe the changing ethnic composition of AML staff. However, what emerges from the 1930s onwards is the gradual entry of female nurses, although no overt strategy for their recruitment appears within the official reports. By 1950 the AML comprised 220 nurses, 23 percent of whom were female.[91]

A midwifery school which operated at the Vientiane hospital from 1924 also encountered difficulty in recruitment. It was exacerbated by the requirement that all students be female, and willing to undergo a two-year curriculum rather than the shorter, six-month nursing curriculum. Several of the early graduates were of mixed race, either Lao-Vietnamese or Lao-French, possibly because they were more likely to possess the formal education required for acceptance into the course, and to enjoy family support to seek a profession.[92] The midwifery school in neighbouring Cambodia, which also opened in 1924, is reported to have recruited mixed-race women.[93] The Vientiane school closed its doors in 1932, after teaching only three or four students per year.[94] The Phnom Penh school also closed in 1932, suggesting the closures were prompted by Indochinese health policy as much as by specific local circumstances.[95] The Vientiane school re-opened in August 1940

[91] RSL, Box 12: 'Rapport annuel de 1950', p.6.
[92] RSL, Box 4: 'AML Rapport annuel de 1930', p.10.
[93] Sokhieng Au devotes a chapter to women's health, which also deals with 'native' midwives; see Au, *Mixed Medicines*, pp.119-156. Also see Kate Frieson, 'Sentimental Education: Les Sages Femmes and Colonial Cambodia,' *Journal of Colonialism and Colonial History*, 1(1) Fall 2000, http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/journal_of_colonialism_and_colonial_history/v001/1.1frieson.html.
[94] RSL, Box 4: 'Rapport annuel 1935', p.24.
[95] Ovesen and Trankell, *Cambodians and their Doctors*, p.183.

as the Nursing and Midwifery School with ten students (eight male and two female).[96]

Midwifery training was revived in the immediate post-World War II period, and administratively placed in the new Social Welfare section of the larger Medical and Social Welfare Service. This initiative began with midwifery training in France for two young Lao women, who were intended to serve as instructors on their return. Ultimately, only one travelled to France, while the other remained in Laos to marry.[97] A parallel initiative involved training a cadre of lower level, rural auxiliary midwives (*accoucheuses rurales*), who would undergo six months' training in the nearest hospital, before returning to practise in their local area. An ambitious plan set out to train a corps of approximately 120 young women beginning in 1949.[98] Interestingly, the plan did not appear to follow an earlier Vietnamese strategy of providing biomedical top-up training to traditional midwives who were already practising, but rather was intended to train young women new to the profession.[99] By 1950, one state-registered midwife (*sage-femme d'état*) was employed by the AML, presumably trained in France, as well as four lower-level Indochinese midwives.[100]

No Lao qualified as pharmacists or auxiliary pharmacists during the colonial period. Auxiliary pharmacist positions were filled by a series of staff from Vietnam beginning in 1926.[101] Nor did any Lao qualify as dental

[96] RSL, Box 4: 'Laos. Assistance médicale. Rapport du 4e trimestre 1940', p.13.
[97] Grant Evans, *The Last Century of Lao Royalty. A Documentary History*, (Chiang Mai: Silkworm Books, 2009), p.264.
[98] RSL, Box 11: Prime Minister Souvannarath to Minister of Health, Kou Abhay, 18 January 1949.
[99] Monnais, 'La médicalisation de la mère', pp.242-243; and Au, *Mixed Medicines*, p.150.
[100] RSL, Box 12: 'Rapport annuel de 1950', p.6.
[101] RSL, Box 3: 'Rapport annuel de 1926', p.7.

surgeons or dental assistants. In fact, dental care was not provided by the AML, suggesting that only the most rudimentary care, such as tooth-pulling, was available from private operators in the colonial period.

A final word on staffing: supervision was problematic throughout the colonial period. The consistently low numbers of staff saw newly graduated *médecins auxiliaires* regularly assigned to head up provincial and district-level infirmaries and dispensaries, and new nurses dispatched to even more remote dispensaries and medical posts. Often they had little guidance or supervision and sometimes nothing more than a French-Vietnamese bilingual nursing manual to assist them.[102] Some struggled with their responsibilities. One *médecin auxiliaire stagiaire* was assigned to head the recently opened Xam Neua dispensary fresh out of medical school in 1920, but was officially disciplined several months later for not fulfilling his professional duties. He was transferred to Luang Prabang to recommence his internship under the guidance of a French doctor rather than being fired, presumably due to the scarcity of Lao *médecins auxiliaires*.[103]

Curative Care

The AML endeavoured to provide a range of curative and preventative healthcare services. Contrary to assumption among several present-day health practitioners, the colonial health service provided medical care to both Europeans and natives. The patient load was cosmopolitan, considering the size and remoteness of Laos, and biomedical services received varying degrees of acceptance among different social groups. French doctors quickly realised

[102] RSL, Box 3: 'Rapport annuel 1921', p.9.
[103] RSL, Box 3: 'Rapport annuel 1922', pp.3-4.

that the healthcare services in Laos would differ from those operating in the rest of Indochina. In 1908 the AML head explained:

> The medical and public health services are … very difficult in Laos, due to the diversity of the population … Each people has its [own] morals, its special customs. It is impossible to set up a generalised system … all that we can do from Vientiane is [to support] a combined general program, [with] a kind of template/framework, to be modified in the provinces according to the mentality/mindset of the [local] population.[104]

The colonial record is silent on whether the AML or individual doctors were in fact able to tailor services to the diverse local communities. The AML considered the employment of Lao medical staff as a potential access point to local people, but medical workers from ethnicities other than the Lao were rarely if ever mentioned. Certainly, doctors were aware of the need to re-orient the service to better support people in Laos' rural areas. A recommendation in 1929 noted that the AML should practise primarily rural medicine, rather than hospital-based medicine "which is expensive in Laos … and profits only those in the towns, and especially, Vietnamese immigrants".[105]

The AML offered consultations and hospitalisations for both Europeans and natives, but medical services were segregated. Beds, wards and even buildings were designated for Europeans or natives. All health facilities in Laos contained a vast majority of beds for natives, and there was no situation comparable to Phnom Penh where in 1908 the Hôpital Mixte was reported to possess almost equal numbers of beds for Europeans as for natives (63 as opposed to 83).[106] The number of native beds increased as the health network expanded, while those for Europeans remained relatively steady.

[104] RSL, Box 3: 'Rapport annuel 1907 de l'Assistance médicale du Laos', unpaginated.
[105] RSL, Box 4: 'Rapport annuel de 1929 sur l'Assistance médicale au Laos', pp.126-128.
[106] Ovesen and Trankell, *Cambodians and Their Doctors*, p.46.

However, the percentage of 'European' beds was disproportionate to their actual presence in Laos, if only slightly. For example, in 1950, when Europeans comprised less than one percent of the estimated local population, three percent of hospital beds (14 of the 490 available beds) were set aside for them.[107] Furthermore, hospitals provided meals to patients from 1908, with separate European and native menus. European patients were given more courses, and presumably more food.[108]

The patient mix was varied, with Vietnamese disproportionately represented within the native category until the AML ceased reporting ethnic distinctions. This can be explained initially by the clustering of health facilities in urban centres which, except for Luang Prabang, had majority Vietnamese populations, or near garrisons of the predominantly Vietnamese *garde indigène*.[109] Moreover, Vietnamese immigrants were more likely to have some cultural familiarity with biomedicine, as it had been introduced to Vietnam decades earlier, and at the same time, were less likely to resort to Lao traditional medicine than their Lao counterparts. Thirdly, they were more likely to have some knowledge of French, the official language of the health facilities. However, patients of many other ethnicities also availed themselves of colonial healthcare services, as demonstrated by Figure 3.4.

While the medical care provided by the original *ambulances* was basic, staff diagnosed a wide variety of medical conditions, performed surgery, and dispensed European pharmaceuticals. The caseload was varied, with malaria,

[107] RSL, Box 12: 'Rapport annuel de 1950', p.7.
[108] RSL, Box 3: 'Rapport annuel 1907 de l'Assistance médicale du Laos', unpaginated.
[109] In 1943, five of Laos' six major towns had majority Vietnamese populations. These were, in order, Thakhek (85% Vietnamese), Savannakhet (72.5%), Xieng Khouang (72%), Pakse (62%) and Vientiane (53%). See Eric Pietrantoni, 'La population du Laos en 1943 dans son milieu géographique', *Bulletin de la Société des Études Indochinoises* (Saigon), N.S, Tome XXXII, No.3, 3e trimester, 1957, pp.7-8, quoted in Evans, *Short History*, p.71.

dysentery, respiratory and digestive problems featuring prominently. Records show that there were almost three times as many male patients as females in the 1910s, and two times as many in the 1920s. Possible explanations for this phenomenon will be addressed below. In 1907, 589 natives and 56 Europeans were hospitalised at the four *ambulances*. By 1950, the AML recorded 5,126 patients nationwide, of whom only 67 were European.[110] As such, the number of Lao (or native) patients had increased by more than 800 percent, while the number of European patients had remained steady.

Figure 3.4: Provincial patient numbers by ethnicity, 1926[111]

Facility	Lao	Kha	Meo	Phouthai	Phoutheng	Viet	Chin	Siam	Malay	Malabar
Xam Neua	1009	-	173	432	211	1207	114	-	-	3
Thakhek	119	-	-	-	-	355	3	30	1	-
Xepone	1578	-	-	-	-	2025	64	-	-	-
Attapeu	1787	354	-	-	-	455	21	-	-	-

Colonial officials identified malaria as the major obstacle to the health and well-being for Europeans and locals alike.[112] It was the main reason for hospitalisation, and the main cause of death among hospitalised patients throughout the colonial period. Quinine sulphate, the only known preventative for malaria at the time, was used by as a preventative and treatment. The State Quinine Service for Indochina was established in 1909 under the supervision of the health service.[113] It was introduced to Laos several years later in 1914, although it did not operate in some provinces until the 1920s. The service distributed quinine from the *ambulances* and dispensaries, as well as from

[110] RSL, Box 3: 'Rapport annuel 1907 de l'Assistance médicale du Laos', unpaginated; and Box 12: 'Rapport annuel de 1950', p.12.
[111] RSL, Box 3: 'Rapport annuel de 1926 sur l'Assistance médicale au Laos', pp.45-58.
[112] RSL, Box 3: 'Rapport médical ensemble de 1914 du Chef du Service de l'Assistance médicale au Laos', p.45.
[113] Monnais-Rousselot, *Médecine et colonisation*, p.161.

secondary depots outside of the formal health service.[114] Quinine was mainly distributed free of charge in Laos, as AML Head Dr Pujol predicted in 1914 that it would take some time for Lao people to realise the benefits of quinine, and to be prepared to pay for it.[115] His prediction was borne out in 10 years. The 62 depots in 1923 more than doubled within two years.[116] Despite significant efforts to promote the use of quinine, malaria continued to be the main disease for which the local community sought treatment throughout the colonial period. Twenty six percent of consultations in Vientiane in 1925 were made by patients with malaria.[117] At handover in 1950, the AML was still dealing with a majority of malaria cases.

Medical treatments for other health complaints were not always popular. Colonial doctors observed that Lao people were reluctant to undergo surgery, fearing "bloody operations", and preferring pharmaceuticals to surgery.[118] Acceptance of surgery increased over the decades, because by 1950 the AML reported that it performed 80,095, presumably minor, operations that year.[119]

European pharmaceuticals proved popular, but their supply was irregular, and caused constant headaches, in large part caused by Laos' inland location. Pharmaceuticals and medical supplies were ordered only once or twice a year, to guard against their expiry. Items were sourced from Hanoi, Haiphong or Saigon and in some instances, France. The difficulty in accessing up-to-date price lists, and the long lead times for delivery, meant that the AML

[114] RSL, Box 3: 'Rapport annuel medical d'ensemble de 1913', p.39.
[115] RSL, Box 3: 'Rapport médical ensemble de 1914', p.37.
[116] RSL, Box 3: 'Rapport annuel de 1925 de l'Assistance médicale au Laos', p.90.
[117] Ibid., p.46.
[118] RSL, Box 3: 'Rapport annuel 1907 de l'Assistance médicale du Laos', unpaginated.
[119] RSL, Box 12: 'Rapport annuel de 1950', p.36.

had a hard time balancing the books and keeping its medical warehouses adequately stocked. The early files of the AML reveal numerous examples of delayed or lost medicine shipments.[120] Doctors improvised as best they could in such circumstances, requesting travelling government officials, other Europeans, or colleagues in Phnom Penh to assist with enquiries and deliveries.[121]

The AMI policy promoted a system of free pharmaceuticals in Indochina. In Laos, pharmaceuticals were generally not free, however, except for the poorest of patients. This may have been partly due to the difficulty and cost of securing a consistent supply. It may also have been an attempt to curb the practice reported by French doctors of members of the Lao elite obtaining free (or heavily subsidised) medications, and selling them on to others at profit.[122] This particular example suggests that some who avoided entering the culturally unfamiliar setting of the French colonial health facility were still prepared to buy pharmaceuticals through other channels.

In 1924 a Central Pharmacy was established in Vientiane under the rationale that it would reduce costs for the AML. The move was greeted with a veritable torrent of exasperation from Dr Guillemet, the AML Head at the time, who unloaded his frustration at his predecessor's assumption that a pharmaceutical service could operate without adequate staff, funding or premises. He exclaimed: "The fundamental error consists of thinking that an institution which has proved itself in three countries of the Indochinese Union

[120] RSL, Box 1: Telegram from Dr Philippe of Luang Prabang *ambulance*, 24 June 1903.
[121] RSL, Box 1: Telegram from Dr Lefèvre of Luang Prabang *ambulance*, 1 November 1897; and Telegram from the Resident-Superior to Dr Philippe of Luang Prabang *ambulance*, 20 May 1903; and Box 3: 'Rapport annuel de 1917 de l'Assistance au Laos', p.6.
[122] A pharmacy inspection in 1931 uncovered large sales of quinine occurring in some provinces, raising suspicions of bulk sales to Siamese merchants for re-sale to Lao customers. RSL, Box 4: 'Rapport annuel de 1931 sur l'Assistance médicale du Laos', p.91.

could not fail to achieve similar satisfactory results in the fourth [Laos] … Laos cannot be compared to any other country in the [Indochinese] Union", though he failed to specify exactly why the plan was doomed.[123]

Without a single trained Lao pharmacist or assistant pharmacist throughout the colonial period, Vietnamese *pharmaciens auxiliaires* were appointed to staff the Central Pharmacy from 1924.[124] Difficulties with ordering, transportation and supply plagued the service. On occasion, shipments of medicines arrived without invoices, and so AML staff were unable to price the medicine for sale at its real cost.[125] The situation improved slightly when from 1934 the service began ordering all of its products from the pharmaceutical depot in Tourane (Danang). Hospitals and *ambulances* were re-supplied twice per year, except the Bacteriology Laboratory in Vientiane, which was re-supplied monthly. Vientiane absorbed the bulk of medicine and supplies, followed by Luang Prabang, Champassak, Savannakhet and Thakhek.[126] The service struggled with insufficient staffing, budgets and logistics problems, possibly exacerbated by weak management practices which resulted in stockpiles and shortages of various medicines.

Finally, evacuations were a consistent feature of the AML. Both Europeans and natives were evacuated downstream to Phnom Penh and Saigon, or overland to Vinh and Hanoi. A total of 27 patients were evacuated from Laos in 1906: 16 Europeans and 11 natives.[127] If Vietnamese comprised the bulk of native evacuations (no breakdown by nationality is available), and

[123] RSL, Box 3: 'Rapport annuel de 1924 de l'Assistance médicale au Laos', p.10.
[124] Ibid., p.114.
[125] RSL, Box 4: 'Rapport annuel de 1929 sur l'Assistance médicale du Laos', p.14.
[126] RSL, Box 4: 'Rapport annuel de 1936 de l'Assistance médicale au Laos', pp.15-18.
[127] RSL, Box 3: 'Assistance médicale au Laos. Année 1906. Rapport d'ensemble', unpaginated.

they may well have, many evacuations could be described more correctly as repatriations. Evacuations reduced as the AML's capacity to provide medical services improved, but nevertheless remained a routine element of medical care in Laos.

The Challenges of Preventative Healthcare

Preventative healthcare or public health (*hygiène*) was considered as important as the curative health services offered by colonial hospitals and infirmaries. A multi-stakeholder Public Hygiene Committee was created in November 1905, three years after the formation of similar committees in the other Indochinese territories. Provincial committees were established in 1907, comprising staff from the AML and other offices and, in Vientiane, representatives from the European and Vietnamese communities.[128] To combat practices regarded as backward, unclean, and superstitious, the AML outlined three programs to address hygiene in the main urban centres, in rural villages, and through public health education. Urban efforts were directed at the prevention and control of transmissible and contagious diseases, rabies, smallpox vaccination, and prostitution, as well as food hygiene at markets and abattoirs, cleanliness of public establishments (mainly schools, prisons and workshops), and the general cleanliness of urban centres. The establishment of 'native' births and deaths registers was also attempted unsuccessfully.

In rural areas, the preventative health program involved limiting the spread of epidemic disease, attempting to regulate burials and cremations, and maintaining village cleanliness and order. This included, for example,

[128] RSL, Box 3: 'AML Rapport médicale ensemble pour l'année 1910', unpaginated.

protecting water sources; locating wells at a distance from latrines, manure piles, dumps and cemeteries; promoting the use of rubbish dumps and latrines; and constructing pens for livestock. Public health education included medical rounds and free consultations in schools, military garrisons, work camps and prisons; vaccinations for various diseases such as smallpox, cholera and typhoid; public health meetings; and leaflets and brochures promoting the use of clean drinking water and prevention of trachoma.[129] In the 1920s, maternal and child healthcare was added to the public health agenda, before being passed to the Social Action and later Social Welfare services of the 1930s and 1940s. Governor-General Beau had advised in 1907:

> The local doctors trained…are…the most effective agents of propaganda [information].…[T]hey are admirably equipped to take the lead in this campaign, to explain to their compatriots the benefits of vaccine or the necessity of disinfection, to teach them how dysentery is spread, or typhoid fever, or cholera, or tell them of the dangers of dirty water …[130]

Malaria, smallpox, and cholera were identified as major health problems in colonial Laos. Epidemic control and vaccination formed the major plank of the colonial preventative health program, due largely to the scientific research of the Pasteur Institute in France and Indochina. However, while it has been argued that massive vaccination campaigns for smallpox and cholera had a major effect on population and mortality in Vietnam, Stuart-Fox is not convinced that the same can be said for Laos, implying that mortality rates remained high despite the authorities' attention to vaccination.[131]

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[129] RSL, Box 3: 'Médical annuel ensemble, Année 1909', unpaginated.
[130] RSL, Box 2: Governor-General's Instruction No.99, 31 January 1907.
[131] Pierre Brocheux and Daniel Hémery, *Indochina. An Ambiguous Colonisation, 1858-1954*, (Berkeley: University of California Press, 2009), p.256; and Stuart-Fox, *History of Laos*, p.52.

Vaccination was compulsory throughout Indochina from 1908.[132] Smallpox was the most common vaccination provided in Laos, although cholera, plague and typhoid vaccines were also provided some years. Smallpox vaccines were sourced from the Pasteur Institute in Saigon for southern Laos,[133] and from the vaccine station in Xieng Khouang for northern and central Laos.[134] Au argues that only those groups most accessible to the authorities were vaccinated.[135] In Laos, it is not possible to discern any social groups specifically targeted by the authorities, although it is safe to assume that vaccination was more likely to occur if one lived in a town or a village located on a travel route between two towns.

Vaccination rounds began soon after the establishment of the first *ambulances* in Laos. They were carried out on horseback in the dry season, and by boat in the wet season. Dr Lefèvre made a vaccination tour from Luang Prabang to Vientiane in March 1898, accompanied by the King's brother Tiao Chakravat who liaised with the local communities along the route. His handwritten report states that he vaccinated 1,524 people in 37 villages.[136] The Pak Hinboun doctor reports making vaccination rounds soon after the *ambulance* opened in 1898,[137] as did the Khong doctor. From 1904 the AML had one allocated mobile doctor-vaccinator position, which was later increased to three positions for the whole of Laos. These positions, however, were often vacant due to the difficulty in attracting medical staff. In 1915, the mobile vaccination service was reported to rely on French provincial administrators

[132] Brocheux and Hémery, *Indochina*, p.257.
[133] Monnais-Rousselot, *Médecine et colonisation*, p.90.
[134] RSL, Box 3: 'Rapport médical annuel pour le Laos (Année1908)', p.36.
[135] Au, *Mixed Medicines*, p.76.
[136] RSL, Box 1: Report of Dr Lefèvre of Luang Prabang *ambulance*, March 1898.
[137] RSL, Box 2: Telegram from Dr Mariot of Pak Hinboun *ambulance*, 19 December 1898.

and native vaccinators, including low-level Lao clerks (*samiens*) because of the insufficient numbers of medical personnel.[138] A decade later official policy had changed and the colonial authorities tried to restrict the vaccination work to doctors and/or nurses, to counter charges of rent-seeking and sloppy performance.[139]

In 1922 Dr Guillemet was upbeat about plans to re-institute the mobile vaccination service as the supply of medical staff increased. Xieng Khouang continued to operate as a vaccine station, but no longer supplied northern Laos, as similar stations were established in Luang Prabang and Houayxay, complete with buffaloes and rabbits. BCG vaccinations for tuberculosis were introduced in 1924 in addition to smallpox and cholera, although these were not widely used.[140]

The temporary departure of doctors to conduct vaccinations in rural areas placed pressure on remaining staff, or effectively closed the health facility in their absence. The AML reported relatively high rates of vaccination each year, in both urban and rural areas. One should be careful in interpreting these figures, however, given the known situation of staff shortages, geographic and cultural difficulty in accessing rural communities, and the uncertain quality of the vaccines without refrigeration.

The maternal and child health program met with less success in Laos than in other Indochinese territories. Statistics for consultations and hospitalisations reflect considerable obstacles in providing services to Lao women and children. Of the 112 deliveries recorded in 1924 at Vientiane and

[138] RSL, Box 3: 'Rapport annuel médical d'ensemble de 1915', p.12.
[139] RSL, Box 4: 'AML Rapport annuel de 1930', pp.104-105.
[140] Monnais-Rousselot, *Médecine et colonisation*, p.194.

Luang Prabang maternity clinics, for example, there were 110 Vietnamese, one Chinese and one Lao.[141] Dr Guillemet explained:

> Only the Vietnamese women come to give birth in our *ambulances*. The Lao women never come... [They] have been afraid of and displayed excessive modesty in respect to our health facilities.. [W]e need a doctor who knows the language and the morals [customs] who can on certain occasions make house calls, and can convince them to accept care at the time of delivery.[142]

As mentioned above, colonial health facilities were the professional preserve of men (there were virtually no female staff), many of them foreign and with little fluency in Lao. It is therefore hardly surprising that Lao women avoided such an environment.

The AML was aware that infant mortality was high, but seemed unable to address it.[143] A maternity clinic was constructed at the Vientiane *ambulance* in 1915, but there were no midwives to staff it.[144] A Chinese midwife from Cholon was posted to Vientiane on contract from August 1916 to December 1917, but her contract was not renewed due to a budget shortfall.[145] Moreover, the midwifery school in Vientiane (discussed earlier in this chapter), was supplemented by maternity clinics attached to the main hospitals in later years: Vientiane, Luang Prabang, Pakse, Thakhek, Savannakhet and Xieng Khouang.[146]

After the World War II the AML tried a new approach, employing rural auxiliary midwives in their home villages. The curriculum is unknown,

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[141] RSL, Box 3: 'Rapport annuel de 1924 de l'Assistance médicale au Laos', p.75.
[142] RSL, Box 3: 'Rapport annuel de 1921 de l'Assistance médicale au Laos', p.26.
[143] Ibid., p.7.
[144] RSL, Box 3: 'Rapport annuel médical ensemble de 1915,' p.3.
[145] RSL, Box 3: 'Rapport annuel 1917 de la Circonscription et de l'ambulance de Vientiane', p.4.
[146] RSL, Box 3: 'Rapport annuel de 1923 de l'Assistance médicale du Laos', p.13.

but presumably trained the midwives to provide home-based services and refer women to medical facilities in the event of complications. In 1950, 978 deliveries took place in AML health facilities.[147] This was an increase on the 713 deliveries recorded in 1932 but a slight decrease from the 1,012 recorded in 1939. While the 1950 statistics do not indicate ethnicity, an estimated 90 percent of mothers in 1939 were Vietnamese.[148] As already noted, Vietnamese women were probably more familiar with biomedicine and French language than Lao women. They may also have faced fewer taboos in dealing with male staff, some of whom were Vietnamese.

Multi-faceted marginality of geographical, administrative and cultural distance

Laos' geographical, administrative and cultural distance from Paris and Hanoi meant that it existed on the margins of the larger Indochinese Union. Its different circumstances were routinely overlooked, despite protests from French doctors, conflating its presumed health needs and abilities to respond to policy directives with those of the other territories. Charles Rochet, a long-term colonial education official and friend of Laos, found it necessary to remind his readers, and presumably his fellow administrators, in the mid-1940s that Laos was not the same as Indochina, which often seemed to refer to the Vietnamese territories alone, and neglected the realities of Laos.[149]

Geographically, Laos was relatively isolated from the other Indochinese territories, as well as from other neighbouring countries. It was

[147] RSL, Box 12: 'Rapport annuel de 1950', p.12.
[148] RSL, Box 4: 'Rapport annuel de 1932 de l'Assistance médicale au Laos', p.53; and 'Rapport annuel 1939', p.14.
[149] Rochet, *Pays Lao*, p.64.

landlocked, hemmed in by mountainous terrain, and rapids in its river systems which blocked large boats from accessing its hinterland. Travel within the Lao territory was also difficult and time-consuming, as geographical distances between towns and villages were of a larger magnitude than in other Indochinese territories, there were few roads, and no railways. Telegraph, telephone or other technologies were unable to bridge the geographical distances, as the communications was still in its infancy.

Administrative distance or marginality overlaid the geographic distance. Laos was the smallest, poorest and last Indochinese territory to be annexed by France. It was incorporated into the Indochinese Union more than 35 years after the first French involvement in Cochinchina, and its first biomedical facilities were established several decades after those elsewhere. The Lao health network was locked in a game of catch-up. It remained relatively small, offering a limited range of healthcare services and referring seriously ill and socially-privileged patients to the larger and better equipped cities of Phnom Penh, Saigon and Hanoi.

The AML's inability to secure a larger share of financial resources demonstrate Laos' administrative distance from Hanoi.[150] Laos ran at a loss and relied on subsidies from Hanoi. The local budget funded AML staffing costs, medications and supplies, which totalled more than two-thirds of the budget, as well as the running costs of the facilities and the public health program. The general (Indochina) budget funded major infrastructure

[150] Monnais-Rousselot, *Médecine et colonisation*, pp.78-82.

development, such as the construction of facilities, and occasionally specific staff, such as those posted to work with the road-building teams.[151]

Health expenditure for Laos was one percent of the colonial budget in 1896, rising to a meagre 1.6 percent in 1910.[152] Modest funding supplements were received from the reimbursement of hospitalisation costs of European officials and paying patients, and the sales of medication and state-monopolised quinine.[153] After the boom of the 1920s, budget reductions were the order of the day, before climbing again after the war. In 1907 the Head of the AML deemed the budget allocation "largely sufficient" but most subsequent health managers complained about the limited funding, and ascribed Laos' lack of certain medical facilities or staffing numbers to its limited budgets.[154] For example, construction of a leprosarium was beyond the Lao budget in 1908, requiring Laos to make do with the much cheaper (and incidentally, more humane) option of designated agricultural villages for those with leprosy.[155] The employment of European nurses was ruled out as unaffordable.[156] Permanent quarantine *lazarets* could not be constructed in 1916 because of limited funds,[157] and the AML's 1929 report noted that the health service waited several years before it could afford to construct premises for the Central Pharmacy created in 1924.[158]

[151] RSL, Box 3: 'Rapport annuel de l'Assistance au Laos, 1916', p.3.
[152] Ministry of Information and Culture, *Pavatsat Lao*, p.571.
[153] RSL, Box 4:'Rapport annuel de 1929 sur l'Assistance médicale du Laos', p.20.
[154] RSL, Box 3: 'Rapport annuel 1907 de l'Assistance médicale du Laos', unpaginated.
[155] RSL, Box 3: 'Rapport médical annuel pour le Laos (Année 1908)', p.37.
[156] RSL, Box 3: 'Rapport médical d'ensemble de l'année 1913 du Chef du Service de l'Assistance médicale au Laos', p.7.
[157] RSL, Box 3: 'Rapport annuel de l'Assistance au Laos, 1916', p.16.
[158] RSL, Box 4: 'Rapport annuel de 1929', p.14.

Culturally, a host of factors created distance between the French authorities, the local population, and the plan to introduce and expand healthcare services in Laos. The formal education system had received scant attention from French authorities, and so few Lao students possessed the minimum educational requirements to study medicine in Hanoi, or Saigon or Phnom Penh. At the same time, it was difficult to attract French and Vietnamese medical officers to the unfamiliar cultural environment of Laos, compounded by its geographical and administrative marginality and relative poverty within Indochina. Within Laos, daily communication was challenging as no single ethnic group represented a clear majority, unlike in the Vietnamese territories and Cambodia. The population spoke different languages, many of which had no script, and adhered to a range of customs and beliefs that differed from the ethnic Lao.

Rochet alleged that colonial administrators turned their backs on Laos to face Hanoi, implementing policies to please their superiors rather than benefiting the Lao population.[159] He recommended that to improve the effectiveness of colonial programs in Laos, one needed to reduce the cultural distance, but it is doubtful that this ever happened to any significant degree. Another long-term colonial official, Dr Francière, summed up the practical dilemma faced by the Lao health service in 1930:

> Day by day the service is becoming more and more complicated, with fewer personnel to run it. Its time has certainly not come yet, given the lack of European doctors and lack of Indochinese doctors to create a mobile Hygiene service, unless [we] leave [the whole thing] in the hands of simple nurses.[160]

[159] Rochet, *Pays Lao,* p.65.
[160] RSL, Box 4: 'Rapport annuel de 1930', p.9.

It appears that Hanoi administrators assumed the Lao health service was the same, or similar enough, to keep pace with those in Vietnam and Cambodia. But Laos had fewer staff, a more culturally diverse and predominantly rural population, and larger distances between towns and villages to negotiate. As with other areas of colonial policy, health policy was directed from Hanoi, and rarely took into account Laos' specific needs.

Conclusion

The *Assistance médicale au Laos* registered a number of achievements in the years to 1950. These included construction of a health network, training a Lao cadre of medical and health professionals, and provision of healthcare to both locals and colonials. Health budgets were allocated, doctors and other staff were despatched to the various provinces, and both curative and preventative healthcare services were launched from the network of hospitals and clinics throughout the territory.

Biomedicine, embodied by the AML, was a symbolic tool of empire employed in France's civilising mission of its colonies. Its introduction to Laos was not as closely linked to providing healthcare for the colonial ruling class, or to supporting economic priorities as in many other colonial settings because the territory hosted few French administrators, and its economic position within Indochina was marginal. Therefore, while the French vision for the Lao health service was grand, the colonial presence was light in terms of both funding and staffing. Successful implementation of many medical and healthcare services approved in policy was delayed or hampered by financial and staffing limitations.

Without a budget surplus of its own, Laos' health service and the colonial administration more generally were dependent on the budgets and policies formulated in Paris and Hanoi, rather than Vientiane. And while policies and programs may have been appropriate for the more urban, more educated, more densely populated and more ethnically homogenous populations of Vietnam and to a lesser extent Cambodia, they were often inappropriate for rural, sparsely populated and multi-ethnic Laos. Many of the French doctors posted to Laos grasped this dilemma, and raised their concerns with their superiors with apparently little success.

The short supply of trained staff provided ongoing obstacles for both expansion and quality improvements of the Lao health service. The impetus for training Lao health staff was predicated on making biomedical healthcare more self-sufficient, more financially affordable and more culturally accessible to the Lao population.

The AML had only a superficial effect on the local population, due to its limited coverage. Ongoing funding and staffing shortages reduced its effectiveness, as did Laos' geographical and cultural distance from the metropoles. Biomedicine was concentrated overwhelmingly within AML facilities, as there were rarely sufficient staff to enable effective outreach through mobile services and public health education in the surrounding rural communities, while Lao society was predominantly rural. As such, most Lao continued to rely on traditional medicine dispensed by local healers, Buddhist monks, spirit doctors and shamans rather than adopting or incorporating biomedicine into their healthcare practices.

CHAPTER 4

DIVIDED EFFORTS: THE IMPACT OF WAR AND INSTABILTY ON THE HEALTH SECTOR (1950-1975)

Introduction

The Lao health sector experienced significant fragmentation in the years following independence. It split from a single, colonially-funded and operated service into multiple services under the separate jurisdictions of the RLG and the NLHX resistance administration. The entry into Laos of international assistance agencies and their rapid rise in influence further diversified the mix of stakeholders, especially in the RLG zone. Laos did not yet possess the necessary technical or financial resources to fully manage and control its health sector, particularly since for most of this period Laos itself was divided, and so dependence on external assistance was the rule. Three main health services emerged: the RLG's Ministry of Health, supported primarily by France and the WHO; the parallel Operation Brotherhood (OB) network in the RLG zone, funded by the US; and a service under the Central Health Committee (*Khanakamakane Sathanalasouk Sounkang*) or CHC in the NLHX's Liberated Zone, supported by the Democratic Republic of Vietnam (DRV).

Independence presented the Lao government with the opportunity to shape a health service directed and delivered by Lao nationals, and focused on its own people's needs rather than external policy imperatives. But while efforts to improve and expand healthcare services were made by the

internationally recognised RLG, its overall focus was on the survival of the nation-state in the face of the communist-led NLHX rather than the development of its technical and administrative services. The First and Second Indochina Wars diverted attention away from national development and towards the more immediate demands of the war effort. The long-running political conflict between the RLG and the NLHX and their respective allies fragmented the technical expertise and financial resources available for the health sector development, dividing rather than unifying the development efforts that did take place.

This chapter charts the nationalisation of the Lao health service and the development of the RLG's Ministry of Health from 1950 until the change of regime in 1975. It documents its fragmentation into separate services implemented by the RLG, OB-USAID, and the NLHX's Central Health Committee. The chapter explores some of the internationally-funded projects implemented within the Ministry of Health, and contextualises the contributions of smaller organisations operating within the health sector at the time, such as Tom Dooley and Medico. There are gaps in the story because sources from the post-colonial period are less complete and at times more difficult to access than those of the colonial period.

Divisions within the health sector

The Lao health service handed over to the semi-autonomous RLG in 1950 had been patched together after wartime neglect, and remained the smallest and least developed health service in the post-war Associated States of Indochina. The service required strengthening and consolidation to fill the

gaps left by the departure of Vietnamese *médecins indochinois* in the 1940s and the reassignment of French doctors from managers to specialist advisors in the 1950s, and to expand healthcare into unserved rural areas.[1]

Even before full independence in 1953, the Franco-Lao Treaty of July 1949 and its practical arrangements signed in February 1950 provided for increased autonomy, including assuming the management of several technical sectors.[2] In accordance with these agreements, the Commissioner of the French Republic in Laos handed over responsibility for the administration of public sector health services to the RLG in April 1950.[3]

Consolidation of the health service was quickly jeopardised by political fragmentation and the introduction of various sources of international assistance to both the RLG and the NLHX. Following a short-lived period of independence in 1945-46 one faction of the nationalist Lao Issara movement had accepted to move towards independence under French tutelage, and most of its members had returned from exile in Thailand in 1949-1950 to join the RLG. The other faction joined the Communist-led Lao Front for Independence *(Neo Lao Issara*) which transformed in 1956 into the NLHX resistance administration. The RLG inherited the bulk of colonial health infrastructure and staffing, while the NLHX made efforts to establish and maintain a parallel network of military health facilities in its 'Liberated Zone', albeit with more modest resources.

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[1] Jean Deuve estimates the 'Lao authorities' numbered approximately 400 in the late 1940s, and staff employed in the technical services another 700. See Deuve, *Royaume du Laos*, p.5.
[2] Anonymous, *Laos Mil neuf cent cinquante. Le Royaume du Laos, ses institutions et son organisation générale* (Pathet Lao 1950. Rabiabkane Pok-khong lae Kanechattang Thouapay), (no publication details, undated), p.108. See also Katay Don Sasorith, *Le Laos. Son évolution politique. Sa place dans l'Union française.* (Paris: Éditions Berger-Levrault, 1953) pp.72-73.
[3] RSL, Box 12: 'Rapport annuel de 1950', p.15.

A second fracture came when the US government, frustrated at a perceived lack of capacity and responsiveness within the RLG's Ministry of Health, began to organise its own, separate health facilities in rural areas. It contracted Filipino NGO Operation Brotherhood (OB) to run a predominantly rural network of hospitals and dispensaries, which also included a referral hospital and nursing school in Vientiane. At the same time, a modest private sector of medical clinics, pharmacies and dental clinics operated by RLG staff emerged alongside government health services in the major lowland towns. Further fracturing occurred as RLG and NLHX authorities delineated between their civilian and military health services, although these divisions were sometimes blurred.

Finally, various international donor agencies and technical advisors jostled to provide financial and technical assistance to both RLG and NLHX governments, now engaged in a struggle aggravated and supported by Cold War rivalries. Contrary to the case in former British colonies, where it was common for individual colonial officials to transition into advisory positions after independence, this appears to have been rarely the case in the Lao health sector, except for the very few French military doctors present at the time of handover.[4] Even in this specific case, the transition from colonial official to post-colonial advisor appears to have occurred at the organisational rather than the individual level.

[4] Kothari, 'Spatial practices and imaginaries', pp.235-253.

The RLG Ministry of Health

The RLG's Ministry of Health was the leading health service until 1975.[5] It managed most health facilities and health staff beginning from April 1950. Moreover, it regulated the country's nascent private sector, received the bulk of assistance from international development agencies, and represented Laos in international fora such as the WHO, which it joined in May 1950.

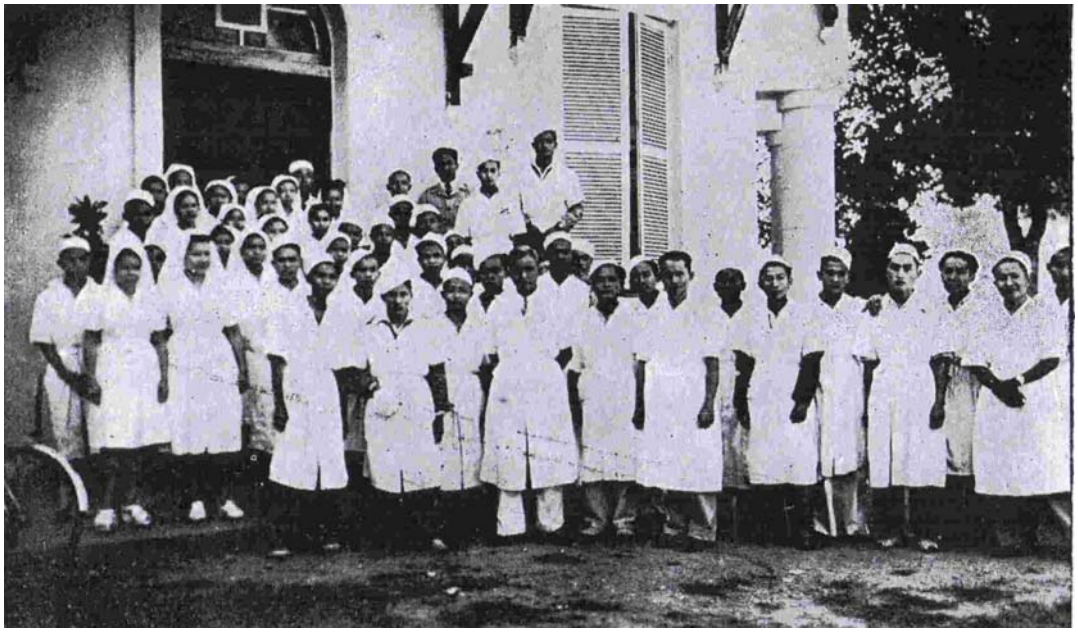
Lao independence required the Ministry of Health to take on policy making, management, financing and administrative functions which had previously been carried out by Hanoi- and/or Paris-based staff, which it was not well-prepared to do. Sources provide scant information about the Ministry's overall health policy or motivations: its aim appears to have been the maintenance and improvement of the existing health service along French lines. However, as LeBar and Suddard argued in 1960, the Ministry faced major obstacles, due to its limited financial means, insufficient staff and the low level of their professional training: "The framework and the intent exist: the problem is to produce personnel with the requisite professional competence," they stated.[6]

Political responsibility for the health service was grouped within a multi-function Ministry of Cults, Education, Health, Social Welfare and Information.[7] The positions of Minister for Health (a member of the Constituent Assembly or Parliament), Secretary of State and Director-General of the Health Service managed the sector. A Secretary of State, similar in rank

[5] The Ministry of Health was referred to in 1950 as the Department of Health (*Direction générale de la Santé publique*) and the Health Service (*Assistance médicale laotienne* or the *Phanek Satharanasouk*). I use the term 'Ministry of Health' throughout the thesis to refer to both the administrative department and the technical health service, as well as the central, provincial and district level services.
[6] LeBar and Suddard, *Laos,* p.185.
[7] Anonymous, *Laos 1950*, p.77.

and position to a Vice-Minister, provided closer policy oversight of health matters than the Minister of a multi-function ministry.[8] It was unproblematic that most Ministers were not medically trained, as the Director-General managed the day-to-day technical and administrative operations.

Figure 4.1 RLG Ministry of Health staff, 1950[9]



The Director-General was assisted by two deputies, who administered the Ministry of Health's two bureaux. The Administrative Bureau managed the functions of personnel, accounts and pharmacy, while the Technical Bureau handled hospital management and social welfare. The *médecin-chef* positions, literally Head Doctors, managed technical and administrative operations in each province, in roles virtually unchanged since the colonial period, except

[8] English language reports often substitute the term 'Secretary of State' with that of 'Minister,' even though this was not strictly correct; it is not clear whether the two terms were consistently distinguished in Lao.
[9] Anonymous, *Laos 1950*, p.99.

that now positions were occupied by Lao *médecins indochinois* rather than French doctors.[10]

The Director-General position was not immediately nationalised, a situation common to other technical services. At least two French military medical officers served consecutively in the dual roles of Director-General and advisor to the Minister of Health until Dr Oudom Souvannavong was appointed Director-General in March 1953.[11] At the time of his appointment, Oudom was the country's only fully qualified medical doctor.[12] Mathurin and Fontan list Koukeo Saycocie, Thongphet (Phetsiriseng) and Khamlek Vilay as successive Directors-General, although they provide neither dates nor references for their information.[13] By 1970 the position was occupied by *médecin assistant* Phouy Phouttasak, who served until the regime change in 1975.[14] Oudom was the inaugural head of the Technical Bureau in 1950, while Koukeo oversaw the Administration Bureau.[15] Oudom had higher professional qualifications, but Koukeo had seniority in terms of work experience. Oudom transferred into politics within 18 months of his promotion to Director-General serving as Minister for Health from November 1954 until 1958. He remained

[10] Anonymous, *Laos. 1950*, p.97; *Ordonnance Royale* No.100 of 2 April 1952, annexed to LNAD, RLG/MOH, 211-007: 'Legislation administrative de l'Hôpital Mahosot', 15 May 1967; and RSL, Box 12: 'Rapport annuel de 1950', p.17.
[11] Ibid., pp.1, 5; Anonymous, *Laos. 1950*, pp.86, 136-138; and ANOM, Haut Commissariat Indochinois, SPCE, Box 393: 'Personnalités laotiennes. Le cabinet de S.E. KATAY- DON-SASORITH (investi le 25 novembre 1954', Direction de Service de Protection de la Representation Civile Française et du Corps Expeditionnaire en Indochine), p.2. I thank Martin Rathie for sharing the latter reference.
[12] RSL, Box 12: 'Rapport annuel de 1950', p.15.
[13] Koukeo and Khamlek were *médecins indochinois*, while Thongphet was a *médecin assistant*. See Mathurin and Fontan, 'La médecine au Laos', p.646.
[14] WHO, WPR/RC21/4, 1970.
[15] RSL, Box 12: 'Rapport annuel de 1950', p.15.

involved in the health sector, later appointed as Inspector-General for Health and President of the Lao Red Cross.[16]

While RLG cabinet reshuffles repeatedly changed the Ministry's political leadership, its structure remained stable. In 1967 Dr Khamphaï Abhay, Laos' first qualified pharmacist, was appointed Secretary of State for Health; he remained in the position until 1974, when he was promoted to Minister.[17] By early 1967 the Ministry's two original bureaux had expanded to three with the separation of the Technical Bureau into curative and preventative healthcare branches. The curative branch supervised hospitals and health facilities, whereas the preventative branch of public health comprised four initial departments (*services*): malaria eradication; maternal and child health; laboratory, research, hygiene and prophylaxis; and pharmacy.[18] All public health services except pharmacy were the focus of ongoing WHO-supported projects, which provided technical advisors and modest operational funds. The laboratory department later split from hygiene and prophylaxis to form a separate department.[19] By 1973, management responsibility for the School of Public Health had been added to the preventative health branch, while external relations, through which international cooperation and funding flowed, had been transferred out of the Ministry and into the Secretary of State's Cabinet Office.[20]

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[16] Oudom continued to serve in the Lao Red Cross post-1975, seemingly demoted to Vice-President. Lao media articles mention him by name in 1977, 1978 and 1980. See Foreign Broadcasting Information Service (FBIS), 'Briefs: Soviet Red Cross Aid', 3 September 1977; 'Red Cross delegation returns', 2 November 1978; and 'Soviet Red Cross delegation heads for home', 16 December 1980.
[17] Dr Khamphaï Abhay, by email, 10 October 2012.
[18] Dominique M. Guerrini, *Organigrammes: Organisation politique et administrative du Laos*, January 1967, p.21, found at http://digital.library.wisc.edu/1711.dl/SEAiT.Organigrammes.
[19] LNAD, RLG/MOH, 211-011: 'Rapport statistique de l'Assistance médicale. Année 1968', Table B/1.
[20] LNAD, RLG/MOH, 211-024: 'Rapport annuel des statistiques sanitaires 1973', p.2.

Foreign aid

The Lao health sector began its long-standing relationship with the international development sector in the 1950s. The sources of external assistance broadened from the former colonial power of France to include the United States, the United Kingdom and Japan and also the Soviet Union, among others. This process of increased diversification of external assistance to Laos laid the foundations for some of the management challenges experienced in later years.

The RLG's first five-year development plan, promulgated in 1959, stated that all health activities would be funded from domestic revenue. This was completely unfeasible, as the budget had been in deficit each year since independence.[21] A large proportion of the RLG's meagre funds was directed to the war effort, and the funding shortfall remained even after the introduction of a business turnover tax in 1961 which included a contribution to health and education financing.[22] As such, the RLG health sector remained heavily reliant on external funding. Detailed health budgets for the first decade were not available.[23] Khamsone Sassady states that RLG allocations to the health sector for 1956-1960 ranged from 2.46 to 6.99 percent of the government's budget.[24] This figure fluctuated from year to year, averaging 2.64 percent from 1962-1973 (see Figure 4.2), when the US considered that 10-15 percent would have been more appropriate.[25] The most expensive budget items were salaries and

[21] LeBar and Suddard, *Laos,* p.189.
[22] NARA, RG 59, Box 2560: 'Economic Review Covering Second Three Biweekly periods of 1961: February 16 - March 31', 13 April 1961.
[23]The Lao National Archives Department may have an almost complete set of RLG Ministry of Health budgets and reports, but access is highly restricted and even indexes can suddenly become unavailable to researchers.
[24] Khamsone Sassady, 'Contribution à l'étude', p.111.
[25] NARA, RG 286, Box 2: 'Draft GAO Report. Medical section', November 1971, Chapter 1, p.3.

pharmaceuticals, which in 1968 accounted for 61.5 percent of the total health budget.[26]

Foreign influence increased as funds from international assistance agencies plugged the considerable financial and material gaps in the system. International donor funds were relied upon for the construction and maintenance of health facilities, professional education and training, and medical equipment and supplies, as domestic budgets were swallowed by staffing and pharmaceutical costs. Assistance most commonly took the form of cooperation projects, international health advisors and overseas scholarships.[27]

Figure 4.2 RLG Ministry of Health budgets, 1962-1973[28]

Year	Health allocation (kip)	% of RLG budget
1962-63	100,463,060	1.40%
1963-64	117,503,990	2.53%
1964-65	202,762,874	2.63%
1965-66	416,417,890	2.82%
1966-67	438,002,300	2.84%
1967-68	424,851,000	2.64%
1968-69	440,966,000	2.76%
1969-70	469.448,000	2.70%
1970-71	517,888,000	3.40%
1971-72	544,355,000	n/a
1972-73	n/a	n/a
1973-74	641,562,000	n/a

The Ministry's statistical reports from the 1960s and early 1970s make no reference to international financial and technical contributions, emphasising

[26] LNAD, RLG/MOH, 211-011: 'Rapport statistique … Anneé 1968', Table B/2.
[27] WHO, WPR/RC21/4, 1970, p.91.
[28] Figures are drawn from the Ministry of Health's annual statistical reports for 1966-73, found in LNAD, RLG/MOH, 211-004, 211-008, 211-011, 211-014, 211-017, 211-018, and 211-024. The report for 1972 was missing.

only its own technical achievements but remaining silent about its reliance on external assistance. One must refer to WHO or USAID records to learn of the many international donors, for example, France's *Mission d'aide économique et technique* (MAET), USAID, WHO, UNICEF, UNDP, and the Colombo Plan.[29] The seeming reluctance to highlight international assistance contrasts markedly with the Lao PDR period, when the securing of assistance was viewed as an achievement in its own right.[30]

International assistance influenced not only the functioning of the Lao health sector but even its structure. Absence of donor funds could effectively void specific components of national health development plans, while earmarking of funding could steer plans in directions favoured by donors. For example, a National Malaria Department was established when WHO and USAID funds for anti-malaria activities became available in the mid-1950s, and stood vacant when external funding dried up. A National Maternal and Child Health Department appeared during the early stages of the WHO-funded Maternal and Child Health Project in the 1960s. The Head of this new Department was well aware of the tensions involved in a weak administration receiving large volumes of external development assistance:

> Knowing that lack of credibility/trust [on the part of foreign donors] has been a general and persistent problem in all departments of the Ministry, we must count on international and foreign aid for our program's development. At the same time, we must focus our attention on [ensuring] the regularity and consistency of our own available budget. Because the harmonious expansion of a program depends on

[29] WHO, WPR/RC19/3, 1968, p.125.

[30] The RLG Ministry of Health reporting formats closely followed those of the colonial *Assistance médicale au Laos*. It could be argued that during colonial times the source of external assistance was of no importance, as the French Union of Indochina was the only such source. During the Lao PDR period, however, reporting formats highlighted the wide international recognition and support that the regime enjoyed, with the receipt of international development assistance, or cooperation, being evidence of this support.

> the credibility that regularly comes from a well-utilised staff, suitable facilities, and available equipment. Foreign aid that adds to our reputation cannot be well utilised except when it relies on what is locally available and on the development of our Service.[31]

While the US was the RLG's largest donor and Laos was per capita the largest recipient of American aid worldwide in the decade from 1949-1959,[32] France was the most influential bilateral donor to the Ministry of Health. Its involvement shifted from colonial management and implementation to post-colonial technical advice and financial assistance. Health was France's third largest sector of development assistance to Laos from 1955 to 1971, receiving 5.3 percent of its budget, behind education (80.05 percent) and public works (11.31 percent).[33] Assistance flowed through both the MAET and the *Mission militaire française* (MMF). [34] Scholarships for medicine, pharmacy and midwifery studies in France were provided.[35] Moreover, France furnished the majority of international instructors at the Royal School of Medicine, and provided support for medical infrastructure, equipment and supplies, and various teaching materials.[36] The MMF contributed skilled personnel, such as the military doctors who served concurrently as Director-General of Health and advisor to the Minister of Health in the early 1950s prior to appointment of a Lao candidate. French military doctors and nurses served as technical specialists at Mahosot and major provincial hospitals until at least 1973, when 16 French health professionals still served within the Ministry. Over time

[31] LNAD, RLG/MOH, 211-046: Direction du Service national de la PMI, 'Rapport annuel 1968', pp.7-8.
[32] Judith Cousins and Alfred W. McCoy, 'Living it up in Laos. Congressional Testimony on US aid to Laos in the 1950s', in *Laos. War and Revolution*, ed. Nina S. Adams and Alfred W. McCoy, (New York: Harper and Row, 1970), p.340.
[33] Viliam Phraxayavong, *History of Aid*, p.96.
[34] Stuart-Fox, *History of Laos*, p.92.
[35] Viliam Phraxayavong, *History of Aid*, p.55.
[36] Joel M. Halpern, *Laotian Health Problems*, Laos project paper 20, (Amherst, MA: University of Massachusetts, 1961), p.25.

fewer French specialists were based in the provinces, presumably due to the ongoing conflict, and the RLG's increasing concentration of staff and services at Mahosot.[37]

The US government allocated 7.7 percent of its development budget, or USD 33,359,000, to the Lao health sector over the period 1955-75.[38] However, much of this assistance was directed not to the Ministry but to USAID's own parallel health network, discussed later in this chapter. American assistance to the Ministry included funding support for the construction of health infrastructure at Mahosot and in the provinces, as well as equipment and supplies.

More modest assistance was provided by Colombo Plan members, including Japan, and socialist nations. Britain and Japan provided small numbers of medical staff to assist several provincial facilities. During the 1960s, British doctors served in Xayabouly, Salavan, Luang Prabang and Thakhek hospitals.[39] Japan operated a mobile clinic in the Vientiane Plain area, and placed doctors in Savannakhet hospital and at a dispensary on the outskirts of Vientiane.[40] Indian medical teams assisted hospitals in Vientiane and Paksan from 1964-68,[41] and Swiss technical advisors assisted Luang Prabang hospital in the 1970s.[42] Australia and Canada provided modest amounts of medical equipment and supplies, including pharmaceuticals and some scholarships. Assistance from socialist bloc nations such as the Soviet Union

[37] LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.11.
[38] USAID, 'Termination Report, USAID Laos', (Washington DC: USAID, 1976), p.332.
[39] USAID, 'Foreign Assistance to Laos', (Vientiane: USAID, 1969), p.10, and Brown, *At War in Shangri-La*, pp.34, 93-94, 123.
[40] NARA, RG 59, Box 2560: 'Bi-weekly economic review for Laos, No. 6 (March 11-24), 28 March 1960; and LNAD, RLG/MOH, 211-024: 'Rapport annuel …1973', p.11.
[41] USAID, 'Foreign Assistance', p.13.
[42] LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.11.

and Czechoslovakia began in the early 1960s to Souvanna Phouma's neutralist government and then the Second Government of National Union, and generally took the form of scholarships to study medicine in those countries.[43]

The WHO, and to a lesser extent other United Nations agencies such as UNICEF, were the main multilateral donors.[44] WHO archives show that assistance to the Associated States of Indochina, including Laos, was prioritised from 1951, and that funds were allocated to assist the Lao Ministry of Health from 1952.[45] The WHO initially monitored its activities in Laos from Saigon; a country liaison officer was first posted to Laos in 1962, and a WHO country office opened in 1968.[46] Throughout this period WHO assistance was directed only to the RLG, which was a WHO member, and not to the NLHX.[47]

RLG representatives participated in WHO meetings in Geneva and Manila, and regularly served as French-language *rapporteurs* at international conferences, although they were often absent from non-routine meetings and training opportunities. The WHO initiated a number of health development and capacity building projects with the Ministry of Health, including yaws and malaria eradication in the 1950s; maternal and child healthcare and family planning, rural health, and health administration in the 1960s and 1970s; and support to nursing education and development of the Royal Medical School. However, weak government structures and staff capacity posed problems for

[43] USAID, 'Foreign Assistance', p.16.
[44] The Kingdom of Laos joined the WHO on 17 May 1950. See World Health Organization, *Twenty Five Years - Western Pacific Region*, (Manila: WHO, 1973), p.5.
[45] WHO, WPR/RC2, 18-21 September 1951, p.14 and p.79; and WHO, WPR/RC3, 25-30 September 1952, p.13.
[46] WHO, *50 Years Working for Health in the Lao People's Democratic Republic, 1962-2012*, (WHO: Manila, 2013), p.ii.
[47] Despite its rhetoric of neutrality, the WHO assisted South Vietnam rather than North Vietnam, and Taiwan rather than the People's Republic of China during this period.

WHO advisors. A health planning advisor in 1961 cited "… lack of organisational machinery, inadequate coordination between government agencies, the relative unfamiliarity of national staff with the planning process, lack of budgetary and material resources and, in certain instances, internal instability …" as limitations on health development efforts.[48]

The numbers of WHO advisors posted to Laos rose rapidly in the 1960s and 1970s to support the increasing number of WHO development projects, which peaked at 22 in 1973.[49] The organisation's budget for Laos climbed from USD 92,000 in 1966 to USD 251,000 in 1969.[50] Tellingly, WHO reports about its Lao program focus on planned projects and initiatives, but rarely report on actual achievements. A typical paragraph reads:

> In Laos the government ***plans to*** extend the medical services throughout the country, especially in the rural areas, to intensify campaigns against endemo-epidemic and social diseases and to undertake work in the field of urban and rural sanitation. A considerable number of sub-professional workers ***will be required*** and a training area ***will have to be established*** … ***it is hoped to develop*** a general plan for local health service development …[51][my emphasis]

Reporting in this manner suggests that Ministry staff were thinly stretched and unable to fully realise many of the WHO's plans.

The Ministry of Health was assisted not only by bilateral and multilateral donors, but also by international NGOs that fielded technical specialists to work in Lao health facilities. Such specialists often brought additional funding raised from their respective governments or private sources. American Tom Dooley represents perhaps the best-known example of NGO

[48] WHO, WPR/RC15/3, 1964, p.11.
[49] LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.11.
[50] USAID, 'Foreign Assistance', p.5.
[51] WHO, WPR/RC11/3, 1960, p.16.

assistance during this period. The Ministry also received assistance from OB, as well as International Voluntary Services, the Swiss Red Cross, Catholic Relief Services and smaller church groups.

Dooley worked in Laos under the aegis of a small American NGO, Medical International Cooperation Organization (Medico), specifically created for his mission. Despite being a committed Catholic, his work in Laos was motivated not by religion but by anti-communism, or 'freedom' as he termed it. Dooley became a household name in the US, due to his high-profile fundraising efforts and the books he wrote about his work in Laos and Vietnam.[52] His example helped popularise the concept of secular but highly politicised aid work and may have inspired the formation of the Peace Corps.

Dooley and a small team of two to three male ex-navy nurses (corpsmen) worked in rural infirmaries and dispensaries in Vang Vieng, Namtha, Meuang Sing and Houayxay from 1956-60.[53] They supplemented the meagre RLG Ministry staff, provided on-the-job training, and expanded the range and quality of healthcare locally available. Dooley and his team seem to have dominated these facilities, due to their access to funds and supplies beyond the reach of Ministry staff. Therefore, while Dooley talked of the need for sustainability rather than dependence on external technical advisors and funding sources to justify the short-term nature of Medico's assistance to each facility, it is unclear to what extent his organisation contributed to longer-term sustainability.

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[52] See Dooley, *Tom Dooley's Three Great Books*, and James T. Fisher, *Dr. America. The Lives of Thomas A. Dooley, 1927-1961*, (Amherst, MA: University of Massachusetts Press, 1997).
[53] See Halpern, *Laotian Health Problems*, p.27; and Thomas A. Dooley, *The Night They Burned the Mountain*, (Kingswood, Surrey: The World's Work (1913) Ltd, 1962 [1960]), pp.34-36.

Evidently, the US Government was not overly impressed with Dooley or the Dooley Foundation that replaced Medico after his premature death from cancer in 1961. An internal USAID minute from 1969 sums up its general view of the Dooley Foundation:

> They have no doctor at present [in the Khong facility being discussed]. There is a large amount of equipment from the Foundation which is not or cannot be used [presumably because it was in disrepair, unable to be fixed in Laos, incompatible with existing equipment, or unfamiliar to local staff]. Dooley Foundation has been plagued with lack of funds, lack of doctors, lack of administrative capacity, over-extension and over-publicity.[54]

RLG's health network

The number of medical facilities under RLG management more than doubled during the period 1950-75. Biomedical health facilities opened in areas distant from the major towns, although sources reveal little about staffing, supplies or the quality of healthcare services provided. The statistics demonstrate, however, the Ministry's desire to expand biomedicine into rural Laos. In 1950 the health network consisted of six hospitals in the major towns, six smaller *infirmeries-ambulances* in smaller provincial towns such as Salavan and Attapeu, and 64 rural dispensaries.[55] The network began to expand in the 1960s. The number of main hospitals under RLG management remained constant, while the number of *infirmeries-ambulances* more than doubled to 14 in 1966. By 1973 some infirmaries had been upgraded to hospitals, taking the total number of hospitals to 16. The number of rural dispensaries increased at a greater rate, from 64 in 1950 to 106 in 1966 and

[54] NARA, RG 286, Box 1: 'USAID mission to Laos. Executive Staff meeting, Monday December 22, 1969'.
[55] See RSL, Box 12: 'Rapport annuel de 1950', p.7.

148 in 1973.[56] Growth was not incremental, though, as dispensaries opened and closed as territory was gained or lost in the ongoing fighting between RLG and NLHX forces. Nor did growth necessarily correlate with quality of service; visiting a dispensary in Namtha province in the late 1950s, Dooley reported that it had "nothing in the way of medicines, not even aspirins, quinine or adhesive tape".[57]

Figure 4.3 RLG health facilities, 1950, 1966, 1973

Type of Health Facility	1950[1]	1966[1]	1973[1]
Principal hospital	1	1	1
Hospital	5	5	14
Small hospital - Infirmary (*infirmerie-ambulance*)	6	16	8
Health centre	-	-	5
Rural dispensary	64	106	148

Mahosot hospital was the nation's largest and most advanced health facility, even though one observer considered it only "moderately well equipped by western standards" in 1961.[58] Luang Prabang and Pakse hospitals were reported in 1950 to have greater bed capacity, but as RLG development concentrated on Vientiane, Mahosot's capacity rose from 52 in 1950 to 394 in 1973.[59] Moreover, in an important break with the colonial past, the RLG dispensed with the practice of classifying hospital beds for Europeans and natives (*indigènes*). In Vientiane, the Ministry opened specialist health centres

[56] Ibid., insert between p.6 and p.7; LNAD, RLG/MOH, 211-004: 'Rapport statistique de l'Assistance médicale, Anneé 1966', Table L/1, and 211-024: 'Rapport annuel … 1973', p.23.
[57] Dooley, *Three Great Books*, p.234.
[58] Joel M. Halpern, *Laotian Health Statistics*, Laos Project Paper No. 10, (Amherst: University of Massachusetts, 1961), p.4.
[59] See RSL, Box 12: 'Rapport annuel de 1950', p.18; and LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.24.

for tuberculosis, ophthalmology and dermatology. Two villages outside of Luang Prabang and Pakse served as sites for the semi-isolation of people suffering from leprosy, in a continuation from the colonial period. They were often officially referred to as 'leprosaria', although no leprosarium as such was ever built in Laos and treatment could be fairly described as community-based.[60]

Funds to construct and/or upgrade health facilities were provided mainly by international donors. France funded an extension to Luang Prabang hospital in the 1950s and new buildings for the Royal Medical School in Vientiane in the late 1960s.[61] For its part, the US funded a new Nursing School at Mahosot, the Maternal and Child Health Centre in Vientiane, five Maternal and Child Health wings in provincial hospitals, and the renovation of similar wings in an additional ten sites.[62] Martin Stuart-Fox concludes that hospital construction was one of the success stories of USAID's assistance to the RLG.[63]

RLG health staffing, Lao and international

As health facilities increased, so did the number and professional diversity of health workers at all levels. Lao staff with high-level qualifications were in most demand to manage the various departments of the Ministry, provide technical guidance, and work with the mounting number of international donors. However, while management roles were allocated to

[60] LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.24.
[61] USAID, 'Foreign Assistance', p.7.
[62] USAID, Report of Audit of Maternal and Child Health Project No. 439-11-570-081, March 31, 1969 to March 31, 1971 (Laos Program), p.2.
[63] Stuart-Fox, *History of Laos*, p.154.

national staff, foreigners continued to play important roles in both training and healthcare provision, as sufficient Lao staff could not be produced fast enough.

For the most part, Lao staff were clustered in the middle and lower ranks of the professional hierarchy, due to the continuing low completion rates within the formal education sector. They were employed as assistant doctors (termed *médecins assistants* since independence rather than *médecins indochinois*) [64] and nurses, and from the mid-1960s also as assistant pharmacists, assistant dentists and laboratory technicians. In the meantime, international doctors, pharmacists and dental surgeons continued to supplement the few qualified Lao at the higher levels. The overall number of trained staff in the Ministry of Health increased more than six-fold between 1950 and 1973, from 260 to 1,644, or 2,514 if one includes staff employed in the military's medical service, and expanded to include a much wider selection of health-related professions.[65]

The transition to a reliance on Lao doctors was slow due to the employment choices of medical graduates. It was reported that in 1968 two-thirds of qualified Lao doctors remained overseas, rather than returning home.[66] Of those who returned, many opted to join the military rather than the Ministry of Health, possibly attracted by the higher salaries and symptomatic of the pressure exacted by the long-running conflict on civilian services. An American report from 1971 states: "With only 36 Laotian doctors in the

[64] Lao government documentation rarely mentions *médecins indochinois* after the mid-1960s, despite some colonial-trained doctors remaining in the workforce. Both *médecins indochinois* and *médecins assistants* involved similar training content and duration, but the former seem to have been accorded higher status, possibly due to their seniority in the workplace.
[65] RSL, Box 12: 'Rapport annuel de 1950', p.6; and LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973,' p.4. No reports for the years 1974 or 1975, during the period of the PGNU, were available for consultation.
[66] USAID, 'Termination Report', p.162.

country [a veiled allusion to those remaining abroad], 17 are in the military and the remaining 19 work as administrators in the RLG government and supplement their income with private practices in Vientiane".[67]

With few fully qualified Lao doctors, a high attrition rate [to the military and overseas] and constantly increasing staffing demands, the Ministry of Health relied heavily on international doctors and Lao assistant doctors. It employed significantly more assistant doctors than fully qualified doctors, who were assigned roles and responsibilities similar to those of doctors in other countries. Provincial hospitals and outreach services typically made do with assistant doctors, as fully qualified doctors were rarely assigned outside Vientiane. USAID was highly critical of this Ministry practice. The narrative of an internal USAID document from 1975 hits out at the urban concentration of the RLG health services:

> For many years the cooperating country's [Laos'] efforts and interests could be categorized as "passive". The Lao health officials were content enough to have USAID and OB do the hard (and sometimes dangerous) work in the countryside while the doctor leaders focused on Mahosot hospital … and a few urban centers.[68]

Expansion also occurred in other professional categories. True to its French foundations, the Ministry privileged midwives over nurses. At independence, there was already one Lao registered midwife (*sage-femme d'état*) who had trained in France. Additional graduates returned from France in the 1950s and Saigon in the 1960s. From the late 1960s the Ministry employed auxiliary midwives with two years of Lao-based training, and from the early 1970s, a new auxiliary nurse/midwife was introduced to "provide

[67] NARA, RG 286, Box 2: 'Draft GAO Report. Medical section', November 1971, Chapter 1, p.3.
[68] USAID, 'Project Appraisal Report, VHP, 12 July 1973 to 20 July 1975', p.2.

primary health care with emphasis on MCH and Family Planning at the peripheral level".[69] At the bottom of the hierarchy were rural birth attendants (*accoucheuses rurales*), who provided basic assistance in their own localities. Despite their privileged position, the numbers of midwives increased more slowly than assistant doctors or nurses because, as in the colonial period, the low female education rates nation-wide presented a major obstacle to entry into professional training programs.

By contrast, the nursing cadre increased significantly, as it had the lowest educational entry prerequisite (completion of primary school). The RLG's civilian nurses increased almost four-fold, from 220 in 1950 to 801 general nurses and 29 registered nurses in 1973.[70] Two developments in the nursing profession are noteworthy during this period. Firstly, the upgrading of nursing to a profession and the introduction of auxiliary and registered nurses offered an element of career progression. Secondly, the proportion of female nurses rose steeply from 23 percent in 1950 to 70 percent in 1959, a significant increase possibly hastened by the number of male nurses electing to join the military health service.[71]

While staff numbers increased, the quality of Lao medical staff, notably the colonially-trained *médecins indochinois*, was criticised repeatedly in the 1950s. Médecin-Colonel Benoit, Director-General of Health for Laos in 1951, commented that few of the *médecins indochinois* were of much value,[72] while Oden Meeker, from the American NGO CARE, dismissed them as

[69] WHO, WPR/RC25/3, 1974, p.14.
[70] LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.4.
[71] RSL, Box 12: 'Rapport annuel de 1950', p.6 ; and NARA, RG 59, Box 4601: 'Health: Lao Government Hospital and Medical Personnel Facilities [sic] in Laos as of June 30, 1959', 13 August 1959.
[72] RSL, Box 12: 'Rapport annuel de 1950', p.16.

"often little more than glorified dressers [of wounds] and compounders [of prescriptions]".[73] Joel Halpern alludes to a possible scandal involving senior staff, which may explain the strong views, when he confides: "Several Lao doctors trained in Indochina have been accused of embezzling funds, selling medicines and not bothering to give conscientious treatment to their patients".[74] Criticisms were also directed at the strict observance of hierarchy within the Ministry, presumably at the expense of service delivery.[75]

The shortage of qualified Lao health staff proved to be an ongoing issue for the Ministry as well as international agencies, despite the real staff increases during the period. For instance, WHO reported that in one of its projects its technical advisors "mainly performed operational duties" due to the "shortages of national counterpart staff".[76] Put simply, the advisors had no staff to advise. Situations like this were a key reason why international staff continued to play a major role in the health sector after independence.

International doctors outnumbered Lao doctors in the RLG zone for most of this period, as did international registered nurses. The tiny numbers of Lao pharmacists and dental surgeons were also supplemented with internationals. Ironically, there were as many French medical staff in Laos after independence as there were at the end of the colonial period.[77] French military rotations, however, ensured a frequent turnover of staff, and the unlikelihood of a group of 'old timers' establishing themselves.

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[73] Oden Meeker, *The Little World of Laos*, (New York: Charles Scribner's Sons, 1959), p.36.
[74] Halpern, *Laotian Health Statistics*, p.4.
[75] USAID, 'Termination Report,' p.162.
[76] WHO, WPR/RC19/3, [1968], p.124.
[77] The AML annual report for 1950 records 14 French military doctors were stationed in Laos. By 1958, their numbers had declined to 13, and in 1973 there were seven French doctors, six nurses and one dental surgeon. See RSL, Box 12: 'Rapport annuel de 1950', p.5; Halpern, *Laotian Health Statistics*, p.4; and LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.11.

Figure 4.4 RLG Ministry of Health staff by profession, 1950, 1966, 1973[78]

Profession	1950[79]	1966[80]	1973[81]
Doctor	1	8	36
Assistant doctor	22 (24)[82]	33	102
Pharmacist	-	2	6
Assistant pharmacist	-	2	9
Dental surgeon	-	1	1
Assistant dental surgeon	-	-	11
Registered midwife	1	15	23
Auxiliary midwife	4	9	178
Registered nurse	-	-	29
Auxiliary nurse	-	505	801
Basic nurse	220	-	-
Laboratory technician	-	4	1
Assistant laboratory technician	-	18	27
Radiologist	-	-	1
Radiologist aide	-	3	11
Public health worker	-	22	42
Anti-malaria technician	-	65	88

The high proportion of international advisors working within the Ministry, and the project funds accompanying them, created a delicate situation that at times resembled the power relations of the colonial period. By the 1970s, the extent of foreign involvement and particularly the high level of international staffing seems to have become more sensitive for the Ministry of

[78] These figures do not include staff employed by the Royal Lao Army, Operation Brotherhood, USAID or the NLHX's Central Health Committee.
[79] RSL, Box 12: 'Rapport annuel de 1950', p.6.
[80] LNAD, RLG/MOH, 211-004: 'Rapport statistique … 1966', Table P/5.
[81] LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.4.
[82] RSL, Box 12: 'Rapport annuel de 1950', pp.6, 17. The figures for Lao health staff at the level of *médecin indochinois* and *médecin assistant* are not consistent between the Table on p.6 and the list on p.17.

Health, as staffing demographics became a regular feature of annual statistical reporting. From 1970, the Ministry made overt efforts to show that the number of Lao staff outnumbered foreigners. It boosted the proportion of Lao doctors by statistically combining the numbers of civilian and military doctors, and merging the professional classifications of doctor and assistant doctor.[83] This sensitivity is likely to have been linked more to the control rather than receipt of international assistance. For example, the opportunity to claim more decision-making power and control of international funds may be expected to increase once Lao doctors, or a combination of doctors and *médecins assistants,* could be shown to outnumber international doctors.

Finally, a dramatic change can be observed in geographical staff distribution between the colonial and post-colonial periods, with a heavy concentration of doctors and assistant doctors congregating in Vientiane almost immediately after independence. For most of the colonial period French authorities assigned senior French doctors and Lao *médecins indochinois*, including princes, to manage provincial *infirmeries-ambulances*, even rural dispensaries, for years at a time while Vientiane had no more than two or three more doctors than provincial locations at any time.

From 1950 doctors and *médecins assistants* appear to have been extremely reluctant to serve outside of Vientiane. Seven of the 11 *médecins assistants* who joined the Lao Health Service in 1950 remained in Vientiane. In 1966, seven doctors, four assistant doctors, and an assistant pharmacist were based at Mahosot, and an additional four assistant doctors were assigned to public health functions in Vientiane. By contrast, each province was

[83] LNAD, RLG/MOH, 211-017: 'Rapport annuel des statistiques sanitaires, 1970,'Table P/9.

allocated one *médecin indochinois* and at most two *médecins assistants*.[84] By 1973 a staggering 87.5 percent of all Lao doctors (civilian and military) in government service and 61 percent of all *médecins assistants* were based in Vientiane.[85] The government appears to have been unable to encourage its own staff to work in smaller provinces or rural locations, possibly due to the strong, elite social networks which operated within the Ministry. This compromised its ability to provide healthcare to the rural population, elicited criticism from USAID concerning the Ministry's "relative indifference to the health problems in remote areas", and was undoubtedly a motivating factor for USAID to establish a parallel network of rural health facilities.[86]

The range of professional training on offer in-country expanded considerably from the basic nursing and midwifery training available in the colonial period. Training for assistant doctors became available in 1957-1958, followed by courses for assistant dental surgeons, assistant pharmacists, and auxiliary nurses in the 1960s. Curricula for fully qualified doctors, registered nurses and registered midwives were introduced in 1969. However, professional training for fully qualified pharmacists and dental surgeons remained unavailable until after 1975. Moreover, places were limited. Therefore, many Lao students continued to study abroad. Most scholarships in the 1950s were provided by the RLG, the French government and the WHO. The recipients of RLG and French scholarships tended to study in France,[87]

[84] LNAD, RLG/MOH, 211-004: 'Rapport statistique … 1966', Table P/2.
[85] LNAD, RLG/MOH, 211-024: 'Rapport annuel … 1973', p.7.
[86] USAID, 'Termination Report', p.165.
[87] LNAD, RLG/MOH, 211-004: Rapport statistique … 1966,' Table P/8; and Khamphao Phonekeo, 'Les recherches sur la géographie du Laos', in *Les Recherches en Sciences Humaines sur le Laos, Actes de la conférence international organiseé à Vientiane, 7-10 décembre 1993*, ed. Pierre-Bernard Lafont, (Paris: Publications du Centre d'Histoire et Civilisations de la Peninsule Indochinoise, 1994), p.29.

whereas the majority of WHO scholarship recipients studied at the French-language Royal School of Medicine in Phnom Penh. WHO records highlight that Laos was the only country in the Western Pacific Region to receive WHO scholarships for overseas undergraduate medical study.[88] Doctors, and small numbers of registered midwives, pharmacists and dental surgeons studied in France, whereas assistant doctors and assistant dental surgeons studied in Cambodia. By the late 1960s three nurses had trained as instructors in Canada and Australia.[89]

The first generation of fully qualified Lao doctors studied in France. Tiao Jaisvasd Visoutthiphong was the exception, pursuing his studies in Thailand in the 1950s.[90] The sites for overseas medical training opened up from the 1960s as more international donors provided scholarships. By 1966, Lao medical students were scattered across seven countries: France (the majority), Soviet Union, Thailand, Czechoslovakia, Australia, Canada and Japan. In addition, there were nine pharmacy students and two dental surgery students in France, six dental students in Phnom Penh, five midwifery students in Saigon, and ten nursing students in Thailand.[91] This marked the beginnings of a diverse, patchwork health sector that was to diversify even further after the change of regime in 1975. However, during the RLG period, France was the preferred destination for high-level medical education, and French the predominant language of instruction.

Medical training commenced at the newly opened Royal School of Medicine in Vientiane from 1957-58, under the direction of Frenchman, Dr

[88] WHO, WPR/RC4/2, 1953, p.19 and WPR/RC5/2 1954, p.20.
[89] WHO, WPR/RC26/4, 1975, p.17.
[90] Dr Tiao Jaisvasd, interviewed in Torcy, France, 2 December 2012.
[91] LNAD, RLG/MOH, 211-004: 'Rapport statistique … 1966,'Table P/8.

Laigret.[92] The school received technical and financial assistance from the French government and WHO, which provided equipment and many of the teachers. In the early 1960s, France provided 12 instructors: five from its MAET budget and seven from the MMF budget.[93] WHO faced difficulty recruiting suitable instructors when the medical school upgraded to the Medical Faculty of the Sisavangvong University in the late 1960s because international medical professionals were unwilling to work in Laos, just as they had been in the colonial period. A WHO report from 1968 lamented: "The only assistance which it has been possible to give throughout the past year was the services of a 3-week consultant in preventative and social medicine".[94] Other teaching positions remained vacant.

Initially the medical school offered only a four-year course for *médecins assistants*, due to the limited amount of budget, teachers and students. Classes commenced in January 1958 with seven students, who graduated in 1961.[95] By the 1960s, the average class size settled at around 30 students. Of note, the gender distribution in 1959 was reported to be equal.[96] Curricula for assistant dental surgeons and assistant pharmacists were added in 1965 and 1966 respectively.[97] Courses in nursing and midwifery at the

[92] The Ministry of Health and the University of Health Sciences (UHS) celebrated the 55th anniversary of the medical school in November 2013, despite Khamsone Sassady and WHO stating the school opened in 1957. It is unclear how the Ministry and UHS selected the date of the celebrations. One response I received suggested that management took a consensus decision, rather than consulting historical sources. See Khamsone Sassady, 'Contribution à l'étude', p.113; WHO, WP/RC16/5, 1965, p.57; and the University of Health Sciences' pamphlet, 'Saleum salong khop hob 55 pii khong kane-sangtang hong hian phet' (55th anniversary celebrations of the establishment of the medical school), (Vientiane: UHS, 2013).
[93] Khamsone Sassady, 'Contribution à l'étude', pp.122-123.
[94] WHO, WPR/RC19/3, 1968, p.64.
[95] Khamsone Sassady, 'Contribution à l'étude', pp.124-126.
[96] RLG/Ministry of Education and UNESCO, 'Education in Laos: Report of the UNESCO Mission', undated, cited in Joel M. Halpern, *Government, Politics and Social Structure in Laos. A Study of Tradition and Innovation*, (New Haven: Yale University, 1964), p.192.
[97] Mathurin and Fontan, 'Médecine au Laos', p.647.

Mahosot-based Nursing and Midwifery schools were upgraded in the 1960s with WHO assistance, as part of the Maternal and Child Healthcare and Nursing Education projects. The gradual introduction of various courses, starting at assistant-level, made sense in the low-resource context of limited funding, few Lao with sufficient teaching qualifications and few eligible students.[98]

In October 1969 the first cohort of 25 students embarked on a seven-year *doctorat en médecine* course at the medical school.[99] Former RLG Minister of Health, Khamphaï Abhay reflects that this event, the localisation of professional-level medical training, was among the key contributions of his career. Dr Som-Ock Kingsada, now a Vice Minister in the Ministry of Health, graduated in this first cohort and is reportedly the only member of his class remaining in the Lao PDR. Cohorts in subsequent years numbered approximately 20.[100]

Prior to the opening of the Royal School of Medicine, the only health training institutions in Laos were the Practical Nursing School and the Midwifery School at Mahosot. These schools taught six-month and two-year courses respectively. Rural birth attendants completed six-months of on-the-job training at a provincial hospital before returning to work in their home

[98] Bruce Lockhart, 'Education in Laos in Historical Perspective', unpublished paper, 2001, p.9.
[99] WHO, WPR/RC21/4, 1970, p.55; and Manivanh Souphanthong, 'Kane seuksa phetsard thi mahavitthayalay vitthayasat soukhaphapsard vivatthanakane 55 pii pheua pitouphoum khong bouangxon lao' (Medical education at the University of Health Sciences, 55 years of service to the Lao people), in *Peumbotkhatyo botthopthouan vixakane Kongpaxoum vitthayasard saleum salong van-sang-tang honghianphed khob-hob 55 pii*,(Abstracts for the Scientific Conference to celebrate the 55th anniversary of the establishment of the Medical School), 30 October 2013, p.140.
[100] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk you kongpasoum-ngay khang thi I tae 1 ha 12 toula 1979', (Draft Report on the Health Situation for the First Conference of Health from 1-12 October 1979), p.4.

villages.[101] In-country training expanded significantly with the establishment of auxiliary nursing and midwifery schools in the mid-1960s in Luang Prabang, Savannakhet and Pakse, with assistance from WHO, which offered two-year courses for auxiliary nurses and auxiliary midwives. A three-year course for registered nurses was added to the nursing school in Vientiane in 1969. However, the quality of the nursing school, specifically the lack of qualified local teaching staff, was criticised by USAID advisors.[102]

Despite operating a separate health network, USAID and OB offered summer internships in their hospitals for medical students, and short-term training overseas for Ministry staff. Training opportunities in Thailand and the Philippines proved unpopular, however, as Ministry staff perceived training in France to be superior. USAID also had difficulty recruiting sufficient numbers of appropriately qualified training candidates. Plans for 90 chief ward nurses to undergo short-term training were cut short due to the "lack of suitable candidates".[103]

Major projects supporting the RLG health service

Many of Laos' health developments during this period were enabled by internationally-funded development assistance projects, including yaws eradication, malaria eradication, maternal and child health, and nursing education. The WHO-supported yaws eradication project in three southern provinces began in 1953.[104] It claimed to have reached approximately 94

[101] Anonymous, *Laos. 1950*, p.100.
[102] USAID,'Termination Report', p.162.
[103] Ibid.
[104] Yaws, or endemic treponematosis (*pian* in French; *khi moh* in Lao) is: "a chronic infection that affects mainly skin, bone and cartilage. It is caused by a bacterium related to the one that causes venereal syphilis. However, yaws is an infection transmitted mainly through skin

percent of the population in the project area. Project activities were undoubtedly successful, but WHO overstated its achievements in claiming to have taken "medical care to many remote areas for the first time," when in fact the project was preceded by 60 years of activity by the colonial AML.[105] The field-based project concluded in 1959, and evolved into a laboratory support project which continued until 1975.[106] A visit by a WHO monitoring team in 1965 noted the limitations in the Ministry of Health's capacity for continuation of activities promoted by the project. Re-surveys had not been feasible since project end, due to the withdrawal of WHO's project staff, and the RLG's "limitation in personnel and the demands of other health problems".[107]

A six-year regional project in malaria eradication, co-funded by WHO and the USOM, began in 1956 to address what continued to be cited as the leading health issue in Laos. [108] In 1957, malaria accounted for 73.6 percent of all hospitalised cases, as well as 35.4 percent of hospital deaths.[109] The malaria project relied heavily on technical advisors from the US and Thailand. It facilitated the establishment of the National Service for Malaria Eradication, and a number of provincial field stations. Like the yaws project, it required a large contingent of local field technicians, and some quite possibly transferred from the yaws project to the malaria project.[110] DDT spraying commenced in southern Laos in 1957 and in the north in 1959. By then, the program claimed to have coverage of almost half the total population. However, the Ministry

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contact with an infected person. It is rarely encountered in Laos any more, due to the successful eradication program of the 1950s. See WHO, *50 Years Working*, p.5.

[105] WHO, WPR/RC10/2, 1959, p.40.

[106] WHO, *50 Years Working*, p.6.

[107] WHO, WPR/RC16/5, 1965, p.86.

[108] RSL, Box 12: 'Rapport annuel de 1950', p.29; LeBar and Suddard, *Laos*, p.179, and Laura Watson, 'Lao Malaria Review,' unpublished paper, 1999.

[109] RLG/MOH, *Bulletin statistique du Laos*, No. 4, 1958, p.82, cited in Halpern, *Laotian Health Statistics*, p.4.

[110] Halpern, *Laotian Health Problems*, p.24.

was unable to sustain the activity and spraying ceased in 1961, coinciding with the end of American funding and increasing rural insecurity issues.[111] A second WHO-supported malaria project, which also included DDT spraying, was initiated in 1969 in pilot sites around the Nam Ngum dam construction site, and in refugee camps on the Vientiane Plain.[112] After 1973, the project expanded into a National Malaria Program with the support of the PGNU, and some former USAID medics were retrained to join the project.[113]

The commencement of a Maternal and Child Health (MCH) project in 1959 marked a different type of development engagement, because it required long-term education and behaviour change rather than the more straight-forward vaccination or spraying campaigns. The project, which extended until 1976 with only a short hiatus in 1970 when the project brief was refocused towards the promotion of family planning, aimed to develop an effective MCH service as an integral part of Laos' general health program.[114] The project was complemented with a Nursing Education project from 1962. It supported the establishment of a National MCH Service in 1960, followed by a National MCH Centre which collaborated with the maternity and pediatric wards at Mahosot.[115] MCH centres were progressively opened at the larger provincial hospitals.[116] The provincial MCH centres and maternity wings were constructed by USAID, and supported by four auxiliary nursing and midwifery schools in major towns. Vaccination rounds, a high-profile activity in the colonial period, became less of a feature and more of a routine activity

[111] Watson, 'Lao Malaria Review', p.17.
[112] WHO, *50 Years Working*, p.12.
[113] USAID, 'Termination Report', pp.167-168.
[114] WHO, WPR/RC21/4, 1970, p.90.
[115] WHO, WPR/RC11/3, 1959, p.100; and WHO, WPR/RC21/4, 1970, p.91.
[116] LNAD, RLG/MOH, 211-027: Service national de PMI, 'Rapport annuel 1969,' p.7.

integrated into a more comprehensive set of basic rural healthcare services, alongside MCH services.

WHO's redesigned MCH project, which from 1970 became the Family Health and MCH project, promoted contraception. It complemented the USAID-supported MCH and Family Planning project with a familiar division of labour: USAID handled infrastructure development, while WHO provided staff training for the Ministry's MCH and family planning personnel. However, the USAID project also supported the establishment of 13 small family planning clinics operated by the Lao Family Welfare Association (LFWA), a local NGO affiliate of the International Planned Parenthood Federation.[117] Contraceptive use gained popularity in areas surrounding Vientiane and some provincial locations in the six years it was available, although overall numbers were modest and statisticians found errors in the LPWA's reporting of the number of users, or 'acceptors'.[118]

The conditions in RLG hospitals were quite basic, and international assistance seemed to skim over the surface. Before the proliferation of international assistance, Halpern observed of Luang Prabang, the second largest hospital in Laos, that "sanitation and antiseptic practice is in most cases fairly minimal. Some French claim this is because they can no longer give orders that needles be sterilized and floors scrubbed. The Lao officials are considerably more casual about these matters …."[119] Several years after the commencement of WHO's first projects, an American advisor working in the pediatric ward at Mahosot hospital during 1962-1964 recalls:

[117] USAID, 'Termination Report', p.108.
[118] Ibid., p.113.
[119] Halpern, *Laotian Health Problems*, p.29.

> The *Salle de Pediatrie* had no running water or reliable electricity. The ward was always overcrowded except occasionally when a family member of a patient identified a "*Phi Pop*" [a kind of malevolent spirit], and all patients would flee. It was routine to see sharp knives poking between crib slats to ward off bad spirits. We were always short of medications and medical supplies such as IV fluids. Many children died from measles, pertussis, diphtheria, dysentery and malaria.[120]

WHO also piloted a Rural Development in Public Health Project from 1961 to 1967, in cooperation with a larger rural development project implemented by the UN, UNICEF, UNESCO, International Labour Organization, Food and Agriculture Organization and the Colombo Plan. Efforts were made to improve the quality of public healthcare (now more commonly termed primary health care) provided by rural dispensaries, and WHO nurses and public health advisors stationed there performed health education, especially home sanitation, nutrition promotion, and MCH care. However, the ongoing political conflict in Laos "limited project activities and delayed the signature of an overall agreement".[121] Therefore, rather than expand into more remote areas, the project contracted into a series of peri-urban community health centres in the area immediately surrounding Vientiane in the early 1970s.[122]

The emergence of a private health sector

In addition to its own practice, the Ministry of Health regulated a private health sector, which emerged in the first decade of independence and grew rapidly. It comprised a range of medical clinics, dental surgeries and

[120] Dr Karen Olness, interviewed by email, 6 July 2013.
[121] WHO, 'WPR/RC13/2', 1962, p.14.
[122] See Richard Pottier, *Santé et Société au Laos (1973-1978)*, (Paris: Comité pour la Coopération avec le Laos, 2004).

pharmacies, heavily concentrated in Vientiane. Interestingly, the Ministry's sphere of regulation appears to have expanded to traditional medicine consultations and treatments, judging by the nature of approvals issued.

The *Journal Officiel du Royaume du Laos*, the government's official gazette, listed approvals to operate private medical clinics, pharmacies and dental clinics in the 1950s. Doctors, assistant doctors, and dentists, applied to open clinics and/or to treat patients privately, while nurses and merchants applied to open pharmacies. Some pharmacy applicants also requested permission to produce medicines. Medicines were classified as French, Lao, Chinese, Siamese, and Sino-Annamite.[123]

In 1957-1958, the journal lists the approval of 11 licences for private medical clinics and another 40 for dental clinics and pharmacies mainly in Vientiane, but also in provincial capitals.[124] Four years later, Khamsone Sassady reported a total of 14 private medical practitioners, of whom ten were Lao, three French, and one Vietnamese.[125] By 1973, numbers had risen to 106 private practitioners nation-wide, 87 percent of whom were located in Vientiane.[126] Chinese were strongly represented in dental and pharmaceutical businesses.[127] In a break from the colonial past, there appears to have been no requirement to serve in the government health services for a minimum length of time before applying for a licence to operate privately, as two *médecins assistants* applied for licences in 1958 while still Ministry interns.[128]

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[123] *Journal Officiel du Royaume du Laos* (JORL), 1957-1958, 1957 and 1958.
[124] Ibid.
[125] Khamsone Sassady, 'Contribution à l'étude', p.111.
[126] LNAD, RLG/MOH, 211-024: 'Rapport annuel …1973', p.30.
[127] NARA, RG 59, Box 4598: 'Chinese Business Concerns in Vientiane, Laos', 19 February 1959.
[128] Extrait Arrêté 494/SP, cited in JORL, 1958, p.1574.

Lao and foreign commentators alike considered that the private sector placed pressure on the existing health service; the relationship between the two was effectively a zero-sum game. Khamsone Sassady observed in the early 1960s that the Lao director of studies at the Royal School of Medicine was juggling his responsibilities between the school, the main hospital and his private practice.[129] Several years later, USAID officials commented in seeming frustration that most Lao doctors "devoted 80% or more of their time to private practice."[130] NLHX and later Lao PDR propaganda accused private doctors of "exploiting the population" by charging for services, though fees were not necessarily exorbitant.[131] In a country with few doctors, and a large proportion of poor people who could not afford private medicine, this situation posed an awkward problem.

The USAID-Operation Brotherhood (OB) health service

USAID, the international development agency of the US government, created a health service that functioned in parallel to the RLG's service. It came about due to the US' consideration of the "failings of the RLG in every field – economic, political and military," which prompted its direct intervention.[132] Funded by USAID's Public Health Division, this health service comprised facilities operated by the Filipino NGO Operation Brotherhood (OB), and others operated by USAID itself. It was managed by USAID's Chief of Public Health Division under the Village Health Program

[129] Khamsone Sassady, 'Contribution à l'étude', p.121.
[130] USAID, 'Termination Report', p.162.
[131] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk', pp.2-3.
[132] Fred Branfman, 'Presidential War in Laos, 1964-1970', in *Laos: War and Revolution*, ed. Nina S. Adams and Alfred. W. McCoy (New York: Harper and Row, 1970), p.230.

(VHP).[133] The program almost matched the Ministry of Health in terms of the numbers of health facilities, Lao staff, and patients. However, it was based on American-style healthcare, used English rather than French as its working language, trained and employed local staff with at times minimal formal education, and strived to provide services in the more remote and ethnic minority-populated areas, which were of strategic significance to the US.

As the war developed, VHP activities shifted from a focus on the health of military and para-military combatants to the large refugee populations caused by relentless bombing and land battles. This chapter does not address the American financial and technical assistance to military health facilities such as Sisavangvong Hospital (now known as Hospital 103), as many relevant sources remain classified. It is also unclear to what extent the military and civilian health services intersected.[134]

The VHP consisted of two components: the OB project, which supported a rural hospital network run by OB under contract to USAID, and a network of rural dispensaries and some hospitals established and directly operated by USAID. The Maternal and Child Health and Family Planning Project was added to the USAID Division of Public Health portfolio in 1969, and a Narcotics Detoxification Project in 1971.[135] The MCH project, mentioned earlier, promoted the use of contraception and funded improvements in MCH infrastructure in both OB and RLG health facilities.

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[133] Weldon, *Tragedy in Paradise*. Charles Weldon was Chief of USAID's Public Health Division in Laos from 1963-74.

[134] Sisavangvong military hospital began operating in 1969. In January 1971, the US government considered sending a medical assistance team to work at the hospital. See NARA, RG 286, Box 8: 'Hospital Services for FAR/FAN', US government memo, 4 November 1970.

[135] USAID, 'Termination Report', pp.103-120, 129-156.

The USAID-OB health service began to take shape in the late 1950s. It was formalised in 1963 when USAID redesigned its program of development assistance to Laos. Assistance ended abruptly in June 1975, a month after anti-American elements within the PGNU ordered USAID to depart. Looking back, USAID's 'Termination Report for Laos' explained the initial rationale for establishing the VHP as providing immediate medical assistance to areas disrupted by war, compounded by:

> … the inability of the RLG through its rudimentary civilian health services to provide medical care and health support to areas disrupted by the insurgency; the near complete lack of an effective field military medical organization … and the … Geneva Accords which precluded U.S. military assistance to the health field.[136]

A 1955 field trip by USOM officials based in Vientiane had confirmed the almost non-existent reach of RLG services into the countryside. A cable to Washington stated:

> Most popular items were the medical supplies, and it was obvious that the people had not received any (rpt. Any) for years. This first aid station at Vang Vieng … had only fifty diarrhea pills in its entire stock. This is particularly shocking in view of the large stocks of medical supplies in Vientiane.[137]

USAID's VHP was funded entirely by the US government, although it likely had multiple government funding agencies. What attracted attention, and in some instances criticism, was the difficulty in identifying these agencies. As Castle's study has shown, it was not uncommon for USAID projects in Laos to be co-funded by the Department of Defense and/or the

[136] Ibid., p.157.
[137] NARA, RG 59, Box 4601: 'Transmitting USOM Report on Trip up Luang Prabang Road', 5 December 1955.

CIA.[138] A 1971 USAID document specifically mentioned that "DOD-[Department of Defense] financed medical care for Lao civilians on behalf of USAID."[139] Moreover, during the 1971-72 enquiry of the US Government Accounting Office (GAO), it was disclosed that the OB contract was partly funded by the CIA: "The costs of the Operation Brotherhood Project since its inception in 1963 have been borne by USAID/Laos. Starting in fiscal year 1972 the CIA is sharing these costs based on a predetermined formula".[140] Castle cites high-ranking USAID officials describing USAID's operations in Laos as "unprecedented" and "unique".[141] While the cost-sharing arrangements investigated by the GAO focused on the political processes behind the provision of medical assistance, there is no evidence that partial funding of the OB contract by the CIA or Defense distorted in any way the quality of medical care provided.

OB worked in Laos from 1957-1975; from 1963 it was an integral part of USAID's Public Health Program. Under the banner of 'Asians helping Asians', it transferred from the refugee camps of South Vietnam to Laos in 1957, where its focus evolved from emergency relief to longer-term healthcare training, service provision, and community development.[142] Its medical and community development teams made a significant impression on the local

[138] Castle, *In the Shadow*, p.105.
[139] NARA, RG 286, Box 1: Letter to Hon. Melvin R. Laird, US Secretary of Defense, from John A. Hannah, Administrator of USAID, 19 April 1971.
[140] NARA, RG 286, Box 2: 'Draft GAO Report. Medical section', November 1971, chapter 4, p.2.
[141] Castle, *In the Shadow*, pp.59, 99.
[142] The cover of Bernad, *Filipinos in Laos*, describes OB's work in Laos as an "Asian People Partnership".

population, and the term *moh filipin* (Filipino doctor) was almost a tautology in 1960s' Laos.[143]

OB operated multiple health facilities in rural Laos. Initially, its teams worked from RLG dispensaries and small hospitals (*infirmeries*), as Dooley had also done, in locations that had experienced some level of healthcare during the colonial period. These sites (termed 'stations' by OB) tended to be in smaller provincial towns or army garrisons, with which OB coordinated closely. In the early 1960s, OB began to build and operate its own facilities, such as its hospital in Vientiane, known since the early 1970s as Setthathirath Hospital, which served as a teaching and referral hospital for the USAID-OB health service. Altogether, OB established a long-term presence in seven locations, and made shorter-term contributions in another 12 locations.[144] Additionally, OB teams supervised and supported rural dispensaries in the areas surrounding its hospitals.

From 1967, USAID instructed OB to begin a phased transfer of administrative and financial responsibility for its facilities to the Ministry of Health. The transfer proved problematic due to the RLG's insufficient funds and staffing levels. The GAO team visiting in 1971 observed: "The administrative function of the hospitals was transferred to the RLG, on paper, in 1967, however the Filipino personnel actually operate the hospitals".[145] The

[143] A letter from the Philippines Ambassador to Lao PDR, to Mekong Circle International (a voluntary organisation established by former OB staff and other Filipinos who had worked in Laos pre-1975) emphasised the positive impression their work had created among Lao people. She stated the OB legacy had opened doors for her mission almost 40 years after their departure from Laos. See Mekong Circle International's newsletter, February 2013.
[144] For OB's work from 1956-60, see Bernad, *Filipinos in Laos*. OB's work from 1963-75 is discussed in Weldon, *Tragedy in Paradise*, pp.42-50.
[145] NARA, RG 286, Box 2: 'Draft GAO Report. Medical section', chapter 2, p.8.

deadline for transfer was extended until 1975 because of RLG resource limitations.

Figure 4.5 Operation Brotherhood (OB) stations in Laos, 1957-1975[146]

Number	Station name	Date of operations
1	Vientiane	1957-1975
2	Paksong	1957-1972
3	Nhommalath	1957
4	Meuang Xay (Muong Xai)	1957-1959
5	Xieng Khouang	1957
6	Ban Ban	1957-1960
7	Nam Bak (Nam Bac)	1957-1959 [?]
8	Thakhek	1957-1960
9	Attapeu (Attopeu)	1957-1968
10	Xam Neua	1958-1959; 1959-1960
11	Xieng Ngeun	1958-1959
12	Phongsaly	1959
13	Xayabouly (Sayaboury)	1959-1975
14	Kengkok	1964-1975
15	Vang Vieng	1964-1975
16	Salavan	1965-1968
17	Khong Sedone/Vapi	[??]- 1972
18	Pakse	1968-1975
19	Houayxay (Houei Xai)	1969-1975

USAID's health facilities were based in remote rural locations chosen for their strategic importance in the escalating conflict. Often, these sites had had no previous biomedical healthcare service provided by either the AML or the RLG. Many of the USAID facilities were accessible only by air or on foot, given the poor state of road transport and the ongoing fighting, which added considerably to the cost of replenishing supplies and supporting services. USAID operated fewer hospital-level facilities than OB, but considerably more dispensaries. The number of USAID dispensaries varied from month to month, as many of them were located in contested areas and were thus liable to be closed if the area passed out of RLG control. USAID reports indicate that it operated approximately 150 dispensaries in 1964, considerably more than

[146] Dates provided in Bernad, *Filipinos in Laos*; and from various USAID documents.

the 106 operated by the Ministry of Health in 1966, and 250 in 1972 compared to the RLG's 148 in 1973.[147] However, as the number of RLG dispensaries slowly rose, those of USAID gradually reduced from 1972. Some were captured by the NLHX, some were handed over to the RLG, and some closed because the Ministry was unable to support them.[148]

USAID directly ran its own hospitals under the VHP. In 1964 the agency reported that it operated nine "bamboo hospitals", although they may have been glorified dispensaries.[149] Larger USAID hospitals were established at several of the remote Lima Sites (LS), small landing strips which allowed for the air transport of people, equipment and supplies to remote locations for military and civilian purposes. The Sam Thong (LS20) hospital, established in 1963, treated large numbers of Hmong and other ethnic minority groups near the fighting, and served as a medical training centre. At the time it was captured by NLHX forces in March 1970 it had 250 beds, and x-ray, laboratory and surgical capacity, placing it on a par with Mahosot in patient capacity if not in staffing terms. After its capture, staff and patients were transferred to the newly-built hospital at Ban Xone (LS 272). Additional USAID hospitals functioned for a time in northern Laos.[150]

The USAID and OB facilities worked hand in hand as an integrated network. USAID dispensaries referred patients to OB's rural hospitals, which transferred serious cases to its main Vientiane facility or the military hospital

[147] See USAID, 'US Economic Assistance to the Royal Lao Government, 1962-1972', (Vientiane, December 1972), p.10; LNAD, RLG/MOH, 211-004: 'Rapport statistique… 1966', Table L/1; and 211-024: 'Rapport annuel …1973', p.23.
[148] USAID, 'Termination Report', pp.158, 162, 166.
[149] USAID, 'American Aid to Laos,' (Vientiane: USAID, 1964), p.9.
[150] USAID, 'Termination Report', pp.158-159, 166.

there. OB medical and nursing staff filled gaps in USAID facilities, and provided medical training for their Lao staff.[151]

OB began work in Laos with all-Filipino teams, and gradually added Lao staff to its payroll, initially because its own staff could not speak Lao or French. The Filipino staff consisted of doctors, surgeons, dentists, nurses and health administrators, as well as community development teams of social workers, nutritionists and agricultural extension workers. OB's Filipino staff numbered 44 at the close of its first year of operations in Laos, and had almost tripled to 129 in 1974.[152] USAID advised OB in 1969 of the RLG's requirement to phase-out and transfer its Lao staff to the Ministry of Health, but few were willing to transfer: Lao staff still numbered 550 in 1974.[153] One informant explained that the reluctance to transfer stemmed from OB's American-financed salaries which were substantially higher than government rates.[154]

USAID's staffing structure appears to have been similar to OB, with a small core of international staff surrounded by a much larger pool of Lao trained by the two organisations. References to American doctors and nurses assisting the Lao teams at rural USAID facilities appear from the early 1960s.[155] In 1967, USAID's health staff numbered 12 internationals and 420 Lao, including one doctor, 67 nurses, 304 medics, and 48 non-medical

[151] Ms Bounthanh Oudom, retired OB and Lao PDR nurse, interviewed in Vientiane, 3 February 2012.
[152] See Bernad, *Filipinos in Laos*, p.5; and USAID, 'Project Appraisal Report for National Health Development Project – Operation Brotherhood', FY74, p.3.
[153] USAID, 'Termination Report', p.163.
[154] Ms Syphanom Viravong, former OB nurse, interviewed in Sydney, Australia, 25 July 2012.
[155] Dr Joe Westermeyer, former USAID doctor, interviewed by email, 13 June 2013.

personnel.[156] By 1973, only USAID's Public Works program employed more Lao than its Public Health program, which had approximately 650 Lao on its payroll in addition to OB's 550.[157] As such, the Lao staff employed by the USAID-OB network comprised nearly one half of the RLG zone's total civilian health workforce.

The USAID-OB health service trained and categorised its Lao staff according to an American-style system. OB conducted training programs for its own nurses and nursing aides in Vientiane from 1959. At least 148 practical nurses were trained from 1961-69. At the time its training program began, OB produced the most highly qualified nurses in Laos.[158] However, from 1969 the Ministry of Health with WHO support, offered superior education with the introduction of its three-year courses for registered nurses. From then on, OB ceased nurse training as its own hospital network was sleighted for integration into the RLG health service, and the Ministry was able to train nurses itself. OB continued, however, to offer on-the-job training for nursing aides and other health personnel.

USAID employed more medics than practical nurses. In USAID terms, 'medics' were men with minimal education who performed simple tasks at rural dispensaries, while the majority but certainly not all of 'practical nurses' were female.[159] Many ethnic minority medics, who did not meet the minimum educational level required under either the RLG or the OB services, trained at

[156] NARA, RG 286, Box 1: 'The Civilian Health and War Casualty Program in Laos. Report to the Sub-committee to Investigate Problems with Refugees and Escapees Committee on the Judiciary', US Senate, 25 November 1970, p.11.
[157] NARA, RG 286, Box 4: 'USAID Local Staffing – Refugee Relief', 30 July 1973.
[158] The Mekong Circle International pamphlet 'Those were the days', (produced in 2004) states OB trained130 practical nurses between 1963 and 1969, but the year on year total from figures in the same pamphlet is 148.
[159] Weldon, *Tragedy in Paradise*, p.120.

the Sam Thong hospital.[160] It is unclear to what degree OB assisted in training these USAID staff, but a 1975 report states that OB had "participated very effectively" in the training of almost 2,000 health workers to date, exceeding the number of practical nurses and nursing aides trained for its own facilities.[161]

Training activities under the VHP appear to have declined as plans to handover operations to the RLG gradually progressed. When US officials visited Laos in 1971 to gather information for the GAO report, they found very few obvious training activities taking place.[162] The program's phase-out plan was hampered not only by the reluctance of Lao staff to transfer to the RLG's lower wages, but also by the lack of compatibility of staff training and skills. Their professional classifications of 'practical nurse', 'nursing aide' and 'medic' did not accord with French-style classifications used by the Ministry, and furthermore, their technical training had emphasised use of English terminology over French.[163]

The main focus of the USAID-OB health network was curative medicine, although some aspects of public health were also addressed. Vaccinations were provided, as were MCH services, and from the early 1970s, family planning services. The Senate committee report of 1970 found that "A significant portion of USAID-funded medical supplies provided under the Village Health Program is made available to military combatants, paramilitary forces and their dependents, and other groups", but USAID emphasised the

[160] USAID, 'Termination Report', p.159.
[161] USAID, Project Appraisal Report, Public Health Development – VHP, OBI, 12 July 1973 – 20 July 1975.
[162] NARA, RG 286, Box 2: 'Draft GAO report. Medical section', Chapter 2, November 1971, p.6.
[163] USAID, 'Termination Report', pp.164-165.

opposite.[164] The devil is in the detail, because while the Senate committee referred to supplies, USAID specified consultations. Moreover, many non-combatants could have also been classified as dependents of combatants, or within the vague classification of 'other groups'. Such comments suggest the deliberate, although at times perhaps unintentional, obscuring of the situation. It is also interesting to consider why the USAID-OB network regularly claimed a larger share of patients than the Ministry of Health. For example, the GAO reports that in 1970 OB treated 20,831 in-patients at its seven hospitals and a further 26,887 in 1971.[165] For the same years, the Ministry reported 17,897 and 27,452 hospitalisations respectively. However, its figures purport to contain those of the OB hospitals, which were now at least on paper integrated into the RLG's Ministry of Health.[166] Such discrepancies suggest problems with statistics, but also hint at the lack of correspondence between the two health networks.

The US Senate enquiries of the early 1970s drew attention to USAID's refugee relief and health programs and hastened the unraveling of the USAID-OB health network. In retrospect, USAID officials confirmed in 1976 that their approach had not focused on development of a health service, but on more immediate political objectives: "From the inception … the [US] Mission was concerned about the severe lack of trained health personnel particularly at the professional and middle levels, but the urgent need for immediate medical

[164] 'NARA, RG 286, Box 1: 'The Civilian Health and War Casualty Program in Laos. Report to the Sub-committee to Investigate Problems with Refugees and Escapees Committee on the Judiciary'. US Senate, 25 November 1970, p.20; and USAID, 'Termination Report', p.161.
[165] NARA, RG 286, Box 2: Draft GAO report, November 1971, Chapter 4, p.4.
[166] LNAD, RLG/MOH, 211-017: 'Rapport annuel…1970', Table 7; 211-018: 'Rapport annuel des statistiques sanitaires, 1971', Table 39.

services caused by the expanding insurgency, had to receive priority attention".[167] The report continues:

> The Health Development Project despite its name was not a development project in the sense of building a lasting institutional base for a long-term health delivery system. It was created and expanded as an expediency in response to humanitarian military and political needs. In terms of providing acute medical care for insurgent and refugee areas, it was highly successful.[168]

The GAO questioned the network's focus and funding. Its 1971 report observed: "The statement of goals of the VHP are so vaguely worded making it practically impossible to show progress or the lack of progress". Moreover, "Documentation of management decisions is virtually non-existent" and evaluation of USAID's health activities impossible.

> Public Health Division officials evaluate their program by citing the general absence of known catastrophies [sic] such as epidemics, large numbers of deaths in a particular area, or complaints from the Laotian people themselves. Because of the general lack of documentation, we cannot dispute the quality of medical care being provided the Laotians based on these criteria; neither, however, can we say that this care is being provided in the most efficient and effective manner possible ...[169]

The GAO report also expressed the opinion that neither USAID nor the RLG could afford the "luxury" of an expedient medical program like the VHP. It recommended a shift in focus to more long-term training of personnel and institutional development.[170] The recommendations were not implemented. Later, after USAID withdrew from Laos it acknowledged the Ministry's difficulties in attempting to integrate the large numbers of USAID-OB staff,

[167] USAID, 'Termination Report', p.161.
[168] Ibid., p.164.
[169] NARA, RG 286, Box 2: Draft GAO report, Chapter 2, November 1971, pp.3-7.
[170] Ibid., p.12.

which may have been addressed if the US had been more mindful of institutional needs when designing its program of assistance:

> This total body of some 1,200 health workers …had been trained under a system which did not comply with [RLG] standardised qualifications ... Many of the workers … were recruited from young people in the areas where they served. Many were from the tribal minorities and most had less than the required amount of preliminary education. The technical training and categories of health workers designed in response to the … war did not correlate with [Ministry] patterns.[171]

Ultimately, the integration of USAID and OB staff and facilities into the RLG health service fell to the PGNU after the 1973 ceasefire, and was continued by the Ministry of Health post-1975.

The NLHX's Central Health Committee *(Khana Sathalanasouk Sounkang*)

The third health service to operate within Laos during the post-colonial period belonged to the NLHX. The Central Health Committee (CHC), or *Khana Sathalanasouk Sounkang*, split from the NLHX's military medical service in the mid-1960s, and proceeded to establish civilian health committees at all levels of the NLHX administration. Compared to the RLG, the NLHX operated on a much lower budget, in remote, mountainous regions with lower population density, greater ethnic diversity, and even lower education levels. Moreover, it was located within a zone of escalating wartime conflict, in which the resistance leadership and rural communities were obliged to relocate regularly in order to escape aerial bombing and/or land battles.

[171] USAID, 'Termination Report', p.164.

Despite unfavourable conditions, the NLHX managed to establish a basic health service with the assistance of friendly socialist donors, notably the DRV.[172] It included a modest network of health facilities and village-based first aid, medical training schools and some elements of primary health care outreach. A large component was consumed with healthcare for Party cadres and combatants. Frequently it is difficult to distinguish in archival sources between the military and civilian health services in the Liberated Zone, suggesting that the distinction was neither clear nor consistent.[173]

The NLHX's 1956 program of action contained a clear but very broad reference to health and social welfare: "to develop medical services to protect the health of the population and organise social assistance to support people at risk of famine, especially the infirm".[174] Key policies from 1967-68 onward were reported to include training of health staff, production and distribution of pharmaceuticals, rehabilitation of traditional medicine, control of contagious diseases, and promotion of mother and child health.[175] From the early 1970s, the CHC reported statistics that seemed intent on proving its parity with the RLG's Ministry of Health, reminiscent of Cuba's competitive health policy vis-à-vis that of the US.[176] This sheds light on the political strategy and possibly the health ambitions of the NLHX administration.

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[172] Donald P. Whitaker, *et al*, *Laos. A country study*, (Washington DC: Foreign Areas Studies, The American University, 1985 [1971]), p.68.
[173] My counterparts at the (civilian) University of Health Sciences (UHS) in Vientiane were reluctant to approach the military health services in relation to this research, despite a verbal invitation of assistance from a military doctor. Senior health officials counseled me to be content studying the civilian services.
[174] Programme d'action du Front Patriotique Laotien, cited in Deuve, *Royaume du Laos*, p.273.
[175] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk', p.6.
[176] Julie Feinsilver, 'Fifty Years of Cuba's Medical Diplomacy: From Idealism to Pragmatism', *Cuban Studies*, 41, 2010, p.85.

The NLHX health service divided into military and civilian services in the mid-1960s.[177] Prior to the split, the military service provided healthcare to both combatants and civilians. After the split, the CHC was responsible for civilian healthcare, whereas the military service remained responsible for battlefield medics and rear-area military hospitals. The split coincided roughly with the move of NLHX leadership from Xieng Khouang to the cave complex of Viengxay after the disintegration of the second coalition government in 1962, the formalisation of the NLHX administrative and technical services with DRV assistance, and the commencement of America's air war in 1964.

The CHC was re-organised in 1970 with the assistance of Vietnamese advisors. At the time the Committee comprised four members: the Director, Apheuy Keobounheuang, a Deputy, the French-educated Dr Khamlieng Pholsena, and two committee members, Ke Panmalaythong and Somlith. Meeting minutes explain that the committee members with political responsibilities, Apheuy and Ke, were answerable to the Party Politburo, whereas those with technical responsibilities, Khamlieng and Somlith, were answerable to the general population to whom they provided healthcare services.[178]

The organisational structure called for health committees to be formed at each level of the administration, down to the village level. Health committees were also to be formed within workplaces, in accordance with the

[177] An undated NLHX report (presumably from 1970) states the two services separated in 1965, whereas an official report from 1979 says 1964. See NLHX/CHC, 01/02/425: 'Lay-ngane saloup kane-patibat viak-ngane sathalanasouk nay 3 pii (1967-1970), (Report of the implementation of health work for the past three years (1967-1970), undated; and Anonymous, 'Hang Lay-ngane saphab viak-ngan sathalanasouk', p.5.

[178] LNAD, NLHX/CHC, 01/02/423: 'Bantheuk kong-paxoum khong khana-satha-sounkang kio kap kane pap-poung sap-xone khana-satha', (Minutes of the Central Health Committee meeting to improve and reorganise the Health Committee), 15 March 1970.

socialist model where one's workplace or work unit took care of all livelihood matters. A special department responsible for leaders' health was formed, and staffed by Vietnamese doctors. Although the documentation does not provide details, this is almost certain to have been a military rather than civilian undertaking.[179]

No budget details of the NLHX health service or its international donors are available. However, it likely had very low operating costs, as staffing and pharmaceutical expenses were kept to a minimum. NLHX cadres and soldiers received no salaries, although the administration had responsibility to meet the basic food, clothing and accommodation needs of its staff. In addition, the CHC emphasised the local production of basic pharmaceuticals, and promoted a revival of traditional medicines to supplement donated medications. Such practices also demonstrated compliance with the Party's self-sufficiency policy.

NLHX health activities can be presumed to have relied heavily on assistance from fraternal nations. The DRV was the main donor to the NLHX's health services, both military and civilian. Most international support is likely to have been received in-kind, in the form of technical advisors, scholarships construction materials, medical equipment and supplies, pharmaceuticals and fuel. It is reasonable to assume that the amount of assistance received by the NLHX was significantly less than that received by the RLG. A handwritten note in the Lao National Archives lists thousands of kilograms of pharmaceuticals received from the DRV, China, and several East

[179] Nguyen Tien Dinh 'Ten Years of Providing Healthcare for Leaders of the Lao Patriotic Front in the Anti-American Resistance (1966-1975)', in *History of Vietnam-Laos, Laos-Vietnam Special Relationship 1930-2007*, Hanoi: National Political Publishing House, 2012, pp.531-538.

European countries in 1968-70.[180] Cuba provided assistance in the final years preceding the establishment of the Lao PDR, when it sent a medical brigade to work in Viengxay.

The NLHX health network and staffing

The CHC developed a formula for the distribution and size of health facilities. Ideally, each province was to have a 30-50 bed hospital, each district a 15-20 bed hospital, and each sub-district (*tasseng*) a small health facility of five to seven beds.[181] By 1975, the NLHX claimed that the number of health facilities under its control rivalled that of the RLG, an impressive achievement given its limited resources, but it is not possible to determine the level of quality or the actual services provided. In one instance, a former NLHX health worker refers to a hospital (*hong moh*) consisting of only two beds, signalling the vast variation in definitions which existed across health services in Laos.[182]

Figure 4.6 NLHX Central Health Committee facilities, 1970, 1973, 1975

Type of Health Facility	1970[183]	1973[184]	1975[185]
Central hospital	-	2	20
Provincial hospital	-	16	
District hospital (small hospital)	-	81	69 + 7
Tasseng hospital (*paxasouk*)	61	114	85
Village drug kit	2,202	-	3,064

[180] LNAD, NLHX/CHC, 01/02/426: Handwritten note attached to 'Sathiti viak-ngane sathalanasouk thi day patibath nay laya 3 pii thi phane mah' (Statistics of health work implemented in the past 3 years), 14 March 1971.
[181] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk', p.6.
[182] Chanpheng Thongphimpha, *Botbantheuk-xivith kanekheuanevay pakorbsouane hetkanepathivath nay vongkanephed khong Pa Chanpheng Thongphimpha, tae pii 1953 theung 2000*, (Memoirs of Aunt Chanpheng Thongphimpha's contribution to the revolution in the medical sector, from 1953 – 2000), (Vientiane, 2013), p.11.
[183] LNAD, NLHX/CHC, 01/02/425: 'Lay-ngane saloup kane-patibat … 1967-1970', unpaginated.
[184] LNAD, NLHX/CHC, 23-05: 'Lay-ngane saloup viak-ngane sathalanasouk nay 6 deuane ton pii 1973', (Summary report of health work for the first 6 months of 1973), 1 July 1973.
[185] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk', p.7.

CHC reports cite rapidly rising numbers of health facilities throughout the Liberated Zone, although reported numbers differ and often make no distinction in terms of size or function. A report from 1970 lists 13 hospitals in 1967, 51 in 1968 and 81 in 1969.[186] In some provinces like Attapeu, the military and civilian hospitals were co-located, while in others they were separate.[187] In an interesting departure from the RLG and OB services, a number of villages in the Liberated Zone received drug kits comprising basic medicines to compensate for the absence of a nearby health facility.

Before the CHC's formation, the NLHX's health network was a patchwork of facilities inherited from the colonial health service, those established by the NLHX itself or with DRV assistance, those captured from USAID, OB or the RLG, and those built by villagers. The regroupment area assigned to the Pathet Lao[188] by the Geneva conference of 1954 contained two colonial *infirmeries-ambulances* and six rural dispensaries in Xam Neua and Phongsaly, although it is not known how many of these facilities continued to function after their handover to the Lao government in 1950.[189]

The NLHX constructed hospitals, dispensaries, small pharmaceutical factories and medical schools in areas under its control. The DRV forces also constructed facilities within Lao territory, which they operated themselves; these provided medical care for Vietnamese troops and civilian advisors, as well as training for Lao health staff and treatment of the local population. The Central Hospital in Xam Neua was staffed with DRV advisors and trainers as

[186] LNAD, NLHX/CHC, 01/02/425: 'Lay-gnane saloup kane patibat … 1967-1970', unpaginated.
[187] LNAD, NLHX/CHC, 23-05: 'Saloup saphap sathalanasouk 1974', (Summary of the health situation, 1974)', 25 February 1974, p.3.
[188] The name, Neo Lao Hak Xat (NLHX) was adopted in 1956. Prior to that the resistance forces were referred to as the Neo Lao Issara, and the Pathet Lao.
[189] RSL, Box 12: 'Rapport annuel de 1950', pp.19-21.

early as 1954.[190] In Xieng Khouang, a hospital operated by the DRV Red Cross was handed over to the coalition government in 1962.[191] In addition, there was a complex network of small NLHX military hospitals.[192] Three Vietnamese and two Lao "rudimentary" hospitals in Namtha were reported by a Vietnamese defector in 1966-1967, and another mentions a hospital and training school in Oudomxay.[193] In southern Laos, sources mention a large hospital staffed by 30 (North) Vietnamese personnel at Houay A-lay and a joint Pathet Lao-DRV hospital in Houay Ta-Ngao operating near the Cambodian border in 1964,[194] as well as a hospital and training school in Phine district and Hospital 48 in Nong district of Savannakhet, on the Ho Chi Minh Trail.[195]

The status of NLHX health facilities, and the reliance on Vietnamese assistance for both construction and operation, becomes clearer after the CHC's formation. Acknowledging Vietnamese assistance in numerous rural locations, a 1971 report complained that "some Vietnamese advisors do not have sufficient confidence in the abilities of their Lao counterparts, making plans and implementing health initiatives without consultation".[196]

A retired Lao surgeon who worked in the NLHX's Liberated Zone recalls three types of hospital operating in the Viengxay area during the 1960s

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[190] Bounheng Banxalit, 'Special Relationship between Laos and Vietnam in Military Medicine', in *History of Vietnam-Laos, Laos-Vietnam Special Relationship (1930-2007). Memoirs – Volume II*, (Hanoi: National Political Publishing House, 2012), p.193.
[191] See photos V.2041-/V.2055 in KPL archives.
[192] See Khammeung Volachit, *Nang Phet Pativat*.
[193] Paul F. Langer and Joseph J. Zasloff, *North Vietnam and the Pathet Lao. Partners in the Struggle for Laos*, (Cambridge: Harvard University Press, 1970), p.158.
[194] Interview with Bounlap, published in the Lao neutralist newspaper, *Sai Kang*, No. 97, 7 March 1964, pp.10-11.
[195] Nguyen Phuong Thoan, 'The Lao Twins Saved and Brought Up by the Truong Son Military Medical Corps – Then and Now', in *History of Vietnam-Laos, Laos-Vietnam*, p.632.
[196] LNAD, NLHX/CHC, 01/02/426: 'Samlouad tilahkha khong kanexouay-leua lae phouaphanh lavang lao lae Vietnam', (An Evaluation of the Assistance and Liaison between Laos and Vietnam), 18 July 1971.

and 1970s: for Party leaders, the military, and civilians.[197] In 1969 an official order (*Kham sang*) advised that construction of the temporary Central Hospital (*Hongmoh sounkang*) was complete; patients would be accepted for midwifery, ear/nose/throat, internal medicine, pediatrics, laboratory and traditional medicine services. Patients were to bring with them medical referral papers, blankets, mosquito nets, clothing, a bowl and spoon, and 15 days of food rations.[198] The 50-bed hospital, also known as Hang Long hospital, was located in a cave for protection from American bombing. It was replaced in 1972 by the Lao-Vietnam Friendship hospital, a 100-bed facility also known as Xieng Louang hospital, which had been carved from the rock walls of a large cave. Wards had doors at either end, but no windows.[199] Dr Ponemek Daraloy, a medical graduate from Montpellier University, served as hospital director until the change of regime in 1975.

As the war progressed, the NLHX gained territory including RLG and OB health facilities. However, it is not known to what extent the CHC was able to staff and supply these newly acquired facilities beyond appropriating abandoned pharmaceuticals and basic medical equipment and supplies.

The NLHX health service had its own categories of health workers. Professional classifications were reduced to a simplified three-level hierarchy of high, mid or low-level health workers (*phet xanh soung*, *kang*, *tonh*), often

[197] Personal discussions with former NLHX doctor and retired Director of the Vientiane Municipality Health Service, in Vientiane, November 2012 and August 2013.
[198] LNAD, NLHX/CHC, 01/02/423: 'Khamsang – theung bandah phanek-kane, hong-kane, hong-ngane, samnak-gnane ome-khang sounkang', (Order – to all departments, offices, factories and offices surrounding the Centre), 20 October 1969.
[199] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk', p.6. It is unclear if this is the same hospital that Oliver Tappe refers to as the Lao-Cuban Friendship Hospital. See Oliver Tappe, 'National *Lieu de Mémoire* vs. Multivocal Memories: The Case of Viengxay, Lao PDR', in *Interactions with a Violent Past. Reading Post-Conflict Landscapes in Cambodia, Laos and Vietnam*, ed. by Vatthana Pholsena and Oliver Tappe, (Singapore: NUS Press, 2013), p.55.

with little reference to their specialisation. On occasion, some distinction was made between medical workers, pharmacists, midwives and traditional medicine practitioners, but little else.

The number of health staff working in the Liberated Zone before the mid-1960s is unknown, but from the late 1960s NLHX statistics challenge the assumption that the RLG employed more staff (see Figure 4.4). In 1970 the CHC gave a breakdown of its staffing by profession and by region, but there was wide divergence in the figures. A total 2,093 staff were reported by profession, 53 of whom were responsible for politics (*kane meuang*), but only 999 when calculated by region.[200] It is not possible to guess which figures are more correct.

Sources suggest that health staff were recruited and trained by the NLHX as early as 1954.[201] As the war progressed, small numbers of RLG medical staff and graduating medical students also joined the NLHX; some of the latter were returning from France or the Soviet Union from scholarships made available to the RLG. The NLHX also recruited rural teenagers into the revolutionary movement from their villages.[202]

Despite significant social, cultural and economic differences in the areas under their administration, the CHC's professional distribution of staff looks very similar to that of the RLG's Ministry of Health. In 1970 there were 18 high-level doctors (similar to RLG's *docteurs en médecine*) and one high-level pharmacist employed by the NLHX, 117 mid-level doctors (similar to

[200] LNAD, NLHX/CHC, 01/02/424: 'Kouad-ka phene-kane pii tae 1967-1970 khong sathalanasouk', (Assessment of the 1967-1970 plan for health), undated, unpaginated.
[201] Chanpheng Thongphimpha, *Botbantheuk-xivith*, p.2.
[202] Vatthana Pholsena, 'La production d'hommes et de femmes socialistes nouveaux. Expériences de l'éducation communiste au Laos révolutionnaire', in *Laos. Sociétés et pouvoirs*, ed. Vanina Bouté and Vatthana Pholsena, (Bangkok: IRASEC, 2012), pp.45-67.

médecins assistants, although their training appears to have been one year shorter) and a much larger group of 1,297 low-level health workers, who had similar (but not identical) training to the RLG's base-level nurses.[203] As in the RLG zone, the number of high and mid-level doctors shot up in the final years preceding the establishment of the Lao PDR.

Due to the limited number of Lao doctors for most of this period, the NLHX relied upon international doctors like the RLG. Many of the clinical doctors and medical teachers were Vietnamese, some recruited from among sympathetic immigrants in Thailand and Laos, and others from the DRV.[204] By 1971 there were Vietnamese advisors in almost every CHC department.[205] This situation confirms that OB's Filipinos were certainly not the only 'Asians helping Asians' in the Lao health sector. One account states that from 1954 until 1957, the Vietnamese sent medical specialists to work in the NLHX regrouping area of Xam Neua, and that they later also sent surgical specialists – although he does not specify when.[206] In later years, a team of Cuban doctors was posted to Viengxay, communicating with Lao and Vietnamese colleagues in French.[207]

Like its rivals, the NLHX had localised lower level medical training to supply its health services. The schools taught rural teenagers with low education levels, and relied upon Vietnamese teachers who improvised with

[203] LNAD, NLHX/CHC, 01/02/424: 'Kouad-ka … 1967-1970', unpaginated.
[204] Bui Van Y, 'Public Health Support for Lao Friends During the Resistance Against French Colonialists,' in *History of Vietnam-Laos, Laos-Vietnam*, pp.243-248.
[205] LNAD, NLHX/CHC, 01/02/426: 'Samlouad tilahkha khong kanexouay-leua lae phouaphanh lavang lao lae Vietnam' (An Evaluation of the Assistance and Liaison between Laos and Vietnam), 18 July 1971.
[206] Bounheng Banxalith, 'Special Relationship', p.193.
[207] Discussion with former NLHX doctor and Head of the Vientiane Prefecture Health Service, in Vientiane, November 2012 and August 2013.

teaching materials and learning styles. Bui Van Y, a medical instructor working in a small team of three in Attapeu, recounts a class he taught:

> … we carried rice from the village for food, wrote lesson plans and delivered lessons by ourselves. If visual aids were not available, we hunted forest animals and brought them to class. For example, for lessons on anatomy, physiology, we hunted animals and conducted surgery to explain from the skeleton, skin and flesh to organs. After having finished the lesson, these animals would be used as food.[208]

He notes that because some students were barely literate, the classes had a strong focus on practical skills rather than theory: "When there were epidemics of malaria, diarrhea [sic], measles, the whole class visited villages to eliminate them and conduct real-life training at the same time. Taking notes was unnecessary".[209]

Several sources note that medical training began with political training. One NLHX health worker spoke of 18 months training at a medical school in Dak Cheung (now in Xekong) in a class of 30 Lao students and 30 young Vietnamese women taught by two Vietnamese women. Before beginning the training, all students studied social and political theory. He says they had to be willing to help other people, not be disgusted by injured patients, and work together and love the Vietnamese "as their siblings" (*pen louk pho dio mae dio kan*).[210] The mix of family and politics arises again in one nurse's memoirs; her medical training began with a question and answer: "Who are the patients? They are your brothers, sisters, fellow-Lao people. The state is your parents. We all live under the same roof".[211]

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[208] Bui Van Y, 'Public Health Support', p.244.
[209] Ibid., p.246.
[210] *Sai Kang*, 7 March 1964, pp.10-11.
[211] Chanpheng Thongphimpha, *Botbantheuk-xivith*, pp.8-9.

Provinces were responsible for the training of their own low-level staff. The Centre (*Sounkang*) was responsible for training mid-level health workers, and high-level health workers were sent for training in the DRV.[212] By 1970 there were a reported 12 low-level medical schools and three mid-level schools in Viengxay, Oudomxay and Savannakhet. Most available information relates to the Viengxay school. A mid-level military medical school also operated nearby at Na Vit, staffed by Lao graduates of a DRV medical school.[213] The civilian, mid-level school in Viengxay provided three-year courses to nine cohorts of students, four cohorts of which graduated, with class sizes of 18 to 43. In addition, the mid-level school in Savannakhet produced at least 36 graduates.[214] In 1970, 142 NLHX students were studying overseas (presumably in the DRV): 26 studying high-level medicine, 11 studying high-level pharmacology and another 105 studying mid-level medicine.[215]

An additional category of health workers swelling the NLHX ranks were low-level public health workers, including village-level nurses, 'hygiene fighters' (*nakhop anamay*), and mobile and village-based environmental health workers.[216] The training provided young people with new knowledge, and new roles in their community. One young village woman recounts her experience as a village-level nurse in Xieng Khouang in the mid-1960s:

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[212] LNAD, NLHX/CHC, 23-05: 'Lay-ngane saloup viak-ngane sathalanasouk nay 6 deuane ton pii 1973', (Summary report of health work for the first 6 months of 1973), 1 July 1973, p.10.
[213] Bounthan Bandavong, 'Vietnam-Laos Special Solidarity in Military Medicine,' *History of Vietnam-Laos, Laos-Vietnam*, p.508.
[214] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk', pp.8-9. Information about the number of cohorts is provided by the KPL photographic archives collection in captions to photographs TK 7158-7160.
[215] Bounheng Banxalith, 'Special Relationship', pp.193-194.
[216] Anonymous, 'Hang lay-ngane saphab viak-ngan sathalanasouk', p.6.

> After six months, we were capable of preventing diseases and treating other typical illnesses. We then went out to practise what we had learned, dividing ourselves up among various villages. They told us to eat and live together with the people. Our duty was to take care of the ill and act in such a way that people would believe and support the Neo Lao [Lao Front] … we didn't take payments for our medical treatments.[217]

Healthcare services in the NLHX's Liberated Zone

The CHC provided clinical healthcare, as well as promoting pharmaceutical production, the use of traditional medicine, and preventative and environmental health. What stands out in the NLHX statistics is the high proportion of cadres receiving medical care, compared to other civilians. For example, in 1973 the CHC reported that one third of patients (285 of 1,064) treated in its health facilities were cadres.[218]

The focus on pharmaceutical production and the use of traditional medicine was motivated by necessity, to keep costs as low as possible, and to avoid the difficulty of delivering pharmaceuticals to remote and potentially insecure areas. Pharmaceutical production also accorded with the NLHX's policy of scientific development, while bringing traditional medicine practitioners into the official health sector swelled the numbers of health workers in the Liberated Zone.

The training and employment of public health workers demonstrated the NLHX's policy commitment to preventative and environmental health. The 'Three Cleans' (*sam sa-at*) campaign, of eating, drinking and living hygienically, was first practised at village level by health workers.[219] When

[217] Former NLHX nurse, quoted in Branfman, *Voices from the Plain of Jars.* p.51.
[218] LNAD, NLHX/CHC, 23-05: 'Lay-ngane saloup … 6 deuane ton pii 1973', p.11.
[219] The Lao PDR's Ministry of Health continues in 2015 to implement the 'Three Cleans' campaign throughout the country with mixed success.

internal refugees began returning home after the ceasefire in 1973, the CHC instructed that they be encouraged to rebuild their villages in accordance with hygienic principles, by digging wells and locating latrines, rubbish pits and animal pens away from houses. An official report from 1974 paints a rosy picture of villages re-established in perfect accordance with hygienic principles – in contrast to the actual situations encountered by environmental health teams in the following decade.[220]

In summary, the NLHX managed to create a network of health facilities across many provinces, establish low and mid-level medical training schools, and employ a cadre of health staff that worked cooperatively with DRV technical advisors. The ceasefire of 1973 and the formation of the PGNU marked the final chapter for the CHC before it assumed responsibility for the health of the entire nation.

Uniting Laos' divided health sector

The political situation leading up to the eventual announcement of the establishment of the Lao PDR in December 1975 was fluid. The 1973 ceasefire was followed by the formation of the third coalition government, the PGNU, on 5 April 1974. The Ministry of Health was upgraded to a full ministry, with its own Minister, rather than a Secretary of State within a multi-function ministry. The RLG's Secretary of State for Health, Khamphaï Abhay, assumed the role. His Vice-Minister was Khamlieng Pholsena, Deputy Head of the NLHX's CHC, in an arrangement stipulated by the ceasefire which

[220] LNAD, NLHX/CHC, 23-05: 'Saloup saphap sathalanasouk 1974', p.2.

paired one RLG official with one NLHX deputy, or vice-versa, in each of the new government's 12 ministries.

There is scant documentation about the internal changes to the health sector brought about by the coalition government. One must therefore turn to records of USAID's Public Health Division and WHO. Behind the PGNU's public presentation of unity, pro-NLHX staff within the Ministry of Health lobbied for the adoption of socialist-style policies. The provision of free healthcare for Ministry staff was one such example, documented in meeting minutes from 1974.[221] In another example, NLHX health workers who had entered the major towns and were working alongside RLG staff were advised in 1975 that RLG hospitals were places where "the enemy has large amounts of modern scientific equipment. There are things that we do not yet know how to use. If we can remember how it is used, and take good care of it, it will be convenient for our future work in the health sector".[222]

An internal document from July 1975 reveals that the CHC was planning to assume responsibility for the entire health sector, in the context of the NLHX's nationwide seizure of power, which was gradually gaining momentum over the course of the year. NLHX health teams had been despatched to Luang Prabang, Savannakhet, Pakse and Vientiane provinces to generate support for the NLHX movement among health workers and in the community at large. The document, titled a 'plan', assessed the political situation among health workers:

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[221] LNAD, PGNU/MOH, AF-03: 'Bantheuk kane-paxoum khanakamakane phichalana kane-pin-poua kharaxakane thi bo sia kha thang mot', (Minutes of the committee meeting to consider free medical treatment of staff)', No. 72/KS-TB, 2 July 1975.

[222] LNAD, NLHX/CHC, 23-03: 'Phenekane khong sathalanasouk sapho nay khet yeud amnat kanebok-khong nay khet beuang nanh', (Plan for health work only in the Seized [RLG] Zone administered by that side), No.551, 13 July 1975.

> Compared to the campaign to seize power the work of the health sector in [the RLG] zone is relatively weak. For example, some older doctors in some provinces have not yet studied [our theories] and changed their ways of thinking. And we have not yet entered some of the provincial hospitals where we have been invited to do so. In respect to the inspection and requisitioning of pharmaceuticals and supplies, this has occurred in a few instances only. In some localities they [health staff] are treating patients in the old manner, continuing to exploit them.[223]

Looking ahead, the plan went on:

> Most [RLG technical health staff] are the children of [ordinary], exploited people, although some are from the wealthy class that has aided the enemy ... It is the capitalists and the American imperialists who have incited them to use their professional skills to seek income and thus exploit the people … In order to implement the policies of the Centre **[**Party leadership], we must clearly distinguish the different types [of staff], by mobilising them to study the Centre's policy documents. If some of these staff are good, we should allow them to continue studying documents about the characteristics of revolutionary health workers (*phet pativat*), so that they can change their political thinking and use their technical skills once again for the service of the people … under strict Party leadership."[224]

A separate but parallel process was the integration of the USAID-OB health network. The coalition government reiterated the need for integration, and so in 1974 the goal of the VHP was amended to: "helping the PGNU provide medical care to refugees and rural areas. Provide medical facilities and training and integrate them into the PNGU Medical Service".[225] The anti-USAID demonstrations of May 1975, in the wake of the fall of Phnom Penh and Saigon the previous month, brought the "premature, abrupt, unplanned turnover of all health facilities" to the PGNU. All international personnel of

[223] Ibid.
[224] Ibid.
[225] USAID, 'Project Appraisal Report, VHP, 12 July 1973 to 20 July 1975', p.3.

USAID and OB were required to depart before 30 June - a hurried departure for the international assistance agencies and staff who had assisted the Lao health sector for almost two decades.[226]

Figure 4.7: Staff Comparison of RLG, NLHX and USAID-OB, 1973

Profession	RLG	NLHX	USAID-OB
TOTAL reported health staff:	1,402	2,010	1,200
Including the following professions			
Doctor of medicine/ High-level medical doctor	36 (+20 military)	36	0
Pharmacist/ High-level pharmacist	7 (+1 military)	1	0
Dental surgeon/	1	-	0
Assistant doctor/ Mid-level medical doctor	102 (+44 military)	160	0
Registered midwife/ Sage-femme d'état	23	-	0
Registered nurse/ Infirmier/infirmiere d'état	29	-	0
Assistant pharmacist/ Mid-level pharmacist	12 (+ 3 military)	24	-
Assistant dental technician/	12 (+ 1 military)	-	-
Lab technician	1	-	-
Auxiliary midwife/ Sage-femme auxiliaire	178	-	-
Auxiliary nurse/ Infirmier/infirmière auxiliaire	801 (+ 801 military)	-	148
Auxiliary nurse-midwife/ Infirmière-sage-femme auxiliaire	42?	-	-
Assistant lab technician	27	31	-
Dental mechanic	11	?	-
Nurse/Nursing aide/ Low-level med worker	-	1,081	-
Aide pharmacien-préparateur/ Low-level pharmacy worker	-	198	-
Traditional medicine doctor	-	134	-

The political situation changed rapidly. Minister of Health Khamphaï did not return to Vientiane from a scheduled WHO meeting in Geneva in May 1975, and was granted political asylum in France.[227] Tiao Jaisvasd, former Director of the Royal School of Medicine and the Department of Hospital Services, replaced him as Minister. He recalls hoping that Lao health

[226] USAID, 'Termination Report', p.10.
[227] Dr Khamphaï Abhay, former RLG Minister of Health, by email, 10 October 2012.

professionals of all political persuasions would find a way of working together. However, from 29 September 1975 he was confined (*theuk khouab khoum toua*) with Crown Prince Vong Savang to the former USAID compound, and presumably unable to perform his role as Minister.[228] Fearing possible deportation to a re-education camp, Tiao Jaisvasd fled to Thailand four days after the establishment of the Lao PDR in December 1975, and resettled in France as a refugee.[229]

Conclusion

National independence did not remove the colonial-era problems of geographical, political and cultural marginality or afford Laos a degree of control of its own destiny. Instead, the newly independent nation plunged into several decades of armed conflict, divided along political and territorial lines as well as in terms of technical skills and services, which in turn consolidated its dependence on external assistance. While international assistance boosted budgets available for health development, the strength and coherence of the health sector was severely constrained by its high degree of fragmentation.

All three civilian health services made important achievements during this period. The number of health facilities more than doubled, the number of Lao health staff increased more than tenfold, and the first Lao became fully-qualified medical doctors, pharmacists, registered nurses and midwives. International assistance supported the implementation of a number of specific projects: the provision of medical care, yaws and malaria eradication, maternal and child healthcare, as well as nursing and medical education. The range of

[228] Dr Tiao Jaisvasd's curriculum vitae, kindly provided at interview in Torcy, France, 2 December 2012.
[229] Dr Tiao Jaisvasd, interviewed in Torcy, France, 2 December 2012.

healthcare services broadened, and was supplemented by an emerging private sector.

The quality of healthcare continued to struggle, however, because it relied on the availability and equitable distribution of trained staff, equipment and supplies. The RLG recruited the most highly qualified staff of the three services, but had difficulties with staff distribution. The USAID-OB and NLHX services had no choice but to adopt more flexible recruitment and training standards, and consequently their staff were more likely to remain in rural areas. All three services struggled to provide basic equipment, supplies and utilities to health facilities, especially in rural areas. Weak budgets and supply chains, compounded by poor roads and expensive air access, resulted in frequent gaps in the supply of pharmaceuticals and basic medical supplies, and health staff. Equipment was difficult to maintain, and utilities such as electricity and running water were often absent. Such limitations were characteristic of Laos' international marginality as a geographically remote, extremely poor and now also, a war-torn country. In the words of a US project proposal from 1974: "Laos compares unfavourably with most of the developing countries by almost any yardstick of national development."[230]

Lao health sector development was not only limited by Laos' poverty, but also, paradoxically, by its dependence on international assistance. The cultural and technical uniformity of the French colonial period was gone. The diversity of international donors, and their political motivations, resulted in a jumble of technical advice, scholarships, and training, as well as medical equipment and supplies which were not necessarily complementary or

[230] USAID, Laos. Maternal and Child Health/Family Planning Prop (FY 75-79), (USAID, 1974), p.17.

interchangeable. The professional classifications and training curricula used by the three health services did not correspond, and health professionals working in the various services shared neither a common technical approach nor a common language of training. Finally, USAID's departure signalled the exit of Laos' largest international donor, and left the health sector without access to large-scale financial and technical support.

CHAPTER 5

DOCTRINE AS CURE:

THE ATTEMPTED CONTRUCTION OF A SOCIALIST HEALTH SYSTEM (1975-1990)

… [we must] transform their thinking into that of revolutionary socialist health workers who serve the multi-ethnic people of Laos, that is, the workers.[1]

Introduction

The establishment of the Lao PDR on 2 December 1975 marked the end of the NLHX revolutionary liberation struggle and the beginning of the nation's "march towards socialism".[2] The new leadership launched an ambitious plan to reshape Laos' political system, economy and society based on Marxist-Leninist doctrine. The plan included the transformation of the existing health services into a single, government-managed socialist system tasked with the expansion of a nationwide network staffed by a cadre of revolutionary health workers providing healthcare and pharmaceuticals free-of-charge to *all* members of the population. Guided by political training, they were to promote equity, self-reliance and modernity inside and outside the workplace, and thereby contribute to the nation's development under socialism.

[1] LNAD, Lao PDR/MOH, 23-05, 'Saloup saphap kane viak-ngane 1 pii 1978 lae phenekane to 1979', (Summarised Annual Work Report for 1978 and Work Plan for 1979), 11 December 1978.
[2] MacAlister Brown and Joseph J. Zasloff, 'Laos 1979: Caught in Vietnam's Wake', *Asian Survey*, 20 (2), (February 1980), p.109.

The administrative and technical work of government was powered by a unique combination of ideological optimism engendered by 'political work' (*viak kane meuang*), encompassing political training and ideological guidance, and the pragmatism of 'policy work' (*viak nayobay*), which promoted self-reliance as a means to deal with the economic hardships of the 1970s and 1980s. In a whirlwind of international meetings at home and abroad, high-ranking officials negotiated technical and financial assistance packages to support the government's unfunded plans. The new regime termed this 'international work' (*viak kane-tang-pathet*), involving cooperation with friendly nations, a subtle change from the foreign aid received by the former regime. However, 'political', 'policy' and 'international work' sapped the time and energy of health personnel, and redirected their efforts away from the Ministry's 'specialised' or 'specific work' (*viak saphoh*) of healthcare provision,[3] and towards political training, participation in the activities of the Party's mass organisations, communal gardening, livestock-raising, cultural displays and sporting competitions.

This chapter concerns the early Lao PDR period, which Grant Evans dubbed more colourfully as Laos' period of "high socialism".[4] It spans the 15 years from December 1975 until the collapse of the Soviet Union, the nation's major benefactor, in 1990-91. The demise of socialism in Eastern Europe

[3] The term *viak saphoh* or sometimes *visah saphoh* could be translated as 'specialised work', as it is likely derived from the Vietnamese term *chuyên ngành*, which means something like 'specialty'. I prefer to translate it as 'specific work', to avoid the connotations of specialisation in terms of advanced or higher level of technical competence, which would be misleading in the Lao context. Beyond the small cadre of well-trained staff at central level, most health workers possessed only basic qualifications and skill levels.

[4] Grant Evans, *Lao Peasants under Socialism and Post-socialism*, (Chiang Mai: Silkworm Books, 1995), p.xxv.

significantly changed the profile of international development assistance to Laos, and forced a re-assessment of overall health policy and health financing, discussed in Chapter Six.

This chapter relies heavily on primary sources from the Lao National Archives to chart the interactions of 'specific work' with 'political', 'policy' and 'international work' within the health sector. The sources show how the government set about re-shaping the health sector to make it, in its own words, "better than before" (*dee koua kao*), a line repeated time and again in official reports. The new regime reunified the health services, restructured the administrative framework of the Ministry of Health, expanded the health network deeper into rural areas, and trained significantly more health staff at all professional levels.

Health inputs and outputs were tempered by poor agricultural harvests brought on by floods and droughts, a reduction in the overall amount of international assistance received, and what has been described as "ideologically-driven mismanagement" combined with corruption, a fate which reportedly also affected other sectors of the administration.[5] The weight of the Lao PDR's political, policy and international work ate into the time and motivation available for the Ministry of Health's primary responsibility, the provision of healthcare, and ultimately impacted on the quality and quantity of care provided.

The few present-day references to the history of health and development in Laos often take 1975 as their starting point, as if little of substance occurred

[5] Brown and Zasloff, 'Laos 1979', p.110.

beforehand.[6] This supposition is not only misleading but incorrect. The year 1975 did not mark the beginning of health services in Laos but rather a turning point in their development.

Setting the Scene for Socialism

The new regime embarked on a period of reforms and restructuring to build a socialist society with a one-party political system, a centralised, state-managed economy that would bypass capitalism, and a socialist-inspired society designed to restore Lao pride and sovereignty following almost thirty years of conflict. However, as Stuart-Fox has remarked, its leaders "were not aware of the magnitude of the task that lay ahead, and the problems likely to be encountered".[7] Certainly, its methods lacked nuance. The Lao king was pressured to abdicate, and in 1977 he and a number of immediate family members were detained in Houaphan province (formerly Xam Neua) until their deaths several years later. The new regime also despatched approximately 25,000 of Laos' small, urban class of military officers, administrators and technical specialists to political re-education camps within the first year of its administration, provoking caution and

[6] A PhD thesis from 2009 is representative of this trend, presumably relying on politically-motivated responses of Lao officials. It states: "The beginning of the PDR marks the veritable beginnings of public health in Laos. Before 1975, no modern and organised sanitary system existed: traditional medicine rituals and remedies (from medicinal plants and animal products) were the main forms of medical knowledge and remedies." See Bochaton, 'Pai Thaï, pai fang nan', p.58. For other examples, see Jönsson *et al,* 'Health Policy Evolution', p.4; and Stephen Holland *et al, Impact of Economic and Institutional Reforms on the Health Sector in Laos: Implications for Health System Management*, (Brighton, Sussex: Institute of Development Studies. IDS Research Report 28, October 1995), p.22.

[7] Stuart-Fox, *History of Laos*, p. 169.

fear among many of the educated, technical staff who remained in the urban centres.[8]

Several issues required the immediate attention of the Ministry of Health. The multiple health services of the former period had not been fully integrated by the short-lived PGNU, and many CHC staff from the former revolutionary base of Viengxay and other areas had not yet relocated to Vientiane or the provincial capitals. Moreover, economic problems impacted on government salaries and urban living conditions, and therefore staff morale, as well as limiting the funding available for health activities.

Initially, the Ministry attended to the unification of the multiple health services. The blurred division between civilian and military services was preserved. The Ministry shared donated pharmaceuticals and medical equipment with the military's medical service, and exchanged medical staff based on local needs. The unification process faced obstacles as professional categories and training curricula between the previous services were inconsistent. For example, Didier Sicard, a French instructor from 1974-1978 at the Medical University (the former Royal School of Medicine), described the US-trained medics in rural Laos, whom he understood to have had only three months of basic health training, as "unintegrated, unintegratable" into the Ministry of Health.[9] In addition, Ministry reports indicate that former USAID health staff (presumably those from the USAID-OB network) had not been paid since USAID's withdrawal, despite being

[8] Lao People's Army, *Pavatsat Kongthap*, p. 497.
[9] Sicard, *Au nom de Marx*, p.93.

incorporated into the Ministry at that time.[10] Several years later, in 1979, a report prepared for the Minister of Health declared that former NLHX and RLG staff had been integrated, and that a good level of workplace cooperation had been achieved, although this was not always the case.[11] One of my informants, resident in the United States since the 1980s, confided that her departure was prompted partly by poor workplace relations and what she considered as the privileging of staff from the former Liberated Zone.[12]

Former NLHX health staff, medical students and technical advisors were stranded in Viengxay in the early months of the Lao PDR due to a lack of transport to convey them to Vientiane, and a lack of accommodation once they arrived. While NLHX staff and students remained in the countryside, many high-ranking and/or highly-qualified Ministry staff fled into exile. The exodus had begun over the course of 1975, as the NLHX gradually asserted its power throughout the country. Sicard recounts five doctors fleeing after an ordinary morning's work at Mahosot in mid-1975, an event he admits to having judged harshly at the time.[13] A Ministry report in early 1976 states that between 49 and 60 staff (the official figures are inconsistent) fled in the eight weeks following 2 December 1975. Of these, 22 had *doctorat en médécine* qualifications or

[10] A former OB nurse recalled staff demonstrations at the Setthathirat (OB) hospital in Vientiane in 1975 concerning unpaid wages. Ms Sivilay Sivongxay interviewed in Vientiane, Lao PDR, 14 February 2014. The FBIS reports earlier staff demonstrations at Setthathirat in September 1974, concerning wage reductions and the treatment of Lao workers by foreign supervisors, presumably Filipino and Thai. See FBIS, 'Strike at US-financed hospital in Vientiane ends', 25 September 1974.
[11] LNAD, Lao PDR/MOH, 23-04: 'Botlayngane saloup saphap viak-ngane sathalanasouk nay laya 4 pii (1976-1979) to kongpaxoum sathalanasouk thoua pathet , nay van thi ... deuan peutsapha pii 1980' ([Draft] Summary Report on 4 years of health work 1976-1979 for the National Health Conference of … [sic] May 1980)), p.20.
[12] Former OB Lao nurse (anonymous) interviewed in San Diego, USA, 6 August 2012.
[13] Sicard, *Au nom de Marx*, p.97.

equivalent, and were therefore likely to have held senior positions.[14] The Ministry requisitioned the houses of fleeing senior personnel to help meet its need for staff and student accommodation.[15]

The Ministry of Health underwent administrative changes in the immediate and longer term. The health service was afforded its own ministry for most of the early Lao PDR period. The Ministry merged with Social Welfare to become the Ministry of Health and Social Welfare in 1988, but reverted to the Ministry of Health three years later when Social Welfare joined Labour.[16] The Ministry was substantially restructured in 1980, and in 1987 was subject to a government-wide decentralisation process which allowed each province to set its own health priorities, and assume responsibility for its own staff training and operational budgets. One account has noted that decentralisation was not a well-planned policy, occurring almost by default, due to the central government's inability to effectively administer and support the provinces.[17]

The new regime made a number of generic changes to the roles of ministers and vice-ministers across all ministries, of which there were initially 12, plus two ministry-equivalent committees.[18] The former RLG positions of minister and director-general were combined, making Lao PDR ministers responsible for both political and technical matters. Most were members of the Party's Central

[14] A typographic or calculation error must have been made in the MOH report, because while the text states that 60 staff had fled, the statistical breakdown by level adds up to only 49. See LNAD, Lao PDR/MOH, 23-05: 'Lay-ngane saphap kane-kheuan-vay khong kasouang sathalanasouk nap tae sangtang latthabane may mah theung pachouban-ny: 25-1-76' (Report on the situation of the Ministry of Health from the establishment of the new government until the present: 25-1-76).
[15] Ibid.
[16] Phongsavath Boupha, *Evolution of the Lao State*, p.109.
[17] Holland *et al*, *Impact of Economic and Institutional Reforms*, p.18.
[18] MacAlister Brown and Joseph J. Zasloff, 'Laos in 1975: People's Democratic Revolution - Lao-style', *Asian Survey*, 16(2), (February1976), p.197.

Committee, although they were not necessarily representatives in the Supreme People's Assembly (SPA), the new Lao parliament which rarely met and operated as little more than a rubber stamp for Party decisions.[19] The new arrangements located political functions very clearly within each ministry rather than the SPA. Vice-ministers first appeared during the PGNU in a role similar to that of the RLG position of Secretary of State. Central-level departments (*kom*) and provincial-level services (*phanek*) were now directed by committees rather than individuals. District health services, also directed by committees, were added to the official hierarchy.

The new regime appointed Tiao Souk Vongsak, a Luang Prabang-born relative of the Lao king, as its first Minister of Health.[20] Despite his royal pedigree, Tiao Souk was a member of the Party's Central Committee, and had been a long-serving official in the Liberated Zone.[21] He had no medical training. He was assisted by a single vice-minister, Dr Khamlieng Pholsena.

[19] Former *médecin indochinois*, Khamsouk Keola, served as Vice-President and Secretary-General of the SPA from 1975-1989. Dr Ponemek Daraloy, Director of the Ministry of Health's Cabinet Office, was also a member of the SPA's first legislature. Vice-Minister Vannareth Latsapho was included in the SPA's second legislature, 1989-1992, but Ponemek was not. See National Assembly of the Lao PDR/UNDP, *The National Assembly of the Lao People's Democratic Republic Directory, 1975-2002*, (Vientiane: National Assembly of the Lao PDR/UNDP, 2000), pp.7, 9.

[20] Prince Souvanna Phouma, former RLG Prime Minister, is reported to have called Tiao (Prince) Souk Vongsak "nephew". See Arthur J. Dommen,'Towards Negotiations in Laos', *Asian Survey*. 11(1), January 1971, p.48.

[21] Stuart-Fox, *History of Laos*, p.179; and Institute of Historical Research, *Bantheuk hetkane pavatsat lao lem II 1976-2006*, (Notes on Events in Lao History, volume II, 1976-2006), (Vientiane: National Academy of Social Science, Institute of Historical Research, 2011), p.109.

Figure 5.1: Tiao Souk Vongsak, the Lao PDR's first Minister of Health, in the late 1970s. One of the slogans behind him reads: "To donate blood is to love the country, love the new regime".

(Source: Lao News Agency (KPL) archives, Vientiane.)

Khamlieng hailed from an influential neutralist family, and had joined the NLHX in the 1960s on return from his medical studies in Bordeaux, France. He provided the continuity between the old and new regimes, having served as the NLHX-appointed Vice-Minister of Health in the PGNU administration under the RLG-appointed Ministers, Drs Khamphaï and Tiao Jaisvasd. A second vice-minister, Professor Dr Vannareth Latsapho (Rajpho), French-educated and with 13 years' experience under the former RLG, was appointed in 1980. Vice-ministers quickly multiplied: by 1990 four assisted the Minister.[22] Khamlieng was promoted to Minister of Health in 1982 but replaced in 1988 by Khambou Sounixay, a Party man with no medical background.[23] Vannareth succeeded Khambou in the mid-1990s.

[22] UNICEF, *Children and Women in the Lao People's Democratic Republic*, (Vientiane: UNICEF, April 1992), p.141.

[23] Khamlieng was reduced to President of the Lao Red Cross in 1988. Post-1975 the Lao Red Cross accepted a number of former high-ranking Ministry of Health personnel into its ranks,

The Ministry of Health's organisational restructure of 1980 separated its administrative (or political) functions from its technical functions. It now had seven administrative departments and 11 technical institutes (*sathabanh*), including the Medical University and the nursing school, renamed the mid-level health school.[24] The restructure formalised a new balance of power whereby administratively-focused departments were more politically powerful than the technically-focused institutes. Sicard had observed this shift occurring in the late 1970s, prompting him to quip: "Patients lost priority to the 'health workers,' who in turn lost priority to the Marxist technicians [technocrats]".[25] The move to favour technocrats over health workers is comparable to similar moves in neighbouring Vietnam and several years later, in the People's Republic of Kampuchea. Lao cadres had more power than their technical colleagues, but were unable to solve the entrenched problems of poor management and urban bias.

By 1990 the Ministry of Health comprised five administrative departments, four technical institutes, five technical centres, five national coordinating committees, and four hospitals at central-level. The structure had developed "from the top by the introduction of vertical programs,"[26] and as such, was not well-coordinated. A second key change was the 1987 decentralisation drive, summed up as follows:

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including the RLG's Dr Oudom Souvannavong as Vice President and Koukeo Saycocie as Secretary, and later Vice President. See FBIS, 'Red Cross Delegation Returns', 2 November 1978. A former MOH staff member remembered the challenge of interpreting for Khambou, because first one had to translate into Lao, and then explain the technical concepts. Former Lao PDR health worker (anonymous) interviewed in Vientiane, Lao PDR, 17 December 2012.

[24] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap viak-ngane 6 deuan ton pii 1980', (Summary Report on Work for the First 6 months of 1980).

[25] Sicard, *Au nom de Marx*, p.98.

[26] UNICEF, *Children and Women*, pp.141-142.

> The technical and planning functions managed from the central level became separated from political and financial decision making at the local level and the ministry lost influence on the direction of health policy. The lack of coordination extended [downwards], resulting in little meaningful cooperation between district authorities and either the [Provincial/Municipal or District Health Offices] …[27]

The absence of clear lines of responsibility for each level of the system or of individual job descriptions compounded the challenges of the decentralisation experiment.

A Socialist Health Program of 'Specific Work'

The Ministry of Health's main role, or 'specific work' (*viak saphoh*) was the provision of healthcare. Symbolic representations of the health sector formed part of the regime's depictions of new socialist society. Medical scenes featured on the Liberation Kip bills from 1968 were repeated in 1979. A series of stamps bearing health scenes was issued in 1988 to commemorate the 40th anniversary of WHO, and '*Phet Pativat*' (Revolutionary health worker/s) was included in a recording of revolutionary songs. A Ministry report from 1977 asserted:

> The party and state have given special prioritisation to the work of healthcare. They have studied various models to ensure that doctors will have correct equipment and skills, are compassionate towards patients, and motivated to support the revolution with sincerity.[28]

In fact, it is difficult to identify a sector of the administration or technical services that did not receive at least rhetorical prioritisation in official discourse, which

[27] Holland *et al*, *Impact of Economic and Institutional Reforms*, p.19.
[28] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap kane viak-ngane 6 deuan ton pii 1977', (Summary Report on Work for the First 6 months of 1977), undated, p.2.

makes it difficult to determine which sectors were in fact given actual priority. Government budgets could be expected to reveal such prioritisation, but these were treated with utmost secrecy during the early Lao PDR period.

The new regime's socio-cultural agenda was pro-rural and pro-ethnic. In the education sector, policy included the eradication of illiteracy and the promotion of general education.[29] In the health sector, it aimed to close the gap in health status and resource allocation between urban and rural areas through a socialist health system.

Official reports and speeches shied away from an explicit specification of the characteristics of a socialist health system in the Lao context. Reading between the lines, it meant the provision of free healthcare within a single, government-managed health service, by politically-trained and motivated health workers. Key aspects of the policy were the provision of Primary Health Care (PHC), the promotion of the integration of traditional medicine with biomedicine, and the use and, to a lesser extent, the production of pharmaceuticals.

In 1976 the WHO confidently announced that the Lao PDR was "organizing a system of primary health care, with supervision provided by local health committees and services at the periphery by village health workers … a handbook for … health worker[s] is being developed."[30] PHC was defined in the 1978 Declaration of Alma-Ata as "essential health care" focused on health education and promotion, nutrition and food supply, provision of safe water supply, maternal and child health including family planning, immunisation against

[29] Lockhart, 'Education in Laos', p.26.
[30] WHO, WPR/RC27/3, Manila: WHO, 1976, p.5.

major diseases, prevention and control of local endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs, all services to be provided "as close as possible to where people live and work".[31] Some of the most successful PHC systems in the late 1970s were found in communist countries such as Cuba and China which were, at that time, providing assistance to the Lao health sector.

The Lao PDR's adoption of PHC enjoyed international prominence when Vice-Minister Khamlieng was elected one of the vice presidents of WHO's Alma Ata International Conference on PHC, but the real challenge was to move from policy to implementation. A nationwide PHC network required a significant increase in the number of rural health facilities to serve an estimated 11,000 villages, and a corresponding increase in trained personnel. These efforts required construction budgets, matched by funds to equip and supply the facilities, a nationwide logistics system and a supply of trained staff.

In addition to PHC, Lao socialist medicine moved to formalise linkages between traditional medicine and biomedicine, echoing developments in Vietnam and China, and paralleling those in Pol Pot's Democratic Kampuchea.[32] Traditional medicine hospitals were to be established in every province and most districts, and practitioners to be included within the state-managed health service. These moves complemented PHC policy by boosting the number of beds and health personnel recorded in the more remote regions.

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[31] WHO and UNICEF, *Primary Health Care: Report of the International Conference on Primary Health Care. Alma-Ata USSR. 6-12 September 1978*, (Geneva: WHO, 1978), pp.1-2.
[32] Ovesen and Trankell, *Cambodians and their Doctors*, p.87.

While many forms of traditional medicine are practised in Laos, only the more botanical aspects (as opposed to the underlying spiritual beliefs) were to be incorporated into the government-managed health system.[33] Opinions were divided on the policy's merits: French-educated Khamlieng was upbeat about the potential of traditional medicine, while his colleague Vannareth was reportedly "implacably hostile", condemning it as "superstition".[34] Ten traditional medicine hospitals nationwide were listed in a 1979 Ministry document, which also stated there were one or two traditional medicine practitioners in each *tasseng*, and five to ten in each district.[35] Many appear to have been village-based healers drafted into the official health sector, in a bid to quickly swell the numbers of staff, while hoping to 'reform' them with socialist science to steer them away from the more 'magical' aspects of their practice, considered to be unscientific, superstitious, even backward.

Traditional medicine was publicly acknowledged as a cost-saving alternative to biomedicine, as the ingredients did not require importation. Additionally, it was celebrated as a national form of medicine which enhanced self-reliance. One source listed 163 items of traditional medicine material as having marketable properties if produced by the state-owned pharmaceutical

[33] Strigler *et al*, 'Situation nutritionnelle', pp.126-127.
[34] Sicard, *Au nom de Marx*, p.94; and Grant Evans, *The Politics of Ritual and Remembrance. Laos since 1975* (Chiang Mai: Silkworm Books, 1998), p.73. Evans confirmed Vannareth was the vice-minister in question, in personal communication, September 2013.
[35] LNAD, Lao PDR/MOH, 23-04: 'Khampaxay khay kongpasoum khong sahay Souk Vongsak, kammakane sounkang pak paxaxon pathivat lao, latthamonty-va-kane kasouang sathlanasouk, thi kongpaxoum khanengkane sathalanasouk thoua pathet khang tham- it, laya 4 pii (1976-1979)', ([Draft] Opening Speech for Comrade Souk Vongsak, Central Committee member of the Lao People's Revolutionary Party, Minister of Health, for the First National Health Conference for 4 years (1976-1979).

factories;[36] but later reports suggest that the Ministry concentrated on only 12. Other documents reveal that interest was not confined to botanical materials; one source identified geckoes, monkeys and tiger bones as potential medical commodities for exchange or export to socialist nations.[37]

The new regime embraced the use and production of pharmaceuticals, possibly to compensate for their short supply in the Liberated Zone during the war years, and as evidence of socialist science and technology. One government report stated: "A medical doctor without pharmaceuticals is like a gun without bullets".[38] Most pharmaceuticals were dispensed through government-managed health facilities and pharmacies, although some private pharmacy shops remained.[39] In 1987, with the easing of the Lao PDR's socialist economy, trained health staff were authorised to re-open private pharmacy shops, which supplemented their meagre government salaries.[40]

The Lao PDR received shipments of pharmaceuticals, some expired, from bilateral, multilateral and NGO donors.[41] Many were shipped through Vietnamese ports to avoid a Thai embargo on 273 items, including medicine, in the 1970s and

[36] LNAD, Lao PDR/MOH, 23-05, 'Saloup saphap kane viak-ngane 1 pii 1978'.
[37] LNAD, Lao PDR/MOH, 23-04: 'Khampaxay khay kongpasoum'. The text does not specify whether live animals or their by-products were intended for exchange or export.
[38] LNAD, Lao PDR/MOH, 23-05: 'Lay-ngane saloup viak-ngane 6 deuan ton pii 1979 lae phene-kane 6 deuan thay pii 1979', (Report on work achievements for first 6 months of 1979 and work plan for second 6 months of 1979), undated.
[39] One informant decided to flee the Lao PDR in the mid-1980s because the government was attempting to seize his pharmacy business. Former Lao pharmacy owner (anonymous) discussion, in San Diego, USA, 5 August 2012.
[40] Strigler *et al*, 'Situation nutritionnelle', p.129.
[41] An international volunteer at the Ministry of Health from 1986-1990 remembers lobbying French President Mitterand's wife to ensure pharmaceuticals donated by France were within their use-by dates. Doug Handisides interviewed in Vientiane, Lao PDR, 22 December 2012.

1980s.[42] Official reports meticulously list the number of crates, kilograms or tonnes of pharmaceuticals and medical supplies received, but rarely state the types of pharmaceuticals, their expiration dates or distribution details. For example, a draft report from 1979 announced that 153,654 kilograms of pharmaceuticals had been received from international donors since the change of regime in 1975.[43] The problem of expired pharmaceuticals, reportedly provided by the Soviet Union, North Korea, Poland and France, was compounded by poor storage and distribution systems.

The regime also publicised its efforts to domestically produce pharmaceuticals and traditional medicines as a demonstration of self-reliance and scientific capability, despite equipment and many of the raw materials being imported. Pharmaceutical Factory Number 1 in Viengxay closed in 1988,[44] but production continued in Vientiane at Pharmaceutical Factory Number 2 (the former Liberté facility, owned pre-1975 by Khamphaï Abhay) and from 1986, Factory Number 3, constructed with Japanese assistance.[45] The Ministry formed a state-owned enterprise in 1977 to oversee the production and sale of the modest range of pharmaceuticals produced, which included basic items such as 90 percent proof alcohol, saline solution, aspirin and chloroquine.[46] UNICEF estimates that by 1990 approximately 20 percent of national requirements for basic medications

[42] LNAD, Lao PDR/MOH, 23-05: 'Saloup viak-ngane deuan 1/1978 khong kasouang sathalanasouk' (MOH monthly report for January 1978), 2 February 1978; and Stuart-Fox, *History of Laos*, p.178.
[43] Anonymous, 'Hang lay-ngane saphap viak-ngan sathalanasouk', insert between p.14 and p.15.
[44] I thank Audrey Bochaton for sharing the details of her interview with Dr Sananh Chounlamany, Director of the Pharmaceutical Factory No. 2, in Vientiane, Lao PDR, 18 May 2014.
[45] LNAD, Lao PDR/MOH, 23-12: 'Khamsang nae-nam kieo-kap kane-chat-tang hong-ngane phalit yah lek 3', (Explanatory Order concerning the Establishment of Pharmaceutical Factory Number 3), 4 June 1986.
[46] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap … 6 deuan ton pii 1977'.

were manufactured domestically at Vientiane's two pharmaceutical factories, and a third in Pakse.[47]

In a curious aside, a group of Lao health staff was sent to Czechoslovakia in the early 1980s to work in a pharmaceutical factory, possibly in anticipation of the expansion of Lao production. This is a rare case of Lao workers providing cheap labour in the factories of Eastern Europe, a pursuit more common for Vietnamese workers. The staff concerned were disappointed (and perhaps surprised) not to be undertaking formal training courses, which was the common experience of Lao officials at that time. Some were given the opportunity to upgrade their qualifications on their return to the Lao PDR, in what may have been a gesture of apology from the Ministry which had either misunderstood the deal with Czechoslovakia or had not adequately explained it to the participants.[48]

Socialist health policies were managed for maximum political gain and were provocatively contrasted to the situation under the former RLG, when doctors were alleged to have demanded exploitative fees and "traded [blood] at the highest prices." One mischievous explanation from 1979 claimed that blood banks in capitalist countries were so named because of their commercialisation.[49] Sicard observed that "almost all" Lao doctors engaged in "very lucrative" medical practice in the old regime, but that the new regime's ban on private medicine did not stamp out the practice but instead forced it underground.[50]

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[47] UNICEF, *Children and Women*, p.136.
[48] Former Lao PDR health worker (anonymous) interviewed inVientiane, Lao PDR 17 December 2012.
[49] LNAD, Lao PDR/MOH, 23-04: 'Khampaxay khay kongpasoum'.
[50] Sicard, *Au nom de Marx*, p.109.

The Lao PDR's Expanded Health Network

The nationwide roll-out of PHC, announced by the PGNU in the mid-1970s and embraced by the Lao PDR required the rapid construction and/or repair of numerous rural health facilities to demonstrate that the new health service was indeed "better than before". Many district and *tasseng*-level facilities were built with international support, as were some show-case facilities at central and provincial level. Where international assistance was unavailable, the Ministry of Health undertook to construct facilities itself or encouraged villagers to pool local resources to construct simple structures reminiscent of the wave of community construction experienced in the 1920s.

The structure of the new regime's planned health network was formulaic. Every province and district was to have its own hospital, and every *tasseng* a health centre (*hong moh tasseng*, later *souksala*). At village level, every grouping of five to ten houses was to have a health volunteer, termed a 'hygiene fighter' (*nakhob-anamay*), armed with a drug kit and hopefully some rudimentary training in its use. Each province and district was also to have a traditional medicine hospital. This mirrored the specifications of the health network in the pre-1975 NLHX zone, although the war conditions had made it impossible to ever approach the comprehensiveness embodied in its theory.

The number of district hospitals increased from 96 in 1976 to 115 in 1990, or just short of one per district.[51] The increase in sub-district facilities was steeper:

[51] State Planning Committee, *1975-2000. 25* [sic]. *Basic Statistics of the Lao PDR*, (Vientiane: State Planning Committee, 2000), p.133.

from 294 in 1976 to a peak of 1,362 in 1987,[52] before declining in line with a decrease in Soviet assistance. In 1980, only ten percent (60) of such facilities were of brick and concrete construction. Another 62 were planned for construction in the next five years to replace the hospital beds 'lost' when existing bamboo and thatch facilities inevitably disintegrated after four to five years.[53]

Figure 5.2: Health facilities in the Lao PDR, 1976-1990

	Central hospitals	Provincial hospitals	District facilities	Sub-district (*tasseng*) facilities
1976	4	12	96	294
1979[54]	4	13	98	494
1980	4	13	102	610
1985	4	18	107	994
1987	4	16	112	1,362
1989	5	15	110	1,190
1990	8	17	115	937

At central level, Mahosot continued to be Laos' largest health facility, but it was no longer the most exclusive or the best-equipped. It was displaced by Hospital Number 1, a Soviet-built, state-of-the-art, 30-bed facility in the former USAID compound at Km6 as the most exclusive. Opened in May 1978, it was staffed with a team of Soviet specialists, and served the Party elite. And the 150-bed Lao-Soviet Friendship Hospital, opened in the late 1980s after almost ten years of on-and-off construction plagued by shortages of funding and materials,

[52] For the figures for 1976 and 1990, see State Planning Committee, *1975-2000. Basic Statistics*, p.133. For the peak figure in 1987 see, UNICEF, *Children and Women'*, p.136.
[53] LNAD, Lao PDR/MOH, 23-05: 'PHC', 1980. The discussion of PHC appears to have been excerpted from a larger report to which it was no longer attached.
[54] Ibid., p.11.

rivaled Mahosot as the best-equipped.[55] Other changes included the transfer of Setthathirat Hospital (formerly OB-run) from central control to the Health Department of Vientiane prefecture, and the opening of a Traditional Medicine hospital in Vientiane. The new regime also opened district-level hospitals in Vientiane prefecture, a financially inefficient move because the districts were located within the same town, but one that coincided with the formulaic approach of having a hospital in each district nationwide, regardless of its needs or location

At provincial level, the Lao PDR approached the Chinese government to build a new provincial hospital in Oudomxay.[56] A 60-bed hospital was built in Phonesavanh with Mongolian assistance in the early 1980s, and a similar-sized one in Salavan by NGO, Terre des Hommes. Vietnam funded a new district hospital in Nong Het and another in Xepone on the Lao-Vietnam border.[57] UNCHR funded the construction of several district hospitals; the Mekong River Commission funded another, while UNICEF provided funds and equipment for new *tasseng*-level health facilities constructed by the Lao government or local communities. For villages without local health facilities, drug kits, health volunteers, and visits from mobile medical teams were planned. However, it is unlikely that budgets were sufficient for such teams to make regular visits to many remote localities.

While the statistical growth in the number of overall health facilities was impressive, standards were often extremely low, especially at district and *tasseng*-

[55] Anonymous, 'Hang lay-ngane saphap viak-ngane sathalanasouk', p.11 bis.
[56] LNAD, Lao PDR/MOH, 23-05: 'Saloup viakngane deuan 1/1978 khong kasouang sathalanasouk', (Ministry of Health summary of work for 1/1978), 2 February 1978.
[57] LNAD, Lao PDR/MOH, 23-17: 'Bot-neua-nay tob kham-samphad nak-khao tang-pathet', (Notes on responses to foreign journalists interview questions), 11 March 1985.

level. Buildings constructed by villagers were often made of bamboo and thatch, and few had electricity or water connections, which significantly impacted general hygiene and the ability to sterilise medical equipment and store vaccines. UNICEF found that of 110 district-level hospitals reported by the Ministry in 1989, only 20 were actually providing healthcare services. Among *tasseng*-level facilities, "most … have not been in regular operation for two or three years and the others may be opened only a few days each month".[58] As such, an increase in the number of health facilities alone was no guarantee of a health service that was "better than before".

Ministry of Health staffing, professional education and training

Four key changes to staffing occurred in the Lao health sector under the new regime. First, staff were merged into a single, united government-managed health service, discussed above. Secondly, staffing classifications were simplified into three basic categories of high, mid and low-level, and French and English-language titles were abolished. Thirdly, staffing numbers increased across all classifications with the expansion in both overseas medical scholarships and domestic education. Finally and most influentially, the time and energy of health staff was divided between the provision of healthcare, the specific technical work of the Ministry, and the doctrine-based tasks of 'political work', 'policy work' and 'international work'.

The various professional classifications of the three former health services were aligned and simplified based on the extremely simple hierarchy used in the

[58] UNICEF, *Children and Women*, pp.135-136.

NLHX Zone: low-, mid-, and high-level health workers for those with fewer than three years, three to four years, or more than four years of training respectively. Staff numbers in 1976 are reported to have consisted of only 86 high-level doctors and 12 high-level pharmacists, 456 mid-level doctors, an unlisted number of mid-level pharmacists, and 4,000 low-level health staff, mainly nurses.[59] The health workforce increased to approximately 9,392 staff in 1985 and 12,551 in 1990.[60] According to UNICEF, 57 percent of the health sector workforce was female by 1990, the second highest in the Lao PDR behind the obscure-sounding sector of "trade and material supply", a possible reference to retail/sales work in a socialist setting.[61] The number of staff employed at each classification level rose rapidly in the early years of the new regime. This was due as much to the relatively high numbers of both RLG and NLHX students already undergoing health and medical education in 1975 (who began work after graduation) as to Lao PDR increases in staff and student numbers. The vast majority remained clustered at the bottom of the professional hierarchy, and had undergone *ad hoc* training in one of the former health services. Traditional healers whom the new regime had convinced to 'join the revolution' were added to the mix of low-level staff in rural areas.

Lao health staff were supplemented with international technical advisors, who now worked mainly at central level facilities. Many but not all were from socialist nations. The Soviet Union provided a full team of 20-25 specialists for Hospital Number 1 from 1978 until its closure in the early 1990s, dispensing

[59] Anonymous, 'Hang lay-ngane saphap viak-ngane sathalanasouk', p.10.
[60] State Planning Committee, *Ten years of socio-economic development in the Lao PDR*, (Vientiane: SPC, 1985), p.175; and UNICEF, *Children and Women*, p.138.
[61] Ibid., p.100

medical care and training Lao counterparts. Soviet advisors were also assigned to the Lao-Soviet Friendship Hospital. Vietnam provided technical advisors for the malaria program in Champassak and Vientiane provinces, the Medical University and health schools, and a food safety laboratory. Cuba provided a medical brigade of approximately 15 persons, on rotation since the early 1970s. The brigade was initially based in Viengxay, but moved to Vientiane and other provincial towns after 1975.[62] Brigade members assisted various health programs, including hospital management, medical school curriculum, leprosy treatment and primary health care.[63] Soviet and Cuban advisors were contracted through WHO, which also assigned advisors from other nations to its projects.

Figure 5.3: Ministry of Health staff numbers by level, 1976-1989[64]

	1976	1977	1978	1980	1985	1989
High-level staff	86	94	129	175	551	1,247
Mid-level staff	456	547	717	846	2,088	3,566
Low-level staff	4,000	4,523	5,457	4,991	6,753	8,271
Total	4,542	5,164	6,303	6,012	9,392	13,084

Many workplaces required interpreters, because only long-term advisors developed fluency in Lao. Lao graduates from overseas were called upon to interpret, in addition to performing their own work. It would be foolish to think

[62] FBIS, 'Pasason Article Views Lao-Cuban Ties', 4 November 1989.
[63] LNAD, Lao PDR/MOH, 23-04: 'Saloup layngane deuan kolokot (7) 1978 [lae] phenekane deuan singha (8) 1978', (Summary report for July (7) 1978 [and] work plan for August (8) 1978).
[64] For 1976-1978 statistics, see Anonymous, 'Hang lay-ngane saphap viak-ngane sathalanasouk', p.10. For 1980 and 1985 statistics see: State Planning Committee, *Ten years of socio-economic development'*, p.175; and for 1989, see Holland *et al*, *Impact of Economic and Institutional Reforms*, p.26.

that nothing was lost in translation, especially as it is highly unlikely that such staff had formal training in interpreting or translating.

The professional education and training of Lao health staff increased apace. Many Lao students continued to study abroad.[65] Domestic education options also expanded, in terms of the range of courses offered and the number of student places available. A disproportionate number of scholarships were for study in socialist countries: approximately 1,000 to 1,500 students were sent to study overseas each year from 1980, mainly to the Soviet Union and Vietnam,[66] although medical students also studied in East Germany, Czechoslovakia, Bulgaria and Mongolia and elsewhere. More than 17,000 Lao students received education and training at universities in the Soviet Union from the early 1960s until 1991, although it is not possible to say how many of these studied medicine.[67] A UNICEF report mentions that more than 50 fellowships per year were provided to Lao doctors until 1989.[68] In addition, many Lao students upgraded their qualifications (*nhok ladab*) overseas, presumably from medical assistant to doctor, or from doctor to post-graduate specialist.[69] Some 'patriotic' Lao students who returned from France in 1977 before having graduated were

[65] I do not have statistics for medical students who obtained international scholarships. Archival sources indicate that the Ministry of Health was involved in selecting candidates for professional upgrading courses overseas, but not in selecting secondary school graduates to undertake university courses.
[66] Ng Shui Meng, 'Social Development in the Lao People's Democratic Republic: Problems and Prospects,' in *Laos: Beyond the Revolution*, ed. Joseph J. Zasloff and Leonard Unger, Basingstoke: Macmillan, 1991, p.164.
[67] Elshad Talybov, First Secretary, Russian Embassy to Lao PDR (by telephone) on 19 June 2012.
[68] UNICEF, *Children and Women*, p.138.
[69] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap kane viak-ngane 1 pii 1978'.

among those given the chance to complete their studies under the technical upgrading program.[70]

The poor standard of general education in the Lao PDR had a knock-on effect to the health sector, and created pitfalls for students abroad. Stuart-Fox notes that students returning from overseas "too often possessed diplomas, but little or no knowledge," resulting from their low educational base and their lack of mastery of the foreign language of instruction.[71] Another scholar noted specifically of medical students that they "reported, not without some bitterness, that they went through their entire practical medical training courses without being allowed to handle certain medical equipment and patients because of inadequate background or skills".[72]

An additional problem was the lack of a common professional language among returnees. In a "socialist bloc analogue to the Tower of Babel" doctors and other professionals returned home fluent in Russian, German, Hungarian or Vietnamese, for example, but without a common technical Lao vocabulary or *lingua franca* like French.[73]

Professional education opportunities in Laos also expanded considerably in the post-1975 period, and had the advantage of being mainly taught in Lao. The network of education institutions comprised the Medical University; mid-level health colleges in Vientiane, Luang Prabang and Pakse; and low-level health schools in every province nationwide. Ministry of Health institutes, including the

[70] Lao PDR Ministry of Health administrator (anonymous), discussion, in Vientiane, October 2013.
[71] Stuart-Fox, *History of Laos*, p.193.
[72] Ng, 'Social Development', p.166.
[73] Evans, *Politics of Ritual*, p.161.

Traditional Medicine Institute, also offered short and longer-term upgrading courses. The Medical University provided high-level courses in medicine, which had commenced in 1968-69 under the RLG, and from 1981 for pharmacists. It also offered courses in mid-level pharmacy and dentistry, and low-level dental mechanics. Cohorts of medical students increased from 20 to 100 or more in 1978 in response to the Ministry's ambitious targets for its PHC network. Without a corresponding increase in the number or quality of teachers, facilities or learning materials, standards invariably fell.[74]

The three mid-level health colleges were reincarnations of those established in the RLG period as low-level schools. (The NLHX mid-level college in Viengxay was handed over to the Army and no longer trained civilians.) The Luang Prabang and Pakse colleges re-opened in the late 1970s. In 1985 the mid-level courses on offer included nursing, pharmacy, dentistry, laboratory analysis, prosthetics and orthotics, and physiotherapy.[75] The mid and low-level dental courses ceased in 1989, presumably due to funding shortages.[76]

Large numbers of mid-level doctors or medical assistants (*phet xanh kang* or *phet xouay*) continued to be trained. Their course was reduced from four to three years, to speed their training and help fill vacancies in provincial and district locations. However, the WHO-supported course for registered nurses appears to have lapsed in the late 1970s, and was not re-introduced until the mid-1980s.

[74] This point is acknowledged in a Ministry-produced human resources assessment in 1998 which states that pre-1990s the health development plans had focused on quantity at the expense of quality. See Ponemek Dalaloy *et al*, 'Analysis on Health Manpower Management in Lao PDR', December 1998, p.1. Also, MacAlister Brown and Joseph J. Zasloff, *Apprentice Revolutionaries. The Communist Movement in Laos, 1930-1985, (*Stanford, CA: Hoover Institution Press, Stanford University, 1986), p.240.
[75] LNAD, Lao PDR/MOH, 23-17 'Bot-neua-nay… nak-khao tang-pathet'.
[76] Strigler *et al*, 'Situation nutritionnelle', p.129.

Finally, each province was responsible for establishing a low-level medical school and training its own nurses (*phet xanh tonh*). There was rhetorical commitment to standardising the curriculum – copies of curricula were prepared in the late 1970s, even though there was no budget or transport system to distribute them to each province, let alone monitor and support their implementation.[77]

Other plans, such as training in public health and midwifery, proved difficult to get off the ground. A Ministry report from early 1976 mentioned preparations for a School of Public Health (*hong hian anamay*).[78] UNICEF was clearly frustrated the school had not opened by 1990, and listed the major obstacles:

> … the structure and program of the school have only been drafted and still need approval; the delay is mainly linked to the difficulty in finding trainers at the top level who have the appropriate background and capacity, particularly in pedagogy. Other problems include: the unavailability of specified and agreed-upon profiles for each category of personnel; the scarcity of good translators; and the shortage of a well-supplied library. [79]

There was a similar delay in training midwives, despite the key role of Mother and Child Health in PHC programming. The 1976 report mentioned preparations for their training, but a course did not begin until 1987. [80] It ended abruptly five years later. Traditional medicine was added to the medical curriculum as early as 1976,[81] and political theory was incorporated into the curriculum at all levels from

[77] LNAD, Lao PDR/MOH, 23-05: 'Lay-ngane saphap kane-kheuan-vay'.
[78] LNAD, Lao PDR/MOH, 23-04: 'Lay-ngane saphap kane-viak-ngane nay laya thi phane ma – phene-kane 3 deuan (deuan 4-5-6)', (Report on the work situation for the previous period [and] 3 month work plan (April-May-June)), 29 March 1976.
[79] UNICEF, *Children and Women*, p.139.
[80] LNAD, Lao PDR/MOH, 23-04: Lay-ngane saphap-kane viak-ngane'.
[81] WHO, WPR/RC27/3, 1976, p.13

the late 1970s, in the hope that it would reduce the number of students fleeing into exile.

Professional education and training, as with staffing, continued to depend on international technical advisors. French instructors lectured at the Medical University until 1978, when a diplomatic dispute (discussed below) required all French advisors to depart. From 1979, they were replaced with technical advisors from the Soviet Union's Techno-Export Company under contract to WHO.[82] A Lao media release advises that the Soviet Union provided 20 instructors to the Medical University over the ten year period from 1979 until 1989. They assisted in the training of high-level doctors and pharmacists and mid-level dentists, and made preparations for the future introduction of a high-level curriculum for dental surgeons (stomatologists). Soviet advisors wrote lesson plans and wrote or compiled texts on 26 different subjects, of which more than 1,000 were printed. In addition, they supported the professional development of Lao instructors. They reported training 42 Lao instructors in the basic sciences, and sending another seven to the Soviet Union to complete four to five year courses, although their specialisation was not stated.[83] Vietnamese and Cuban advisors also contributed to professional education at the Medical University and the mid-level health colleges. Post-1975 in-country medical education was taught (mainly) in Lao, as more qualified Lao were now available to work as instructors. Textbooks and course notes began to appear in Lao, although French-language curricula persisted, and Lao-language notes sometimes relied heavily on French technical vocabulary.

[82] WHO, WPR/RC32/3, 1979-1981, p.78.
[83] FBIS, 'Soviet Cooperation in Public Health reviewed', Vientiane domestic service, 19 August 1989.

The Politics of Socialist Health: 'Political Work'

Marxist-Leninist doctrine held that personnel would transform the health service into one with socialist characteristics, requiring political as well as technical training. The Ministry of Health's annual report for 1978 stated that staff were to be of good character (*khounsombat*) and have "good enough technical skills" (*khouam samat dee pho khouan*) and an understanding of the Lao PDR's political aims and methods.[84] While perhaps alarming that high technical standards were not prioritised, the main focus rested on transforming the thought of health staff "to that of revolutionary socialist doctor/health workers (*hay kay pen phet-moh pativat sangkhom-niyom*) serving the people of all ethnic groups, [that is,] the workers".[85]

In stark contrast with the old regime, political training and ideological guidance (*viak-kane-meuang, seuksa-ob-hom lae nam-pha-neo-khit*) were accorded important roles within the new regime's Ministry. Significant time and effort was invested in exposing health staff to the foundations of socialist political theory and rooting out 'enemies'. The presumption was that by training them in Party and State policies and resolutions, staff would be committed to their work and less likely to flee into exile.

The Ministry of Health's Party cell managed the 'political life' (*xivit kanemeuang*) of its staff. Regular monthly, six-monthly and annual reports suggest that its political work was primarily concerned with monitoring 'enemy activity' *(kane-kheuanvay khong satou*) within the Ministry and its hospitals and

[84] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap kane viak-ngane 1 pii 1978'.
[85] Ibid.

schools. Political training for staff and medical students; and the monitoring and reporting of staff motivation and attitudes towards their work and the new regime more generally, appear to have taken a secondary place.

References to 'enemies' feature frequently in internal Ministry reports through the early 1980s. In 1978 the Ministry suspected it was a special target of 'enemies' due to its technical functions and high numbers of well-educated staff compared to other ministries.[86] Nearly every monthly report begins with a paragraph on enemy activity, although little hard evidence is cited beyond staff being 'incited' to flee overseas. Approximately 50 Vientiane-based health staff fled each year from 1976 until 1980, 35 in November 1979 alone.[87] The Ministry claims that not all fled because of opposition to the new regime: some allegedly fled to join spouses, others to escape from family problems.[88] Stuart-Fox estimates that approximately ten percent of the population fled following the change of regime, including the vast majority of Laos' tiny educated, urban population.[89]

Rare examples of overt 'enemy' activity are afforded by the reported sabotage of a pharmaceutical factory in 1976, presumably in Vientiane, and the

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[86] Ibid.
[87] LNAD, Lao PDR/MOH, 23-04: 'Lay-ngane saloup yo deuan phachik (11/79)' (Summary report for November (11/79)), 24 November 1979.
[88] LNAD, Lao PDR/MOH, 23-05: 'Saloup viakngane deuan 1/1978'.
[89] Martin Stuart-Fox, *Buddhist Kingdom, Marxist State: The Making of Modern Laos*, (Bangkok: White Lotus, 1996), p.168. The monthly refugee flow was approximately 1,000 per month at the start of 1977 rising to 1,500 by year end; approximately 4,000 per month by year end in 1978; and in 1979 a peak of 6,000 in July. See MacAlister Brown and Joseph J. Zasloff, 'Laos 1977: The Realities of Independence', *Asian Survey*, 8(2), February 1978, p.167; Brown and Zasloff, 'The EBB and Flow of Adversity' *Asian Survey*, 19(2), February 1979, pp.98-99; and Brown and Zasloff, 'Laos 1979', p.107.

capture of seven 'spies' (*nak seup*) on Ministry premises in 1978.[90] It is not clear who sabotaged the factory – the report simply states that the incident halted serum production, although medicines in tablet form continued to be produced.[91] Nor do official reports identify the spies, who were handed over to the police and did not reappear in further reports.

The Ministry conducted mass political training sessions for staff and students to study key political documents. Comparisons between the old and new regimes and petty punishment of former RLG staff may also have been made, as hinted in the comments of a retired nurse:

> They said the French surgeons [in Laos until 1978] exploited us, but they didn't. They used to get angry/impatient, but that concerned the regulations. They were strict. They wanted us to follow the regulations … After Liberation, we all had to collect rubbish. Even though I was a doctor's wife, I led the staff in collecting rubbish. I was a manager, so I had to lead the staff. We had to clean toilets. I led the way, I did it. I washed away shit and piss …[92]

Political training absorbed time and energy, and at times Ministry reports confessed that personnel had not read the entire policy documents, as they had to attend to their 'specific work' of healthcare provision. Senior Ministry staff were sent for political training, removing them from their duties for sometimes months at a time. A 1978 report noted that in some workplaces, no staff remained to

[90] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap kane viak-ngane 1 pii 1978'.
[91] LNAD, Lao PDR/MOH, 23-05: 'Lay-ngane sapharb kane-kheuan-vay', p.6.
[92] Former RLG and Lao PDR nurse (anonymous) interviewed in Vientiane, Lao PDR, 30 January 2012.

provide healthcare as all were involved in training courses.[93] Similar scenarios played out in other ministries.

Political training differed from re-education (*tat sang*), which included punishment. Some former RLG Ministry staff were despatched for political re-education (*sammana*), although official sources do not dwell on this fact. A report from early 1976 states that 14 unnamed personnel who had been the subject of complaints were sent for political re-education in Viengxay in 1975. The same report mentions vaguely that some were sent to the Dong Dok university campus, and others re-educated on-site (presumably at the Ministry or Mahosot).[94] Sicard mentions seven medical students arrested in October 1975 with no explanation, and never seen or spoken of again.[95] In 1979, two Cabinet Office staff were detained and subsequently sent for re-education. The report gives neither names nor positions of the staff, nor any indication of their crimes or 'mistakes' (*khouam phit-phat*).[96]

Finally, 'political work' involved the close monitoring of staff attitudes and motivation. Morale had dropped by 1979 and 1980 due to ongoing economic problems, but possibly also due to problems in the politically-determined management system. In addition to overseas flight, there were resignations, requests for transfer and general lack of motivation in the work place. In 1980, after the launch of new currency and salary packages, it was observed that several

[93] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap kane viak-ngane 1 pii 1978'.
[94] LNAD, Lao PDR/MOH, 23-05: 'Lay-ngane saphap kane-kheuan-vay'.
[95] Sicard, *Au nom de Marx*, pp.110-111.
[96] LNAD, Lao PDR/MOH, 23-04: 'Hang lay-ngane saphap-ngane viakngane lae botbat khong hongvakane kasouang sathalanasouk', (Draft report on the function and role of the Cabinet Office, Ministry of Health).

Ministry staff had turned to pushing barrows in the nearby fresh food market for extra income, causing them to arrive at work late, presumably physically fatigued and less motivated to perform their medical tasks.[97]

The Economics of Aid and Self-Reliance: 'International' and 'Policy Work'

The Lao PDR's self-reliance policy was an awkward fit for the health sector, as it neither produced goods nor generated income. There was little funding for the Ministry, exacerbated by its ideologically-driven abolition of fee-for-service healthcare. 'International work' was meant to attract development assistance to help expand and diversify the sector, and 'policy work' to supplement the low and irregular salaries. The domestic production of pharmaceuticals and medical equipment and supplies, and the integration of traditional medicine contributed to the self-reliance policy. A subtle distinction between self-reliance and the acceptance of international development assistance appears in at least one Ministry document, which describes self-reliance (*pheung ton-eng*, *koum ton-eng*) as taking care of oneself, while international funding support provides a way to improve oneself "with the sincere assistance from fraternal (*ay-nong*) socialist nations".[98]

'International work' was an important strategy to keep the Ministry financially afloat. Despite strident criticism of RLG dependence on foreign aid,

[97] LNAD, Lao PDR/MOH, 23-04: 'Layngane saphapkane lae viakngane deuan 1/1980 khong kasouang sathalanasouk', (Ministry of Health monthly status and work report for January 1980), 1 February 1980.
[98] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap kane viak-ngane 6 deuan ton pii 1977', (Summary Report on Work for the First 6 months of 1977), undated, p.8.

the new regime was equally dependent on external assistance.[99] 'International work' was crucial to secure cooperation and assistance. Figures are not available for the percentage of health expenditure covered by international assistance during this period. However, one report estimated that 42 percent of 1988 government health spending was covered by foreign aid.[100]

External assistance to the health sector was secured by senior Ministry staff who attended a heavy round of international conferences organised by agencies such as the socialist Committee for Mutual Economic Assistance (CMEA), WHO and the International Red Cross, and received official delegations from overseas. Cooperation agreements for assistance to the health sector were signed with a number of socialist nations, for example, the Soviet Union, Vietnam, Hungary, Czechoslovakia and East Germany.[101] Agreements included the construction and upgrading of health infrastructure; provision of pharmaceuticals and medical equipment and supplies; provision of medical teachers and/or technical advisors, overseas medical scholarships and training; and treatment of Lao patients abroad. Agreements were generally short-term (one to two years), and subject to bilateral review and renewal at periodic intervals. It is important to note that a significant proportion of socialist assistance consisted of concessional loans rather than grant aid, which posed a significant change from the pre-1975 period when US assistance consisted overwhelmingly of grant aid.

[99] No ready-analysed statistics are available to show whether the Lao PDR was more, or less, dependent on international development assistance than the former RLG.
[100] Report titled 'Health Sector' and likely to be written by WB, WHO or ADB in 1990, p.1.
[101] LNAD, Lao PDR/MOH, 23-07: Lao-Czechoslovakia Cooperation Agreement (1977); and Lao-Soviet Union Cooperation Agreement (1978); and 23-08: Lao-Hungary Cooperation Agreement (1976); Lao-German Cooperation Agreement (1977); and Lao-Vietnam Cooperation Agreement (1977).

Development assistance was also received from multilateral donors such as the WHO and UNICEF, which had previously assisted the RLG. They were joined by the United Nations High Commissioner for Refugees (UNHCR) which assisted the resettlement of internal refugees displaced by the decades of fighting (and subsequently, Lao returning from Thai refugee camps), UNFPA, and a handful of non-socialist donors such as France, Japan and Sweden. The Soviet Union displaced France as the most influential donor to the Lao health sector, a position it maintained until its withdrawal in 1991. While the USSR was leading health development efforts in Laos, its own health sector was criticised by one scholar as "one of the most backward and neglected sectors of the country's economy".[102]

Impoverished, post-war Vietnam was the second most important donor to the Lao health sector, continuing the technical assistance it had begun in the Liberated Zone and proving that a nation does not have to be wealthy to provide development assistance. Vietnam constructed health facilities, provided shipments of pharmaceuticals and medical equipment, contributed technical advisors to central and provincial-level health services, and offered scholarships for medical students. It also exchanged numerous official health delegations as part of national and provincial-level cooperation agreements.[103] It assisted Laos to

[102] Marina Hepburn, 'Review of *Doctors and the State in the Soviet Union* by Michael Ryan', *Soviet Studies*, 42(4) (October 1990), p.823.
[103] Carlyle A. Thayer , 'Laos and Vietnam: The Anatomy of a "Special Relationship," in *Contemporary Laos.* ed. Stuart-Fox, pp.259-260.

conduct basic surveys of common diseases and local traditional medicine resources,[104] and established a food safety laboratory in Vientiane.[105]

France continued to provide assistance to the health sector, mainly technical advisors to Mahosot and the Medical University, until 1978 when a diplomatic dispute compelled the advisors to leave.[106] Japan returned as a major donor to the Lao health sector by the mid-1980s. In addition to funding the purchase of pharmaceuticals and medical supplies and equipment, Japan supported the construction of health infrastructure and purchase of medical equipment. Sweden became active in the health sector in the late 1980s, adding health, water supply and sanitation to its aid program for 1988-1990.[107]

WHO's five-year health development program with Laos continued despite the change of regime. In 1976 there were 15 WHO-supported projects within the Ministry of Health, including Health Service Development, Organisation of Medical Care, Health Laboratory Services, Nutrition Services, Disease Prevention and Control, Application and Control of Pharmaceuticals,

[104]Ibid., p.260.
[105] Former Lao PDR health worker (anonymous), interviewed in Vientiane, Lao PDR, 22 June 2012.
[106] Surprisingly scant information about the nature of the diplomatic dispute is available. Phongsavath Boupha offers perhaps the most complete explanation, stating: "… France staged hostile acts against the Lao Government through its Embassy in Vientiane which encouraged French and Lao citizens, academics and intellectuals to flee the country. In Paris, the French Government with its support to exiled Lao living in France waged a political campaign against the Lao PDR." A Lao source which lists key dates in Lao history states that Lao diplomats were expelled from France on 3 July 1978 "for no reason," eliciting an official complaint from the Lao government to the French Ambassador to Laos on 21 August 1978. Diplomatic relations between the two nations were upgraded more than three years later on 5 December 1981, and a Lao-French cooperation agreement was signed in Paris in 1989. See Phongsavath Boupha, *Evolution of the Lao State*, pp.137-138; and Institute of Historical Research, *Bantheuk hetkane*, pp.29, 31, 87, 191.
[107] Mark McGillivray *et al*, *Evaluation Study of Long-term Development Cooperation between Laos and Sweden.* (Stockholm: Sida, 2012,) p.68.

Family Health, Health Manpower Development, and Nursing Education.[108] The WHO assistance budget ranged from USD 800,000 to 1 million per year in the late 1970s rising to approximately USD 1.4 million per year in 1986-87, and approximately USD 1.8 million per year in 1990-91.[109] While these are not huge figures in themselves, they are expected to have represented a significant portion of the Lao health budget. UNICEF supported nutrition, immunisation, and water and sanitation activities, including the construction of wells and latrines in selected provinces. More modest assistance was received from international NGOs, notably the International Development Association from the Netherlands and Terre des Hommes.

The financial burden of being in the right place to secure international assistance was heavy, as was management and coordination. On return from an International Red Cross conference in 1986, a delegate reported: "The Lao and Vietnamese delegates pleaded repeatedly as instructed for the IRC to cover the costs of our hotels and per diems, but they refused despite our best efforts. They would only pay our airfare".[110]

The diverse spread of international donors exacerbated the management dilemma. It led one Lao official to remark in 1977 that it would be better if all international assistance to the health sector could be channelled through one

[108] Projects are listed in WHO's biennial WPR committee reports.
[109] The figures are drawn from WHO budget estimates rather than expenditure figures, and so do not reflect actual expenditure in Laos. See WHO Budget Estimates documents, WPR/RC27/2 (1976), WPR/RC31 (1980), WPR/RC33 (1982), WPR/RC35/3 (1984) and WPR/RC37/5 (1986).
[110] LNAD, Lao PDR/MOH, 23-21: 'Bot-saloup kane-pay-houam kong-paxoum-sakon ka deng khang thi 25 you nakhone Geneve pathet Savit tae van-thi 23 ha 31 toula 1986', (Report on participation in the 25th International Conference of the Red Cross in Geneva, Switzerland from 23-31 October 1986),17 November 1986.

organisation.[111] This was a pipe-dream. In 1979 the Lao PDR planned to approach at least 13 nations for assistance: Albania, Bulgaria, China, Cuba, Czechoslovakia, East Germany, Hungary, Mongolia, North Korea, Poland, Romania, the Soviet Union and Vietnam.[112] The assistance requested in 1977 reveals the extent of the Ministry's dependence. The list included not only big-ticket items such as the construction of hospitals, research laboratories and health schools, but items as seemingly minor as fabric to make bed sheets and uniforms.[113] It also reveals the uncertainties the Ministry faced concerning the likelihood of securing international assistance:

> … we must request [assistance] from every country. We have to do it like this because we have based [this list] on our needs for both the short and long-term. But we don't know who will agree to actually help us. Therefore, we must request assistance from every country. Take pharmaceutical factories, for example. 1 or 2 factories would be enough for us (if they were medium or large-sized factories) but in reality we need to request [a factory] from many countries because we don't know who will help us. If we only request assistance from one country at a time, and we are not successful, we will have wasted a year [before we can resubmit the request]. Definitely there is a risk in requesting [the same thing] from many countries, because if many agree [to provide this assistance], from whom will we accept it? We will have to solve such a problem by following the line (*neo thang*) of the Party-state.[114] [emphasis in the original]

While cooperation agreements spoke diplomatically of exchanging technical knowledge and experience, in nearly all circumstances cooperation took the form of a one-directional flow of assistance. This was a source of

[111] LNAD, Lao PDR/MOH, 23-05: 'Saloup saphap kane viak-ngane 6 deuaneton pii 1977'.
[112] LNAD, Lao PDR/MOH, 23-03: 'Phenekane kho kanesouay-leua pii 1979 nam banda pathet sangkhom-niyom', (Plan for 1979 to request assistance from socialist countries), prepared 5 October 1977, submitted 4 April 1978.
[113] LNAD, Lao PDR/MOH, 23-03: 'Phenekane kho kanesouay-leua pii 1979'.
[114] Ibid.

embarrassment for some health officials, particularly in the first years of the Lao PDR.[115] An official reasoned in the late 1970s that if the Ministry produced a small range of pharmaceuticals for export, it would have something to exchange rather than merely requesting assistance. The suggestion hints at the concern to preserve Lao dignity (*kiad*) in relations with fraternal nations, regardless of the country's ability or otherwise to produce a surplus of pharmaceuticals for its own needs. The document reveals more than intended, though, when it lists the pharmaceuticals able to be produced domestically, and proceeds to assure officials in the Prime Minister's Office: "This matter is not just a dream. On the contrary, it is a capability *we really do have*". [my emphasis] Such comments suggest that official documents during this period may have at times grossly overstated a ministry's actual skills, experience or available resources.[116]

'Policy work', contrary to its connotations in English language, concerned the promotion of comprehensive staff well-being and livelihood, as well as socialisation. Policy work had a broader brief than the areas of salaries, working conditions and pensions. It also involved the promotion of membership in the Party's mass organisations: the Lao Youth Union, the Lao Women's Union, and the Lao Federation of Trade Unions. These organisations helped organise and motivate staff to participate in the regime's wider policy agenda: the

[115] Rare examples of Lao medical assistance to other countries include the largely symbolic provision of one set of surgical equipment to the newly established People's Republic of Kampuchea; sending successive medical teams to work in Stung Treng province of Cambodia (which contains a significant ethnic Lao population, and borders the southern Lao province of Champassak) throughout the 1980s; and donating a shipment of traditional medicine to the Soviet Union following an earthquake in Armenia and Azerbaijan in December 1988. Dr Vanliem Bouaravong, Lao PDR doctor and administrator, interviewed in Vientiane, Lao PDR in July 2014; and photograph 91-5251 in the *Khaosane Pathet Lao* (Lao News Agency) archives, Vientiane, Lao PDR.

[116] LNAD, Lao PDR/MOH, 23-03: 'Phenekane kho kanesouay-leua pii 1979'.

establishment of a purchasing cooperative within the Ministry, which also distributed rationed goods; the establishment of an agricultural cooperative and the drafting of staff labour; participation in education upgrading, or in the Ministry's arts and culture troupes or its various sporting teams; and guarding rosters at the Ministry's various premises.

Within the first months of 1976 the Ministry established a cooperative (*sahakone*) that made bulk purchases of meat, fish and vegetables from the market for staff, and opened a staff canteen. Both initiatives were intended to reduce the costs of food, fuel and time, dispensing with the need to visit the market, and to travel between work and home at lunchtimes. Moreover, staff were encouraged to raise livestock and grow their own vegetables.[117] Another immediate 'policy work' plan was the provision of childcare facilities for staff, but the Ministry had to wait five years for an international donor to provide funding and building materials to construct its nursery/crèche. The Ministry soon took a sharp agricultural turn. A monthly report from 1977 juxtaposes Ministry tasks: in May it would send a representative to attend the World Health Assembly in Geneva, and raise ten more pigs.[118] By 1978, in an effort to support agricultural production and the Party's overall policy of agricultural self-reliance, the Ministry's cooperative received increased attention.

The Ministry's various mass organisations rostered staff for agricultural and other forms of physical labour (*ork heng ngane*) in addition to their regular,

[117] LNAD, Lao PDR/MOH, 23-04: 'Lay-ngane saphap-kane viak-ngane', p.1.
[118] LNAD, Lao PDR/MOH, 23-05: 'Saloup-laygnane-hobetane khong kasouang sathalanasouk samlap deuan mesa 1977', (Comprehensive monthly report of the Ministry of Health for April 1977), 26 April 1977.

health-related work. Staff helped dig a dam reservoir and two irrigation canals at Nam Moun and Nam Xouang, within a 10-25 kilometre radius of Vientiane. For some staff, the agricultural labour requirements proved tough. One woman, a young mother at the time, recounted bitter memories of being sent to the countryside for one or two weeks at a time to dig irrigation canals or plant vegetables, leaving her children in their grandparents' care.[119] Other staff reportedly enjoyed the camaraderie of communal labour, treating it as a physical competition that also earned one valuable political points (*phon-ngane*).[120]

By 1979, the Lao PDR's peasant-style socialism was pushing the limits of the Ministry of Health's agricultural prowess. Ministry reports displayed a strong agricultural focus. The various departments and hospitals each cultivated plots of land, to which all staff were required to contribute labour. For example, in September 1979 Mahosot staff planted rice fields, fruit trees and seasonal vegetables. The hospital was reported to have two buffaloes, 26 cattle, two horses (and a cart for market trips) and 280 ducks and geese, as well as six fish ponds. The Rehabilitation Centre's rice fields were reported to contain "excellent rice" (*khao ngame thi sout*).[121] Much of this agricultural produce made its way to the Ministry's canteens, where staff were encouraged to eat communally to save time and money. Other produce was distributed as rations by the Ministry's cooperative. The agricultural focus became so pronounced that during 1979, the

[119] Former OB and Lao PDR nurse (anonymous) interviewed at San Diego, USA, 6 August 2012.
[120] LNAD, Lao PDR/MOH, 23-05: 'Saloup layngane yo deuane kanya (9) 1979 lae phene-kane deuan 10/1979', (Summary report for September (9) 1979 and work plan for 10/1979).
[121] Ibid.

three staff members were sent to study agriculture and forestry, and another to study agricultural cooperatives.

'Policy work' also promoted participation in social and cultural activities. Education upgrading was offered at a variety of levels: basic literacy training, the opportunity to complete lower secondary school, and for those who already had a higher education, foreign language classes in French, English, Russian and Vietnamese, which might increase one's chance of a foreign scholarship.[122] The Ministry's arts and culture troupe organised singing contests and performed for international guests, as well as at important political occasions. Sporting competitions were often organised to celebrate the same events.

Healthcare Services in the Early Lao PDR Period

Minister of Health Khamlieng informed foreign journalists in 1985 that comparing the RLG health service to the present one was like "comparing the earth with the sky".[123]He provided no real basis for comparison, though, only a list of current achievements. And while the Ministry's statistical improvements looked promising at first glance, there were the familiar, underlying problems of inadequate budgets, poor education and skills levels, and weak management and monitoring systems. Frequently the Lao PDR claimed to have introduced healthcare services that could more accurately be described as re-introductions of services that existed under the French, the RLG, or even its own forerunner, the NLHX. In this vein, the Ministry of Health launched an Expanded Program of

[122] LNAD, Lao PDR/MOH, 23-05: Saloup saphap kane viak-ngane 1 pii 1978'.
[123] LNAD, Lao PDR/MOH, 23-17: Bot-neua-nay … nak-khao tang pathet'.

Immunization around 1982,[124] a 'pilot' MCH Program in the 1980s, and a Water and Sanitation Program with assistance from UNICEF. The AML and the RLG's Ministry of Health had run similar programs, but official rhetoric suggested these were completely new. One genuinely new function was the establishment, in 1988, of a National AIDS Committee.

MCH received less attention in the early Lao PDR period than under the RLG, despite the adoption of PHC policy. Somewhat bizarrely, a strong element of the MCH program became the construction of nurseries and crèches for the children of health staff, an activity more aligned with women's participation in the workforce than with MCH.[125] Moreover, the government characterised family planning as an immoral, un-Lao practice, despite it being a standard element of both MCH and PHC programming internationally. It would seem that the leadership worried about territorial incursions by larger and politically stronger neighbours, and was therefore preoccupied with increasing the population, regardless of the health effects on women. As a direct consequence, fertility and maternal mortality rates in Laos remained among the highest in the world throughout the 1980s and 1990s. Family planning returned in the late 1980s under the guise of 'birth spacing' in a WHO/UNFPA-supported project. It was approved not because it would potentially lower the birth rate, but rather because it promised to increase the survival rate of infants and mothers. Indicating that the

[124] Dates are conflicting. The WHO website states 1984, but other sources cite 1979 and 1982.
[125] LNAD, Lao PDR/MOH, 23-17: 'Bot neua-nay … nak-khao tang pathet'.

obsession with population numbers remained, one document referred to it as the "population increase" project.[126]

The water and sanitation program was delivered as part of the Lao PDR's 'three cleans' campaign (continued from the Liberated Zone), which encouraged people to eat clean food, drink clean water, live in a clean house/environment. Village-based 'hygiene fighters' told people to wash their hands, construct and use latrines, dig rubbish pits, and to pen animals away from their houses. The fact that the same campaign continues nowadays with the same basic messages demonstrates that the desired behaviour changes have proven difficult to achieve, and raises questions about the effectiveness of the communication methods.

The use and production of pharmaceuticals were showcased as evidence of the regime's technical and scientific advancement, but did not approach national coverage or sustainability. UNICEF was highly critical of the Lao pharmaceutical system:

> Essential medical supplies are lacking and some drugs are in short supply at peripheral levels, while being kept shelved under bad storage conditions at upper levels, and expiring because of bad management and planning. Others are inadequately supplied or are inappropriate according to WHO guidelines on the rational use of essential drugs.[127]

The assessment of health sector performance through the early 1990s was often similarly unfavourable. The Ministry of Health failed to meet the targets of

[126] Khamphienne Philavong *et al,* 'Issues and Challenges of Public Health of 21st Century of Lao People's Democratic Republic', in *Issues and Challenges of Public Health in the 21st Century*, ed. Khairuddin Yusof *et al.*, (Kuala Lumpur: University of Malaya Press, 1996), p.152.
[127] UNICEF, *Children and Women*, p.136.

its Five Year Plan for 1980-1985,[128] and performance in the second Plan fared no better. Despite the impressive increase in district level health facilities, only 20 of the reported 110 facilities were actually delivering healthcare in 1989.[129] Despite 15 years of socialist heath policy, Laos continued to have some of the worst health indicators worldwide with life expectancy at birth averaging 46 years in 1990, and an infant mortality rate of 159/1,000.[130]

A UNICEF publication concluded that "… despite quantitative improvements, the quality of the [Lao] health care system remains low …". It revealed that the policy of PHC promotion had not been matched by a corresponding budgetary commitment. Only three percent of the Ministry's 1988 budget had been spent on PHC, compared to 75 percent on curative care. "The general picture", UNICEF concluded, "seems to be that the construction of a nationwide primary health care system has *totally failed* [my emphasis], especially at community level, for financial, organizational and political reasons".[131] NGO CCL hinted at similar shortcomings, citing the "mediocre" quality of university training, "insufficient" base-line medical skills, and the frequent lack of supplies and equipment.[132]

The new regime ascribed blame for poor performance to the effects of war, the maladies from the old regime, reactionism and international

[128] Stuart-Fox, *History of Laos*, p.193.
[129] ADB, 'Performance Evaluation Report. Lao People's Democratic Republic. Primary Health Care Project', Project No: PPE LAO 25109, Loan No: 1348-LAO (SF), May 2006, p.3.
[130] UNICEF, *Children and Women*, p.135.
[131] Ibid., pp.135-137.
[132] Jean-François Favarel-Garrigues, 'L'appui au service d'anasthésie-réanimation de l'hôpital Mahosot', in *Le Laos doux et amer. Vingt-cinq ans de pratiques d'une ONG*, ed. Dominique Gentil and Philippe Boumard, (Paris: CCL-Karthala, 2005), p.284.

imperialists.[133] Unsurprisingly, the authorities were reluctant to accept that their new policy approaches had not arrested the health sector's poor performance but had in fact contributed to it. 'Political work' and 'policy work' undoubtedly took their toll, as did hospitality for the frequent international delegations. Added to these obstacles was the decentralisation period from 1987 to 1991. As UNICEF explained:

> … each level lacks the technical and financial resources necessary to support the level(s) below it in training, supervision, technical assistance and specialised care for cases which are referred upwards. At all levels the system lacks planning and managerial skills which result in poor financial, budget and personnel management, inefficient supply of materials and drugs and very weak information and control systems.[134]

The ultimate irony is that while government rhetoric boasted of the major steps in advancing the reach and effectiveness of the health service, high-ranking Party cadres sought healthcare at the exclusive Hospital Number 1, or in the more developed socialist nations. The Soviet Union, Vietnam, Hungary, Czechoslovakia and East Germany all offered free medical treatment in their countries for a quota of Lao patients each year, outlined in their assistance agreements. Even the Minister of Health, Tiao Souk, spent a month convalescing in East Germany in 1979.[135]

[133] LNAD, Lao PDR/MOH, 23-04: 'Lay-ngane saloup viak 6 deuan ton pii 1979'.
[134] UNICEF, *Children and Women*, p.142.
[135] LNAD, Lao PDR/MOH, 23-04: 'Saloup lay-ngane yo deuan 9 1979', (Summary report for September (9) 1979).

Conclusion

The new regime made changes to the Lao health sector but few sustained improvements. It re-united the health service, expanded its network into new rural and workplace locations, and increased the number and diversity of its staff. The range of professional education and training available locally expanded considerably, allowing Lao to increasingly become the language of the workplace, although high-level staff and specialists trained overseas still struggled to find a common technical language.

However, many of the new regime's policies did not progress far beyond the realm of theory because the health service's improvements lacked substance and could not be sustained without external development assistance. Large numbers of facilities, especially in the marginal rural and predominantly ethnic minority areas, offered no or low-quality health services due to insufficient budgets, equipment and supplies, and staffing. An unknown proportion of international and in-country health graduates possessed poor understanding of their technical field (*visah saphoh*) due to their rudimentary command of a foreign language, the low quality of their basic education, or the poor teaching skills of their instructors. The PHC policy was given considerable lip-service but little constructive support. The integration of traditional medicine with biomedicine suffered a similar fate, with grand rhetoric but little follow-through, and pharmaceutical use and production continued to be inconsistent. When international assistance levels declined in the late 1980s, many health facilities and education programs effectively closed. This situation highlighted the

contradiction inherent in the new regime's policy of self-reliance, because little progress was achieved and/or sustained without ongoing external assistance.

The Lao PDR's quest to build a socialist health system that was 'better than before' outpaced its technical and management capacity to do so, as well as its implementation budget as the nation was listed as one of the poorest in the world. While some improvements were made to the sector, the overwhelming verdict is that the health service remained limited in coverage, poor in quality and over-burdened with politically-influenced administration and training during this period.

CHAPTER 6
DONOR DELUGE:
THE POST-SOCIALIST TRANSITION TOWARDS MARKET-BASED HEALTHCARE (1991-2000)

Introduction

The 1990s was a transformative decade for Laos and the wider international community, as the collapse of the Soviet Union and regime changes in much of Eastern Europe ushered in the post-socialist period. These international political events deprived the Lao PDR of its major ideological guide and source of development assistance. They prompted wide-ranging changes in Lao government policies and practices which had been foreseen by 'new thinking' (*chinthanakane may*), the Lao version of *perestroika*, and the market-oriented New Economic Mechanism (NEM) announced at the Fourth Party Congress in 1986, but which were still very much works in progress at the end of the 1980s.[1] These changes led to significant diversification in the international development agencies supporting the health sector, the increased localisation of health-related professional education and training, and a range of policies, regulations and legislation which formalised the partial privatisation of healthcare services.

The World Bank and the ADB filled the void in the Lao health sector left by the departing Soviet Union and several other socialist nations, as their policies broadened from economic development to focus also on social

[1] For a discussion of the meaning behind *chinthanakane-may,* see: Norihiko Yamada, 'Re-thinking of "Chinthanakan-mai" (new thinking): New perspective for understanding Lao PDR', Institute of Developing Economies (IDE) Discussion Paper No. 393, March 2013.

development. A plethora of smaller multilateral organisations, international NGOs and foreign universities also flocked to assist the health sector. The multilateral development banks approved multi-million dollar loans in the mid-1990s for projects intended to rehabilitate, modernise and improve the health network. Funding of this scale assisted health staff to make the ideological about-turn required by the NEM, discarding the principles of socialist health and embracing in its place a market-oriented system which allowed partial privatisation of healthcare services and the (re-) introduction of user-fees.

The deluge of international donors clambering to support the Ministry of Health created special dilemmas. While the increased volume of funding promised opportunities to improve the health sector on a scale never before possible, is also placed heavy demands on the time, efforts and skills of the Ministry's small pool of multi-lingual technocrats who were tasked with managing, coordinating and capitalising on these opportunities. The 'international work' of the early Lao PDR period mushroomed into a full-time occupation for dozens of Ministry staff in the 1990s. What had previously comprised a steady stream of attendance at overseas conferences, hosting of visiting international delegations, and partnering with technical advisors from a limited number of nations became a whirlwind of interpreting, translating, policy-dialogue, project negotiations and fielding of counterparts, all standard requirements for effective cooperation with international development agencies.

As in previous decades, 'specific', health-related work continued to jostle for position with the all-important external relations function of the

Ministry of Health, as the nation itself continued to be unable to cover the costs of its health sector. Only through international development assistance and cooperation could it secure the funding and technical assistance to support the operation of its under-funded, under-developed health service. The heavy reliance on securing and servicing international assistance meant that healthcare provision was still unable to be the Ministry's primary focus.

This chapter begins with a discussion of the policy changes that took place within the Lao health sector in the 1990s. It contextualises the increasing role of multilateral and non-socialist bilateral development agencies, and their cooperation with the Ministry at central and local levels, and concludes by examining actual healthcare delivery and health indicators, as reported and assessed by international organisations. Data has been drawn primarily from Government of Lao PDR official plans and reports, as well as from multilateral and bilateral development assistance agencies. This chapter is also informed by personal experience, as I began working in the Lao development sector in 1998.

Post-socialist structures and policies

Lao PDR government ministries experienced considerable structural and policy change in the 1990s. The collapse of the Soviet Union and regime changes across Eastern Europe resulted in an abrupt end to the relatively stable flow of socialist development assistance to the Lao PDR for the past 15 years. At the same time, the NEM began to filter down to the level of actual implementation. By the Fifth Party Congress of 1991, the outlined economic changes were comprehensive: a new economic structure, new management

techniques, cost accounting, investment, productivity, improved distribution of goods, greater recognition of the private sector, new tax and salary policies, recognition of the importance of foreign investments in national economic development, and the role of overseas Lao in the development of the national economy.[2]

The Ministry of Health was restructured at least twice in the 1990s, first in 1993 and again in 1999, although it is not known to what degree the restructures were linked to the broader political and economic changes taking place nationally. The Ministry also added specialist functions to its structure, for example, centres for ophthalmology, tuberculosis and a Food and Drug Management Office between 1987 and 1991.[3]

The 1993 restructure removed the Social Welfare function from the Ministry of Health, as well as Minister Khambou Sounixay, who transferred to a role at the National Assembly. He was succeeded in turn as Minister by two French-educated doctors, Vannareth Latsapho and Ponemek Daraloy. Both possessed the cultural, linguistic and technical skills required to serve as effective interlocutors in the emerging post-socialist environment. Vannareth, a Vice-Minister since 1980, was elevated to the position of Acting Minister of Health (*latthamonty phang*) in 1993, but may not have been ever appointed to full ministerial rank, judging by Lao media reports which referred to him alternately, and inconsistently, as Acting Minister and Minister from 1993 to 1996.[4] The reticence to appoint him as a full Minister may have been due to

[2] Chou Norindr, 'Laos in the Deadlock. Would Socialism Survive?' *Indochina Report*, Singapore: Information and Resource Centre Pte Ltd, January-March 1992, p.2.
[3] LNAD, Lao PDR/MOH, 23-46: 'Saloup phon-ngane 5 pii tane sathalanasouk (1987-1991)', (Summary of health achievements over 5 years (1987-1991), p.7.
[4] Senior staff from the Ministry of Health and the University of Health Sciences indicated they were unable to confirm the names and dates of service of the various Ministers and Vice-

his RLG past, and his high-level technical and educational skills being overshadowed by his weaker political credentials. The rumoured persistence of bourgeois habits which sat uncomfortably with the public displays of socialist frugality required of the Lao PDR ruling elite at that time may have also played a role.

Figure 6.1: Prof Dr Vannareth Latsapho, Minister of Health (1993-1996)[5]

Ponemek's revolutionary credentials outstripped those of Vannareth. He was appointed Minister of Health in 1996 following Vannareth's premature death in office, and served as Minister until his retirement in 2011. After studies in France, he had served in the NLHX's Liberated Zone as Director of the Central Hospital (*Hongmoh sounkang*) in Viengxay, and post-1975 was appointed Director of the Cabinet Office in the Lao PDR's Ministry of Health.[6] He served in diplomatic postings to Cuba in 1989-1992 and China

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Ministers at a seminar in Vientiane in June 2014. The WHO faced a similar dilemma when preparing a commemorative book on the organisation's 60 years of cooperation with Laos in 2012, with a request to the Ministry of Health unanswered. References to Vannareth in Ministry documents, radio broadcasts and press releases collected in the FBIS from 1993-1996 alternate between according him the title of Minister of Health and Acting Minister of Health. The lack of uniformity suggests that he was officially Acting Minister of Health, even though he in fact performed the role of Minister.

[5] *Khaosane Pathet Lao* (Lao News Agency) photographic archives.

[6] An English language source suggests that Ponemek cared for American Prisoners of War (POW) in the Lao PDR after 1975, but there is no reliable evidence to substantiate this claim.

in 1992-1996 while waiting his turn as Minister. Ponemek scraped into the Party's Central Committee in 2001 as its lowest-ranked member, after serving as Minister of Health for five years. Despite the differences in the political careers of the two men, both were well-qualified to lead the Ministry of Health's process of policy change and international donor negotiations throughout the 1990s.

The abandonment of socialist health policy

The 1990s witnessed the abandonment of much of the socialist health policy introduced in the early Lao PDR period. Its key elements had been the elimination of private healthcare providers, the free provision of healthcare and pharmaceuticals, the promotion of traditional medicine and its integration with biomedicine in government health facilities within a PHC model. Stuart-Fox argues convincingly that the Lao PDR was only ever in transition towards socialism, before deciding to take a policy step backwards towards a market-oriented capitalist-style economy.[7] The health sector was caught up in the overall policy transition. The Ministry of Health's vision of a comprehensive socialist health system was still a work in progress at the time that the party and government adopted the NEM and market-based economics. The policy changes paved the way for the official endorsement of private pharmacies and clinics, and ultimately, the re-introduction of user fees, which was anathema to socialist health. Paradoxically, while these key elements of socialist health

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See Bill Hendon and Elizabeth A. Stewart, *An Enormous Crime. The Definitive Account of American POWs Abandoned in Southeast Asia*, (New York: Thomas Dunne Books, 2007), pp.239-241.

[7] The LPRP did not abandon socialism altogether. It rationalised that its final goal remained socialism, but it was necessary to pass through a phase of capitalism (of indefinite duration) in order to reach it. See Stuart-Fox, *History of Laos*, pp. 194-195.

policy were dismantled, much of the socialist rhetoric endure, making for strange juxtapositions in the health system in future years.[8]

The official authorisation of private pharmacies and clinics in the late 1980s and early 1990s respectively signalled the first steps in the dismantlement of socialist health policy, paving the way for what Jönsson describes as a "partially privatised" sector.[9] In 1987 the Ministry of Health allowed current or retired pharmacists, doctors and assistant doctors to own and operate pharmacies selling a regulated list of pharmaceutical items and medical products outside of government working hours. Pharmacies were categorised as Class One, Two or Three, depending on the owner's level of pharmacology training. Official authorisation of private clinics followed in 1992.[10] Similar to pharmacies, clinics were allowed to be owned by current or retired government health workers, and operated outside of government working hours. For the most part, they were individual businesses run from small shop-fronts erected in front of the health worker's own home or a room inside the home.[11]

The number of private pharmacies multiplied rapidly. They increased nearly 60-fold in the first decade, from approximately 32 in 1986 to 1,850 in 1995.[12] Most were located in Vientiane, and the remainder in the larger provincial towns, and overwhelmingly in the lowest, Class Three category,

[8] A translation of MOH's Seventh Five-Year Health Sector Development Plan (2011-2015), talks of focusing on "a contribution to reach the IXth Party resolution's major targets including the 4 breakthroughs (Ideology, human resource, management and poverty eradication), the fast track change to industrialization and modernization in the direction towards socialism and the reaching [of] all [the] MDGs targets including the targets for health sector and for others". See Ministry of Health, 'Seventh Five-Year Health Sector Development Plan (2011-2015)', (Vientiane: MOH, October 2011), p.3.
[9] Kristina Jönsson *et al*, 'Health Policy Evolution', p.5.
[10] Strigler *et al*, 'Situation nutritionnelle', pp.124-125.
[11] Lao 'clinics' were modest versions of what would be called a 'surgery' in Australia, or a '*cabinet de médecine*' in France.
[12] Jönsson *et al*, 'Health Policy Evolution', p.4.

that is, shops owned by health workers (not necessarily trained pharmacists) permitted to sell a limited range of pharmaceuticals. The tendency was for pharmacies to remain open all day, often staffed (illegally) by an unqualified relative or shop assistant. The growth in private clinics followed a similarly rapid trajectory. Most clinics did not offer access to high quality diagnostic equipment, due to its high capital costs. The selling point was guaranteed access to a doctor's time and attention, services not guaranteed within government health facilities. Following the authorisation of private pharmacies and clinics, the Ministry issued a Decree on the Establishment of Private Hospitals in 1998. However, until 2012 the WHO reported that no private hospitals operated in the Lao PDR.[13]

The policy change to support privatised healthcare signalled a potentially awkward development in party/state rhetoric, which from the early Lao PDR period had represented the private clinical work of RLG staff as being symptomatic of personal greed, class-based exploitation and absence of revolutionary spirit. Despite the inconsistency in policy and rhetoric, the about-turn was accepted by the Lao public without major ado, perhaps due to the woefully low condition of government healthcare services in the 1980s. In addition, Jönsson suggests that many private establishments had been operating unofficially before their authorisation, and that therefore the policy move was as much about regulating an existing practice as it was about introducing a new one.[14]

[13] WHO/Ministry of Health, *Health Service Delivery Profile. Lao PDR 2012*, p.1, available on the WHO's regional office website, http://www.wpro.who.int/health_services/service_delivery_profile_laopdr.pdf
[14] Jönsson *et al*, 'Health Policy Evolution', p.4.

The re-introduction of privatised healthcare provided many government staff with an economic side line to supplement their modest salaries. It did not represent, however, the formation of a medical cadre separate to the government cadre – as those who operated private clinics also worked within the Ministry or its local branches. However, it is interesting to note that even though the public and the private health systems were staffed with the same health workers, patients with the ability to pay often chose the private over the public option.

The government made its most decisive step in moving away from socialist healthcare in 1995, when it introduced user-fees in government health facilities. Prime Ministerial Decree 52 authorised fees for treatment and diagnostics tests, as well as the sale of drugs through Revolving Drug Funds.[15] The ADB and the World Bank reasoned that revenue earned from user-fees would help to finance the recurrent operating costs of health facilities and therefore improve the quality of basic service delivery. Alain Noël, a medical advisor with international NGO, CCL reasons that the Lao government was forced to consider the alternative of user-fees based on the very poor performance of the health service in the 1980s. With some of the lowest levels of per capita health spending in Laos witnessed in the 1980s, and staff salaries comprising an increasing proportion of the health budget, there were virtually no funds for maintenance, medicines or supplies. Noël observes that this situation resulted in degraded and under-equipped health facilities and staff with low levels of motivation. User-fees were understood as a pathway out of

[15] Prime Ministerial Decree 52/PM of 26 June 1995; cited in Christophe Jacqmin and Marianne Beseme, 'Le recouvrement des coûts de santé: expériences locales et politiques nationales', in *Le Laos, doux et amer. Vingt-cinq ans de pratiques d'une ONG*, ed. Dominque Gentil and Philippe Boumard, (Paris: CCL-Karthala, 2005), p.303.

the mess.[16] Unfortunately, official records made available for consultation in the National Archives reveal little of the internal discussions that took place in the lead up to this policy decision and resulting decree.

In fact, the Ministry of Health had experimented with user-fees for some years prior to the issuance of Prime Minister's Decree 52. The Ministry had approached CCL to develop a "paying hospital" in 1988-1990, and the two organisations trialled the practice in the relatively isolated district hospital of Pakkading in Bolikhamxay province from 1989 until 1994. CCL assisted the Ministry to expand cost recovery to Bolikhamxay provincial hospital in 1992,[17] while NGOs Médecins sans Frontières Belgium (MSF Belgium) and Médecins sans Frontières France (MSF France) are reported to have conducted similar user-fees trials in Champassak and Salavan provinces at around the same time.[18]

The policy provided for fee exceptions for current and retired government staff and party cadre, army veterans, Buddhist monks, students and the poor.[19] Problems were encountered with fee exemptions for the poor, mainly because the method of deciding who was poor and therefore entitled to an exemption was highly subjective. Regardless, the Ministry maintained in 2000 that "the introduction of a cost recovery system has improved equity".[20] Jönsson observes that problems arose in part because of the pressure for each health facility to raise sufficient funds to cover its own operating budget. In addition, it proved difficult to identify the genuinely poor. Initially, it was

[16] Ibid., pp.293-306.
[17] Ibid., pp.294-297.
[18] Ibid., p.301.
[19] Ministry of Health, 'Health Strategy up to the Year 2020. A Discussion Paper Prepared for the Donor Round Table Meeting', (Vientiane: MOH, May 2000), p.27.
[20] Ministry of Health, 'Policy of Primary Health Care', p.8.

thought that one's local village chief would issue a certificate attesting to one's poverty, but it quickly unravelled into a system of nepotism, where friends and relatives were classified as poor and received free treatment.[21] The situation observed by CCL in Bolikhamxay provides some insight. It noted that in many instances the poor were required to pay fees, whereas exemptions were granted for health staff and their "ever-expanding families".[22] To correct the problems of Decree 52, the Ministry began preparing a replacement Health Care Law in 1997. However, eight years elapsed before the law was promulgated in 2005.[23] One of the main points picked up in the Health Care Law, and not addressed in the original decree, was the need for health insurance to assist the poor in paying for healthcare.[24]

The profile of traditional medicine, another hallmark of socialist health policy, subsided from its immediate post-war heyday. Traditional medicine practice in Laos was less formalised than it was in either China or Vietnam, and had therefore proved more difficult to integrate into the formal, biomedical sector. Staff with traditional medicine expertise continued to be included on Ministry of Health staff lists into the 1990s, although they were often located in the more remote districts and at the lower rungs of the professional hierarchy. This pattern suggested many had been recruited locally rather than from the pool of health graduates. Their employment could well

[21] Kristina Jönsson, 'Policy making in transitional economies: Poverty reduction and health care in Cambodia and Laos', *Studies in Health Services Organisation and Policy*, 23, 2008, p.173.
[22] Jacqmin and Beseme, 'Le recouvrement des coûts', p.299.
[23] Jönsson *et al*, 'Health Policy Evolution', p.6.
[24] Articles 44-50 of the Health Care Law (2005) address health financing and in particular, the various health insurance schemes available; eg: community health insurance funds, civil servants health insurance funds, enterprise health insurance funds, private health insurance funds and public welfare health insurance funds. Article 50 addresses Public Welfare Health Insurance Funds, which are said to be "established by the State to assist the poor and people with low incomes, who are unable to pay their membership contributions in any other health insurance fund." See Government of Lao PDR, 'Health Care Law', 2005.

have been motivated as much by the Ministry's policy imperative to have health workers stationed in as many remote locations as possible, as by its promotion of traditional medicine.[25]

Primary Health Care policy

Primary Health Care (PHC) was one of the few tenets of socialist health policy retained by the Lao PDR in the post-socialist period. It was overhauled, though, in the wake of scathing performance reviews in the 1980s. The growing number of international donors, and their support for PHC, seems to have been a factor in the Ministry's ongoing PHC endorsement and continued implementation efforts nationwide. From the mid-1990s, PHC was a central component of internationally-funded health projects of the ADB, the World Bank and Save the Children Fund Australia, among others.[26] By 2000, a total of 16 international organisations, comprising multilateral and bilateral donors as well as international NGOs, were assisting the Ministry to deliver healthcare services through a PHC framework.[27]

The Ministry of Health launched a formal PHC policy in 2000, after 25 years focus on PHC. The Ministry confirmed that it "endorses Primary Health Care as the first priority of the health sector, in order to expand basic health services to the grassroots." It went on to state that the PHC policy was:

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[25] For example, an extensive listing of provincial and district health staff in Khammouane province, prepared by JICA consultants in 1994, shows only nine staff employed in the provincial traditional medicine division, and another three staff in the poorest and most remote district, Boualapha. No other districts were reported to employ traditional medicine staff. See O. Sumiko, 'JICA PHC Project, Data on PHC Implementation 1993-1994, Thakhek, Khammouane, Lao PDR', 1994, pp.5, 8.

[26] Save the Children Fund Australia has since merged into the federation of Save the Children International.

[27] Ministry of Health, 'Policy on Primary Health Care', p.18.

> ... an important and essential guide to as well as a management base at the macro level of the Health sector, It defines clear direction, principles, strategies, components, the organization, actual activities, role [sic] and responsibilities, and relationship among each levels [sic] of the health services, village, sub-district health center, district, provincial and central levels.[28]

New donors encouraged the Ministry of Health to go beyond the construction and/or rehabilitation of rudimentary village-level health centres (*souksala*) and appointment of poorly trained, poorly supervised low-level staff, to also focus on improved delivery, monitoring and support. PHC activities broadened to include basic management skills in planning, implementing and reporting on project activities for district and village-level health staff, and funding for outreach work. Central-level Ministry staff were involved in project activities, often as trainers or intermediaries between international technical advisors and Lao health staff in rural areas. Despite the Ministry's all-encompassing policy statement and directives on PHC, it seems that it was well aware of the gap between policy and practice. It conceded that its performance left much to be desired, stating:

> Coverage of the network of basic health services is not yet complete. Many areas in the country have no coverage, and services do not reach ethnic [minority] populations in the remote regions where the services are most needed.[29]

The reach of the health service continued to be a challenge throughout the 1990s. The most highly-trained health staff were reluctant to work in rural areas, and staff and potential students from remote areas rarely had the opportunity to train or upgrade their skills, or to benefit from supportive

[28] Ibid., p.2.
[29] Ibid., p.7.

supervision from higher-ranking staff based in the urban centres. Moreover, the limited transportation network (roads, rivers, and expensive air transport) made it difficult to keep health facilities adequately supplied.

Pharmaceutical policy

Pharmaceuticals, the fetish of the early Lao PDR period, underwent on a process of standardisation. Formal pharmaceutical policies and regulations were prepared and formalised with assistance from SIDA, the Swedish government's international development agency and the Karolinska Institute. The small number of state-owned and joint-venture pharmaceutical factories continued production, but under new economic conditions brought about by the NEM.

Official concern at the influx of counterfeit drugs into the country and the rapid increase in private pharmacies prompted the Ministry of Health to request donor support to construct and outfit a drug quality control laboratory. Technical advisors from SIDA convinced the Ministry to formulate wider policies and practices to regulate the pharmaceutical sector rather than rely solely on a new laboratory. A policy development process was begun in the early 1990s, before the entry of many other international development agencies placed conflicting demands on Ministry staff. The project bore quick results, with a National Drug Policy issued in 1993. SIDA assistance continued for a decade to embed the implementation of the policy within the health and administrative environment. [30]

[30] Jönsson *et al*, 'Health Policy Evolution', p.5.

Lao pharmaceutical needs were met by a combination of local and imported supplies. The production capacity and range of the state-owned factories, Pharmaceutical Factory No. 2 and No. 3 and the military-owned Factory 104, were unable to meet local demand, and so imported pharmaceuticals, both legal and illegal, filled the gap.[31] A complicated management arrangement existed between the state-owned factories, the Ministry's Department of Pharmacy and a state-owned company in charge of marketing the products. From available documents in the National Archives, it is not possible to understand how the roles and responsibilities of the factories, the company and the Ministry were divided, and where accountability and decision-making was located.

Other legislative and regulatory developments

In addition to the PHC and the National Drug policies, a number of other health-related policies and laws were formulated during this decade, including the National Reproductive Health Policy (1995), the National Policy on Population and Development (1999), and the Law on Drugs and Medical Products (2000). Policies and laws were often drafted by international technical advisors in English to satisfy donors who required such documentation as a condition of their funding, and translated into Lao afterwards. In such circumstances, the extent of the involvement of Ministry of Health staff is unclear. In my work as an international development practitioner, it appeared that some Ministry staff had minimal awareness and/or understanding of the many health-related policies, guidelines and laws,

[31] I thank Audrey Bochaton for sharing information on her interview of Dr Sananh Chounlamany, Director of Pharmaceutical Factory No. 2, in Vientiane, Lao PDR, 17 May 2014.

which could have been due to the narrow involvement of only those staff who spoke foreign languages.

The World Bank, ADB and other new donors

Lao government funding for health hovered around five percent of the national budget throughout the 1990s, and a smaller percentage of GDP, according to the ADB.[32] Government budgets covered little more than basic administrative costs and the modest salaries of health staff, which eroded towards the end of the decade as the Asian financial crisis brought about triple-digit inflation in the Lao PDR. If 42 percent of government health spending was estimated to have been covered by foreign aid in 1988,[33] the figure had risen to almost 56 percent in 1992-93.[34] The Ministry of Health itself estimates that throughout the 1990s, approximately 75 percent of public expenditure on health was funded by international assistance.[35]

International development assistance agencies attempted to plug the funding gap that resulted from the low levels of government investment in the health sector. Whereas most technical and financial assistance in the previous 15 years had come from the Soviet Union and other socialist nations, the new donors constituted a more diverse group. They included newcomers such as the World Bank, the ADB, the European Union (EU), Australia, Belgium and Luxembourg, who joined existing donors France, Japan and Sweden, as well

[32] ADB, 'Performance Evaluation Report', p.8.
[33] Report titled 'Health Sector' and likely to be written by World Bank, WHO or ADB in 1990, p.1.
[34] The World Bank estimated total health expenditure for 1992-93 as follows: 19 percent domestically financed by Lao government; 24 percent externally financed by aid (through Lao government), and the remaining 57 percent financed by out-of-pocket by Lao households themselves. World Bank, *Lao PDR Social Development Assessment and Strategy*, (Washington DC: World Bank, 15 August 1995), pp.35-36.
[35] ADB, Performance Evaluation Report', p.4.

as Vietnam, Cuba and China. In its Five Year Health Plan of 1996-1999, the Ministry chose to highlight the generosity of Japan above other donors.[36] The technical and financial contributions of international NGOs to directly support the Ministry of Health also played an increasingly important role over the decade, many of them funded by bilateral donors.

Meanwhile, the role of UN agencies subsided as the 1990s progressed, despite the increased profile of human development within the UN's global programming. WHO and UNICEF were arguably the most influential donors to the Lao health sector, despite their relatively modest financial contributions. WHO funded a range of activities under project titles that became increasingly generic, and therefore difficult to interpret externally, within a country program of approximately USD 1.25 million to 1.75 million per year. In 1991-1992 the WHO's projected funding for the Lao PDR topped USD 3.8 million over two years, its highest amount to date.[37] UNFPA expanded its support to reproductive health and population policy, education and service delivery, and UNICEF continued its long-term support to the Ministry's water and sanitation activities, as well as MCH, along with separate activities supporting education and gender-sensitive development, although budget estimates and/or expenditure figures are not available.[38]

By the end of the decade, the World Bank and the ADB had displaced the United Nations agencies as the key donors and coordinating agencies within the sector. The multilateral banks provided low-interest concessional

[36] LNAD, Lao PDR/MOH, KS/Satha 09-100.2: 'Saloup kane-patibat phene-kane sathalanasouk pii 1996-1999 lae thit-thang nay to-nah', (Summary of health implementation 1996-1999 and future directions), Vientiane, 1999, p.2.
[37] Figures collated from WHO budget projections (not expenditure) in the following reports: WPR/RC39; WPR/RC41; WPR/RC43; WPR/RC45; WPR/RC47; and WPR/RC49.
[38] UNICEF, *Children and their Families in the Lao People's Democratic Republic*, (Vientiane: UNICEF, 1996).

loans, whereas the EU provided grant-aid. The banks and the EU all launched large health projects in 1995, after several years of preliminary feasibility missions and studies. The Lao Health Reform and Malaria Control Project was the World Bank's first concessionary loan to the Lao health sector. It planned to operate over six years from 1995 to 2001, but was ultimately extended until 2004 due to slow disbursement and low government management capacity. The project consisted of a low-interest loan worth USD 19.8 million, supplemented by a financial contribution from the Lao government.[39] The project received parallel funding from the Belgian government's development cooperation agency, Belgian Technical Cooperation. Project components consisted of basic health service provision in the southern provinces of Savannakhet and Sekong, pilot activities in Champassak and Xaysomboun Special Zone, malaria control activities in eight provinces, and health education activities nationwide.[40]

The Primary Health Care Project was the ADB's first foray into the Lao health sector. At USD 5.8 million over six years, its loan was smaller and less ambitious than that of the World Bank. The project design was also simpler, focusing on PHC-related activities, including construction and repair of infrastructure, training staff and supporting outreach services and the establishment of revolving Drug Funds to ensure a supply of essential drugs to district hospitals and villages. The project was designed as a pilot, and operated in Xieng Khouang and Oudomxay provinces only, but with the

[39] World Bank, 'Implementation Completion Report (IDA 26740) on a Credit in the Amount of USD 19.2 million to the Lao People's Democratic Republic for the Health Systems Reform and Malaria Control Project', June 30, 2005, p.1.
[40] Ibid., p.2.

intention to scale up when a workable model was up and running.[41]

The introduction of these large projects funded by loans, plus the introduction of myriad smaller grant-funded projects quickly made coordination of health activities very complex. For example: the EU initiated a multi-year, nationwide Malaria Control Programme designed to complement the World Bank's effort. The Swedish government's support for the three-phase National Drug Policy Program began in 1992 and extended until 2003. In 1997 the Australian government's development cooperation agency, AusAID, initiated a Health and Social Development Project focusing on basic health service delivery in the northern provinces of Houaphan and Phongsaly. Another government development agency, Luxembourg Development (Lux-Dev) began support to the health sector in the same year. International NGOs tended to support smaller implementation sites, and engage less comprehensively with the government health service than bilateral development agencies. Save the Children Fund Australia was an exception. It commenced a PHC project in 1992 in two districts of Xayabouly province, providing technical and financial assistance to provincial and district-level health services, and over the next decade gradually expanded to cover all ten districts of the province. In 2007 the project expanded to include the neighbouring province of Luang Prabang within its mandate.[42]

By the close of the 1990s internationally-funded projects dominated the health sector, and extended across the nation in a patchwork manner, covering dissimilar selections of health activities in some but not all provinces and/or

[41] Asian Development Bank (ADB), 'Performance Evaluation Report. Lao People's Democratic Republic. Primary Health Care Project.' Project No: PPE LAO 25109, Loan No: 1348 (LAO-SF), May 2006, p.v.
[42] Carol Perks, Advisor to Save the Children International, interviewed in Xayabouly, Lao PDR, 17 February 2012.

districts. A Steering Committee for Monitoring International Assistance was established by the Ministry of Health in an effort to keep tabs on the high degree of donor activity, and the increasing size and complexity of international development assistance projects.[43]

Figure 6.2 Health expenditure (USD) in Lao PDR, 1991-2000

Year	Health exp (% of GDP)	Health exp (% GOL budget)	GOL health budget (GOL)	GOL health budget (donors)	Health exp (households)	Health exp (total)	Health exp (per capita)
1991		~5%[44]					
1992			8.4m[45]	8.61m	20.68m	38.18m	8.54
1993							
1994			16.3m	8.43m	26.21m	50.68m	11.26
1995							
1996							
1997			8.31m	22.05m	42.09m	72.45m	14.94
1998							
1999			5.55m	21.69m	34.3m	61.63m	11.81
2000							

The Ministry's coordination efforts could only achieve so much. It was not possible to produce increased numbers of qualified staff required for 'international cooperation' overnight, nor was it possible to streamline the Lao government's unwieldy bureaucratic processes. As such, many internationally-funded health development projects operated at glacial pace. Speeding the pace would have meant bypassing engagement – and therefore development processes – with the limited numbers of Lao government counterparts.

Contraction and consolidation of the health network

[43] Ministry of Health, 'Health Strategy up to the Year 2020', p.18.
[44] ADB, 'Performance Evaluation Report', p.8.
[45] Health expenditure figures for 1992-93; 1994-95; 1997-98; and 1999-2000 are from Audrey Bochaton, 'Pai Thaï, pai fang nan', p.60.

The health network contracted and consolidated throughout the 1990s, mainly at the local level, after its growth spurt in the previous decade. Supported by the various international development agencies, attention shifted from the construction of new health facilities to supporting their actual operation. Concerns included the poor equipment and supply of facilities, the low level of maintenance and the Ministry's inability to staff them appropriately.

Operational problems were found throughout the health network. Much of the health infrastructure inherited from the former RLG regime, particularly at central and provincial-level, was aging and in need of maintenance and/or upgrading. At local level, most district hospitals and *tasseng*-level *souksala* lacked pharmaceuticals and medical supplies at the beginning of the decade, and few facilities had electricity connections or running water, even at decade end.[46] Many *souksala* established in the early years of the Lao PDR had quickly fallen into disrepair due to poor construction, insufficient maintenance, and the neglect of management staff at higher levels within the health service. Poorly trained health staff provided low quality healthcare, on the occasion that they actually attended the workplace, which in turn contributed to the very low usage rates recorded for government health facilities. In response, the Ministry and international donors attempted to improve the standards of infrastructure, equipment and supplies, the staffing, and healthcare delivery at all levels of the network, but with particular focus on the local level, in accordance with the Ministry's ongoing PHC policy.

[46] Asian Development Bank, Health and Education Needs of Ethnic Minorities in the Greater Mekong Sub-Region. Lao PDR Country Report, (Manila: ADB, June 2000), p.5.

Statistically, the overall numbers of both health facilities and hospital beds declined throughout the decade as attention belatedly turned to quality rather than purely quantity of facilities. The numbers of central and provincial health facilities remained reasonably stable, and district hospitals increased slightly from 115 in 1990 to between 121-126 in 2000. The most dramatic change occurred at sub-district level, where *souksala*, the cornerstone of the PHC network, reduced by 42 percent, from 937 in 1990 to between 524- 566 in 2000.[47]

The PHC approach continued to place high importance on *souksala*, but it was clear that poor quality buildings with absent staff and no supplies served no purpose other than to boost statistics. The development banks were keen to apply economic and demographic logic to the location of future facilities. The ADB loan project included funds for the construction of 73 new *souksala*, in addition to three district hospitals, and renovation of additional facilities.[48] It noted that previously *souksala* had been constructed in areas where population density was too low to ensure the facility's viability. From the project's second phase it recommended that each *souksala* needed a surrounding population of at least 3,000 to 4,000 people to be "practical and affordable".[49] Recommendations of this nature created an awkward situation for the Ministry which since the change of regime had promised healthcare services for all rural communities regardless of size or location. However, Lao promises could only be realised with external funding, and without financial

[47] The 1990 figures are provided by the State Planning Committee, whereas those for 2000 are from the Ministry of Health and the State Planning Committee. See State Planning Committee, *1975-2000.* p.133; and Ministry of Health/State Planning Committee, *Health Status of the People in Lao PDR*, (Vientiane: MOH/SPC, January 2001), p.1.
[48] ADB, 'Performance Evaluation Report', p.v.
[49] Ibid., p.16.

support from the ADB or other international donors, the Ministry was unable to build new or revive existing facilities.

While the Ministry of Health claimed that support to local-level health facilities was its major focus of activity, given its ongoing rhetorical support of PHC, in actual fact it was distracted by assistance to central and provincial-level infrastructure. International donors funded the construction of a number of new hospitals during the 1990s, sometimes displaying poor coordination between themselves and the Ministry.

In 1999 the Japanese government agreed to fund construction of a new hospital at Done Koy on the outskirts of Vientiane Capital to replace Setthathirat hospital, built by Operation Brotherhood in 1960.[50] A team of Japanese technical advisors trained Lao health staff in the management and use of the Japanese-funded equipment provided in the hospital construction package.[51] More difficult to explain, in the late 1990s two hospitals were constructed within 10 kilometres of each other in Vientiane province, one supported by Thailand and the other by Luxembourg. The Thai government funded construction of a hospital at Phonehong, while the Luxembourg government funded construction of the Maria-Teresa Hospital in nearby Viengkham district. The Luxembourg-funded hospital was designated as the provincial hospital while the Thai facility served the district. The case raised questions about the management and coordination capacity of the Ministry of Health, and its motivations. Was it a textbook example of weak management

[50] The administrative area known as Vientiane Municipality (*Kampheng-nakhone Vientiane*) in the 1990s was renamed Vientiane Capital (*Nakhone-louang Vientiane*) in the early 2000s. This is in contrast to Vientiane province, which is a separate entity whose territory does not include Vientiane Capital.

[51] http://www.la.emb-japan.go.jp/japans_oda_to_laos/implemented_projects%20of_japans_oda_to_laos.html#grant_aid

of international donor funds, highlighting poor coordination on the part of the Ministry and the Lao government more generally, or was it a cynical manipulation of international development assistance? Certainly, other provinces were in need of newly constructed hospitals as much, if not more so, than Vientiane province. Whether accidental or deliberate, the construction of two facilities virtually side-by-side was a case of mismanagement and missed opportunities.

The Ministry was tasked not only with coordinating construction, but also with equipping its internationally-funded health facilities. A wide range of international development agencies and individuals donated equipment for this purpose to supplement the Ministry's disparate collection of medical equipment, in various states of repair, supplied from France, the United States, the Soviet Union and other nations of Eastern Europe based on its recent history of development cooperation. New or donated equipment was not always compatible with existing equipment as it was sourced from so many different donors. In addition, some state-of-the-art equipment proved too expensive for the Ministry to operate, let alone maintain, such as surgery lights from Japan whose expensive globes had to be replaced after several hours' usage. One advisor observed that Soviet equipment was often more appropriate for Laos' limited health budgets. For example, Soviet surgery lights used globes that were interchangeable with those of car headlights, whereas expensive surgery lights from Japan had to be changed after only a few hours use.[52]

[52] Doug Handisides, former volunteer in the Medical Repair Workshop, Ministry of Health, 1986-1990, interviewed in Vientiane, Lao PDR, 22 December 2012.

Donated second-hand equipment caused problems of compatibility, and was not particularly appreciated. One former doctor, no longer in government service, expressed disgust at the donation of second-hand equipment by some smaller international donors: "It's junk", she said. "It should be thrown away. They should give us new equipment".[53] But while it may have been wiser to discard much of the second-hand equipment received, her comment overlooks the Ministry's poor track record in equipment maintenance, and supervising staff usage practices, which could turn even new equipment into junk within a relatively short space of time.

Health staffing

With the departure of Soviet medical advisors from Hospital Number 1 and the Lao-Soviet Friendship Hospital in the early 1990s, health staffing became comprised almost exclusively of Lao nationals for the first time since the establishment of biomedical health services in Laos. The overall number of health staff decreased from 12,551 in 1990[54] to 11,665 in 2000,[55] as many of the smaller health facilities closed and the Lao government shed staff based on recommendations from the IMF. Staff no longer fled across the Mekong as refugees as was the practice in the 1970s and 1980s, but several opted to leave government service in order to 'take care of their families', a euphemism for making money in the private sector or joining the payroll of the increasing numbers of NGOs, as the Lao economy underwent changes prompted by the economic restructuring of the NEM.

[53] Former Lao PDR health worker (anonymous), interviewed in Vientiane, Lao PDR, May 2014.
[54] This figure includes only doctors, medical assistants and nurses, but no other health-related staff. See UNICEF, *Children and Women*, p.138.
[55] Ministry of Health/State Planning Committee, *Health Status*, p.1.

By the 1990s, the Ministry of Health aimed not only to increase the overall numbers of high-level health staff, but also to increase their proportion of all health staff. It did so by providing upgrading opportunities for mid- and low-level staff, and training more high-level staff. The policy was modestly successful, as the proportion of high-level staff in the workforce did in fact increase vis-à-vis mid- and low-level staff.[56] High-level health staff now included doctors, dental surgeons and pharmacists.

The Ministry acknowledged there were problems with the quality of its staff and staffing systems. It saw low capacity, in terms of both management systems and skills, and the technical skills of its staff as limitations to the provision of healthcare services. In a discussion paper circulated to donors in 2000 it concedes:

> There is little clinical supervision or in-service training. And this, in combination with low utilisation of services, has resulted in gradual deterioration of skill. Health personnel generally lack management skills and few staff have received training in interpersonal communication or in counselling. Health personnel are not appropriately trained for the tasks they are expected to perform, and are not provided with the equipment and supplies they require.[57]

Another ongoing problem was that of staff distribution. The Ministry appeared powerless to address the high concentration of high-level staff in Vientiane and the large provincial towns, a problem that had persisted since the early years of the RLG period. Despite the Ministry's PHC policy requiring much larger numbers of skilled staff to be deployed at the local level. Few doctors or even mid-level assistant doctors were willing to be based in rural areas. There, they would have to accept poor communications, lack of

[56] Strigler *et al*, 'Situation nutritionnelle', p.128.
[57] Ministry of Health, 'Health Strategy up to the Year 2020'.

electricity and running water, low educational opportunities for their children, and limited chance to operate a profitable private clinic out of hours. The Ministry provided few if any incentives for health staff to be deployed in rural areas, and there appear to have been few consequences for staff who abandoned their posts. The ADB Primary Health Project concluded:

> Attractive salaries alone would not be enough to keep the health workers in the remote areas. The provision of housing near the health center [*souksala*] and land near their workplace that they could farm and live on was an important incentive.[58]

Professional Education and Training

The sudden cessation of scholarships from many socialist nations in the early 1990s affected the tertiary education and training of the Lao government's bureaucrats, technocrats and other professional classes.[59] The unexpected situation forced medical and health-related professional education and training to take two divergent paths: the search for new overseas locations for education and training, as well as the increasing localisation of professional formation of Lao health staff. Vietnam was one of the few socialist countries to continue providing high numbers of scholarships at high and mid-level. Other nations began to offer more education and training opportunities, including Thailand, Australia, Japan, India and France. France was often the destination of choice for candidates in the health and medical fields, many who were still competent in French after less than a 15-year

[58] ADB, 'Performance Evaluation Report', p.vi.
[59] Evans, *Short History*, p.258.

hiatus in the teaching of medicine in French language.[60] Scholarships at this time also began to offer specialisations, and so Ministry of Health staff took up graduate diplomas and/or Masters scholarships in a range of topics such as public health, community health, epidemiology and nutrition studies, which added to their background in general medicine. Thailand leveraged its influence, based on the similarity of its language and culture to Laos. Universities such as Khon Kaen University in Thailand's north-east established cooperation arrangements with the Lao Ministry of Health to provide education and training opportunities in Thailand, and perhaps to open up research opportunities for themselves in the Lao PDR.[61] In another link up with Thai universities, UNFPA sent significant numbers of Lao students for post-graduate studies to Mahidol University in Bangkok, and Chiang Mai University.

As international scholarships focused increasingly on post-graduate studies, it became more common for medical students to undertake their undergraduate education in the Lao PDR. By the 1990s, the bulk of medical graduates completed their professional education in Laos, taught by Lao instructors in Lao language. International donors directed renewed support to improve the teaching quality at the University of Medical Science and the mid-level Technical Health College (the former nursing school) in Vientiane. The French government, both directly and through French NGOs, assisted the medical university, as did the Thai government and WHO. The Japanese

[60] The *Annuaire 2008* lists alumni from the Lao Ministry of Health who have completed professional education or training in France. See Embassy of France, *Annuaire 2008*, (Vientiane: Embassy of France, 2008), pp.107-144.
[61] LNAD, Lao PDR/MOH, 23-19: Letter re: 'Kho anoumat sen kho-phouk-phanh lavang mahavitthayalay phet-sat lae mahavitthayalay khone-kene pathet thai', (Request approval to sign an item concerning a relationship between the University of Medical Science and Khon Kaen University, Thailand), 23 January 1991.

government and WHO re-initiated nursing education projects in the health colleges of Vientiane, Luang Prabang, Pakse, Savannakhet and Thakhek, in a move that was reminiscent of the long-running nursing education project conducted by the WHO in the 1960s and 1970s. Personal accounts from nursing staff suggest that curricula were developed anew, rather than building on those existing or previously used.[62]

The University of Medical Sciences consisted of three faculties in the early 1990s: medicine, pharmacy and dentistry. All offered high-level courses, with high-level dentistry commencing in 1991-1992. Medicine and dentistry were six-year courses, pharmacy five years.[63] The Technical Health College in Vientiane offered seven courses at mid- and low-levels, consisting of three year and less than three year curricula. The number of courses on offer reduced throughout the 1990s: midwifery ceased in 1989-90, medical assistants in 1992, and orthotics and prosthetics in 1994. No clear explanation for the cessation of courses emerges from archival documents. One plausible explanation is that discontinuation of Soviet assistance in the early 1990s prompted the decisions. Another explanation is that ambitious Ministry policy intended to replace all mid-level medical assistants with doctors, making their continued training redundant. The remaining courses were mid-level nursing, physiotherapy and laboratory studies.[64]

In 1995 the University of Medical Science was transferred to the newly created National University of Laos (NUOL) under the Ministry of Education,

[62] Personal communication with Lao nursing specialists (anonymous), Vientiane, Lao PDR, July 2014.
[63] University of Health Sciences, '55 pii chak honghian phet xou mahavitthayalay vitthayasart soukhaphap', (55 Years from Medical School to University of Health Sciences), (Vientiane: UHS, 2013), p.6.
[64] University of Health Sciences, '55 pii chak honghian phet', pp.7-9.

where it became known as the Faculty of Medical Science. The transfer created an awkward division between the high-level courses, now under the purview of the Ministry of Education, and the mid-level courses, which remained under the Ministry of Health's Technical Health College. The transfer was badly received within the Ministry of Health, and led to a decade of lobbying before it was reassigned to Health. It also demonstrated the inability or reluctance of the two ministries to work together in a complementary manner.

Large-scale French government assistance returned to support medical education in the mid-1990s after a hiatus of almost twenty years. In 1997 the French Ministry of Foreign Affairs agreed to establish the *Fonds de solidarité prioritaire* (FSP) for education and training in the health sector, known as the *Programme d'enseignement médicale* (PEM). Its purpose was to establish standards and specialisations for health professions in Laos; organise trainings in priority areas; introduce management training for Ministry staff, and establish a national training plan. The technical areas prioritised for development were surgery; anaesthesiology; emergency medicine; obstetrics and gynaecology; and public health. The NGO, CCL was responsible for surgery, anaesthesiology and public health. The anaesthesiology training was centred at Mahosot, but involved staff at the main central (Vientiane-based) and provincial hospitals. The public health training was delivered through the newly-established National Institute for Public Health.[65] An additional priority area, not mentioned in the Lao-French agreement, was the development of a

[65] Odile Cochetel *et al*, 'D'une formation continue au master national en santé publique', in *Le Laos doux et amer. Vingt-cinq ans de pratiques d'une ONG*, ed. Dominque Gentil and Philippe Boumard, (Paris: CCL-Karthala, 2005), p.288.

specialist curriculum in paediatrics. This task was conducted by American NGO, Health Frontiers.[66] Karen Olness, who established the NGO, states that the work began on the training curriculum in 1991, and the University of Health Science reports it was finalised in 1997.[67]

The French government also established a regional Institut Francophone pour la Médecine Tropicale (IFMT) in Vientiane in 1997, which drew modest student numbers from Vietnam, Cambodia and Madagascar. It was located within the same compound as the National Institute of Public Health, which had finally opened after more than two decades of plans and frustrations. CCL developed and delivered the Masters of Tropical Health qualification at the Institute, through the PEM in 1997-2000. Reminiscent of the courses at the medical school in the 1960s and 1970s, 15 of the 32 teachers were French, and the remaining 17 Lao.[68] The course was taught initially in French, and in a combination of French and Lao language once sufficient Lao teachers were trained. However, the Ministry of Education did not recognise the course until 2004, because it was conducted under the auspices of the Ministry of Health rather than Education. Once recognised, it became the first Masters-level qualification in any discipline in the Lao PDR.[69] However, CCL observed that while students had "good memories", their command of some concepts was quite weak.[70] An evaluation of the course published in 2005 recommended that the NIOPH collaborate with the Faculty of Medical Science

[66] Health Frontiers is a NGO established by Karen Olness, who worked as a pediatrician at Mahosot in the early 1960s, and as an employee of USAID's Public Health Division in Laos in the late 1960s.
[67] Dr Karen Olness, interviewed by email, 24 June 2013, and University of Health Sciences, '55 pii chak honghian phet', p.7.
[68] Cochetel *et al*, 'D'une formation continue', p.291.
[69] Ibid., pp.287-289.
[70] Ibid., pp.290-291.

to conduct future courses, which was envisaged to require ongoing external pedagogical and financial assistance.[71]

Healthcare services and outcomes in the 1990s

Modest improvements to the general health of the Lao population were registered in the 1990s amongst policy changes and increased funding to the health sector. While it should be acknowledged that the collection and publication of statistics was sometimes unreliable and slow, statistics do give some indication of the health of the population, and the relative efficacy of health services. For example, life expectancy was reported to have increased from 51 in 1990[72] to 54 in 2000[73]. The infant mortality rate reduced from 137 per 1,000 live births[74] to 99[75] over the 10 year period, and the maternal mortality rate reduced from an estimated 1,200 per 100,000 live births in 1990 to 790 in 2000.[76] The total fertility rate also started to fall after peaking in the early 1990s at an estimated 7.1, one of the highest rates in the world.[77] Whether these improvements were directly or even indirectly attributable to the performance of the health sector is debatable. CCL, working in the health sector throughout the 1990s, considers improvements in health status to have

[71] Cochetel *et al*, 'Évaluation du programme d'enseignement médical en santé publique 2002-2004 au Laos,' *Santé publique*, 2005, 17(1), p.96.
[72] Ministry of Health/WHO, 'Human Resources for Health', (Vientiane: Ministry of Health/WHO, 2007), p.10.
[73] World Bank, *World Development Report 2003. Transforming Institutions, Growth and Quality of Life.* (New York: World Bank and Oxford University Press, 2003), p.234.
[74] Ministry of Health /WHO, 'Human Resources for Health', p.10.
[75] Ministry of Health 'Health Strategy up to the Year 2020', p.3.
[76] MMR rates are estimated at 750 in 1990 and 530 in 2003. See WHO/Ministry of Health, 'Human Resources for Health', p.10. However, in 2011 UNFPA revised the 1990 figure to a startling 1,200 and the 2000 figure to 790. See, UNFPA, *State of the World's Midwifery*, 2011, p.95, or http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_LaoPDR_SoWMy_Profile.pdf
[77] UNICEF, *Children and their Families*', p.103.

been driven by general economic improvements rather than by improvements in the health system.[78]

The Ministry of Health stated in 2000 that malaria presented the "most serious public health problem" in Laos. The Lao Social Indicator Survey (LSIS) of 1993 found that 85 percent of villages nationwide reported the disease as their greatest health issue.[79] The survey estimated there were 1.4 million malaria cases and 14,000 deaths annually attributed to the disease in a nation of approximately 4.5 million people,[80] with pregnant women and children most at risk. A study by Médecins Sans Frontières found that malaria accounted for 44 percent of all hospitalisations in Savannakhet and Bokeo provinces, placing a strain on hospital resources.[81]

The initiation of malaria-related projects by the World Bank, the EU, and the ADB in the mid-1990s helped ramp up what had been until then a limited program of public health and operational research conducted by the Ministry's Centre for Malariology, Parasitology and Entomology assisted by Vietnamese technical advisors in the late 1970s and 1980s. National coverage was not achieved, even with the new levels of increased international support. For example, the World Bank project operated in only 24 districts in a total of eight provinces, leaving another 11 provinces and many more districts outside the program.[82] The new programs promoted standard treatment protocols and net usage. Other standard malaria control activities such as the impregnation of bed nets with Delametrin, and the promotion of their use began in 1998-

[78] Strigler *et al*, 'Situation nutritionnelle', p.132.
[79] Ministry of Health, 'Health Strategy up to the Year 2020', p.6.
[80] The Lao PDR population census of 1995 recorded a nationwide population of 4.6 million people.
[81] UNICEF, *Children and their Families*', p.96.
[82] Ibid.

1999. Subsequent research by Dr Mayfong Mayxay found there was a high resistance to chloroquine in the Lao PDR, prompting a revision of malaria treatment protocols in 2005.[83]

MCH services remained weak, despite renewed assistance from WHO, UNICEF, UNFPA and a number of NGOs. They were also poorly integrated into the wider PHC program, which included immunisation, nutrition monitoring and promotion activities, and family planning. A high burden of diseases that would be easily treatable in a well-functioning health service also continued to plague the population, especially in rural areas. The main causes of child mortality were reportedly malaria, acute respiratory illnesses, and diarrhoea.[84] Childbirth occurred overwhelmingly outside medical facilities, and in 1993 only seven percent of infants were delivered in a health facility.[85] Only rarely was a trained health worker in attendance, partly due to the few midwives employed within the Ministry and the discontinuation of midwifery training in the early 1990s. Few pregnant women sought the three ante-natal check-ups recommended by the Ministry, and even fewer went for post-natal check-ups. Moreover, as with other health services and health behaviours, significant differences were observed between urban and rural areas. In such circumstances, the assessment of a visiting WHO technical advisor in 1991 is not surprising:

> Clearly, there is a lack of competent maternal services in most of the country, and people have no confidence in the public health services. The few obstetric wards in provincial hospitals are largely underutilised, particularly by rural women ... the root of the problem is the insufficient attention given to pregnancy-related issues at all levels.

[83] Dr Mayfong Mayxay, interviewed in Vientiane, Lao PDR, 24 December 2012.
[84] Ministry of Health, 'Health Strategy up to the Year 2020', pp.6-8.
[85] State Planning Committee *et al*, *National Human Development Report 1998*, p.12.

> Midwives in particular have been neglected both in their status and in their practical training: there should be more of them in the districts, with more support, more equipment, more appropriate training and more supervision.[86]

Technical advisors from United Nations agencies convinced the Lao government that renewed attention to MCH was required, and that reproductive health services had the potential to address the high levels of maternal and infant mortality by lowering the fertility rate. The Maternal and Child Health including Birth Spacing Project, a UNFPA/WHO-supported project, commenced in 1989, gathered momentum in the 1990s and promoted ante-natal visits, safe delivery, exclusive breastfeeding of infants, and tetanus vaccination of pregnant women. Parallel programs in the treatment and control of diarrhoea and acute respiratory infections also aimed to make positive impacts on infant and child health. Government documents suggest that the Birth Spacing Program was "launched" in 1994, and followed by the issue of a National Reproductive Health Policy in 1995.[87]

Among the project components of the UNFPA/WHO project was support for family planning methods, repackaged as 'birth spacing', after a government ban of more than a decade. The project's activities involved the operation of a limited number of birth spacing clinics, staff training, and the gauging of public acceptance and demand. Policies included recommending pregnancies between the ages of 18 and 35, and discouraging families of more

[86] Catherine Spring, 'Maternal Mortality in Lao PDR. Population Study, 1991', (Vientiane: WHO, 1991), p.12.
[87] Bounfeng Phoummalaysith *et al*, 'Health and Social Welfare Report in Lao PDR', Paper for Third ASEAN-Japan High-level Officials Meeting on Caring Societies, 29 August – 1 September 2005, p.3.

than five children.[88] Birth spacing clinics at two of Vientiane's major hospitals, Mahosot and Setthathirat, began service provision in February 1991, followed a few months later by selected district hospitals in the peri-urban area, including those in Hatsayfong and Xaythany. Initially the clinics provided services only one day per week, and offered contraceptive pills, condoms and injectables, but even in its early stages, international advisors observed high local demand for birth spacing services.[89]

Birth spacing services expanded quietly into the provinces and larger district towns, in an effort to avoid attracting the attention of aging conservative leaders who may have objected to its continuation. However, even limited access to contraception produced a significant drop in the total fertility rate from 7.1 in 1993 to 4.23 in 2000.[90] The maternal and infant mortality rates also fell, although the maternal rate was still extremely high. The lifetime risk of dying in pregnancy in Laos was calculated to be a 1 in 49 chance, one of the highest rates in the world.[91] This high rate has proved difficult to budge. It is expected that the reduction in the fertility rate will have more influence on reducing this figure than possible improvements in other maternal health services.

Overall, improvements in the health sector fell short of expectations. By the end of the millennium the Lao health system had improved marginally from what UNICEF had described as "one of the worst [health systems] in the

[88] Nenita Balbuena, 'Assessment and evaluation of pre-project activities, Project: Maternal and Child Health including Birth Spacing', (WHO: LAO/MCH/003; UNFPA: LAO/89/PO1) WHO Mission Report, 20 January 1992, p.3.
[89] Ibid., p.2.
[90] UNICEF, *Children and their Families*, p.103; and Ministry of Health/UNFPA, *Lao Reproductive Health Survey,2000* (Vientiane: MOH/UNFPA, 2000).
[91] Anna Scopaz, Liz Eckermann and Matthew Clarke, 'Maternal Health in Lao PDR: repositioning the goal posts,' *Journal of the Asia Pacific Economy*, 16(4), 2011, p.600.

world," but it was still burdened with the legacy of its past.[92] The Ministry of Health's poor management and coordination contributed to lower than expected health and management outcomes. But international development agencies should also be held to account, given that they furnished the grants and loans that provided the bulk of public funds (as opposed to out-of-pocket expenses) for health activities in the country. Despite the Ministry's formation of a Coordination Committee, coordination between health programs and the various international development assistance agencies became increasingly complex throughout the 1990s as the number and diversity of international donors mounted. Many international donors channelled their funds to specific health programs rather than to integrated services, which influenced not only the development of structures within the Ministry of Health and its provincial and district branches, but also the way in which funds were allocated and reported on. These external funding flows, therefore, played a key role in the way that Ministry of Health programs became (or remained) delinked.

These new difficulties compounded the health sector's long-term shortages of staffing and funding, and produced a cyclical catch-22. The coordination and management of international funding, a vital supplement to the very low levels of domestic government funding, required significant numbers of Lao staff possessing solid technical, management and foreign language skills. This requirement put a strain on the Ministry of Health as the number of donors mounted, as it had a pre-existing shortage of both general and skilled staff even before the arrival of new donors. Paradoxically, while the Lao health sector received more international development assistance than

[92] UNICEF, *Children and Women*, p.135.

ever before, the results of that funding were countered by the limited 'absorptive capacity' of the Ministry and its staff at central, provincial and district levels to maximise the potential benefits of the funding opportunities.

Internationally-funded projects were established against the backdrop of specifically identified weaknesses within the Lao health service, but few projects themselves were assessed as being truly successful. Sweden's multi-year support to the National Drug Policy was one of the more successful projects, in part because it began before many other health projects, which allowed it to gain the attention and support of several key personnel within the Ministry. Once the deluge of donors began, the Ministry's modest group of well-trained, English and French-speaking staff were quickly snapped up and projects had to make do with whichever Ministry staff had yet to be allocated as project counterparts.

The World Bank assesses its own Health Systems Reform and Malaria Control Project as having produced mixed results. The project was intended to run for six years but extended to nine years due to the slow disbursements by the Lao government, reflecting a weak and overloaded management system, but also unrealistic planning and expectations from the World Bank. At project end, the Bank assessed outcomes as being "modest" and "satisfactory", but also concluding that the project design had been too complex for an initial project in the health sector.[93]

[93] World Bank, 'Implementation Completion Report (IDA 26740)', pp.3-4.

Conclusion

A donor deluge swept over the Lao PDR and its health sector in the 1990s following the disbanding of the Soviet Union, attempting to address the nation's ongoing poverty and socio-economic marginality within the international community. The end of the Cold War, and the withdrawal of Soviet development assistance marked the entry of new international donors and the abandonment of key aspects of socialist health policy. A partially private sector emerged, consisting of private pharmacies and clinics, and the introduction of user-fees signalled the end of socialist medicine. At the same time, a much larger proportion of medical and health-related education and training was conducted in the Lao PDR, as education places dried up in the former Soviet Union.

A large and diverse group of donors increased their development assistance programs to the Lao PDR during the 1990s. Relatively quickly, the Ministry of Health was swamped with loans, for the first time, from the World Bank and the ADB, and large grants from the EU Sweden, Japan, France, Australia, Luxembourg and Belgium. Their funds filled the gap that opened up with the withdrawal of the Soviet Union and Eastern European donors, but created new problems of management and coordination. The Ministry was poorly prepared to deal with the donor influx, which highlighted its inefficient administrative processes and staffing practices. The pressing financial problems of the East Asian financial crisis of 1997-1998, which crippled Lao government activity for several years, especially the provision of counterpart funds to internationally-supported projects, and radically devalued the salaries of government workers slowed Ministry activities to a crawl. In hindsight,

donors acknowledge that many assistance projects from the 1990s were poorly planned, over-ambitious, and lacking an appreciation of the human, management and technical capacity available in the Lao PDR at that time.

As the new millennium approached, the Ministry of Health struggled with financing, staffing, improving education and training standards and placating the frustrations of its diverse group of donors. It had to instil an element of hope or desire in the international development assistance community to ensure continued support, and to cajole it to have faith in the future, regardless of the present or the past.

CHAPTER 7

CONCLUSION: THE 'ANTI-HISTORY MACHINE': LIMITED DOSES OF HEALTH AND DEVELOPMENT

The past is an impediment, a history that must be transcended:
The present is the platform for launching plans for a better future.[1]

Introduction

This study of the Lao health sector's development trajectory concludes through the lens of international development assistance. Laos' heavy reliance on external assistance and its long-term marginality in regard to the region, the wider international community, and its own rural areas, have left their imprints on the obstacles around which the Lao health sector has negotiated its progress. These obstacles have reconfigured in various historical periods: as colonial distance, post-colonial division and socialist doctrine and post-socialist donor deluge; but have imposed limitations on health sector development. Moreover, the path of the health sector is at times difficult to trace, partly because of the largely a-historical worldview and practices of the development sector.

External assistance has exerted a powerful influence on modern Laos, and has played a formative role in shaping its health system. The long-term dependence on such assistance, and the diverse sources from which it has been provided, go a great way towards explaining the Lao health sector's erratic development. Unpredictable cycles of financial and technical assistance have alternately strengthened and weakened the health network, staffing and

[1] James Scott's sardonic characterisation of the problematic place of history in developmental nation-states alludes to the 'anti-history machine' –style development discussed in this chapter. See James C. Scott, *Seeing Like a State. How Certain Schemes to Improve the Human Condition Have Failed*, (New Haven: Yale University Press, 1998), p.95.

healthcare service delivery beyond the control of national authorities, while at the same time adding layers of complexity, policy influence and reporting requirements. In many instances, donors and donor funding have determined which technical departments were established, which facilities were constructed and where, which scholarships were offered and which programs were implemented. In these circumstances, it is unsurprising that disruptions and conflicting priorities have disturbed the continuities within the Lao health sector.

Limited doses of development assistance for modern Laos

A development plan prepared for northern Laos by international advisers from the neighbouring Chinese province of Yunnan in 2008 observed, "The Lao government takes external cooperation very seriously".[2] And indeed it has done. External assistance was integral to modern Laos even before national independence, as the wealthier territories of French Indochina subsidised the Lao administration which collected almost no tax revenue of its own. In accordance with Kothari's argument that the frameworks and practices of post-colonial international development were set in place during the colonial period,[3] one sees that Laos' dependence on external subsidies to fund its modernising bureaucracy and related technical services took shape prior to independence. Despite achieving lower-middle income status in 2011, Laos remains classified as a landlocked Least Developed Country.[4]

[2] '2008-2020 Planning for Industrial Economic Development and Cooperation in Northern Part of Lao People's Democratic Republic, aka 'North Plan', (Kunming: Northern Laos Industrial Economic Development and Cooperation Planning Preparation Group, 2008), p.8
[3] Kothari, 'From Colonialism to Development'.
[4] http://unohrlls.org/about-lldcs/, accessed 19 November 2015.

Laos has received assistance from a wide and disparate range of donors since the 1950s, ostensibly transferring needed technical knowledge and skills. Some donors have jostled for political influence, others have addressed poverty reduction and national development more directly. Many, however, have been motivated by their own domestic issues or regional geo-political issues, as Viliam Phraxayavong has demonstrated.[5] Development assistance received by Laos over at least five decades has been highly politicised, especially in the years prior to 1990 when it was overtly linked to the Cold War objectives of the major donors. Such assistance evokes Ferguson's "anti-politics machine', a term coined to describe the de-politicised representations of international development's highly politicised and/or politically influential interventions.[6] At the end of the day, one can say that Laos has rarely received development assistance designed specifically for its own needs.

Domestically, Laos' reliance on external assistance has engendered a vulnerability to political forces that are much greater and, at times, seemingly opposed to its national interests, despite the often de-politicised and benevolent representation of assistance. Political objectives and economic abilities of the various donors have determined the waxing and waning of international assistance, exposing Laos' national development aspirations to the fickle nature of international forces. Prime Minister Souvanna Phouma, and his half-brother, Souphanouvong, the leader of the NLHX, were well aware of the political dimensions of aid in the Cold War context. Souvanna Phouma investigated the possibility of seeking aid from communist China in 1956, as a counter-weight to the US's rapidly growing influence in Laos.

[5] Viliam Phraxayavong, *History of Aid*.
[6] Ferguson, *Anti-Politics Machine*.

Several years later, Souphanouvong, in the role of Minister of Economy and Development in the second coalition government of the early 1960s, requested donors provide unconditional aid rather than assistance tied to the government's foreign policy loyalty.[7] Later, in the 1990s the Lao government struggled to coordinate and derive maximum benefit from the bilateral, multilateral and NGO donors that flooded into the country in the wake of the collapse of socialism in Eastern Europe.

Successive Lao governments have grappled with the political and practical difficulties which have arisen from the high volatility and unpredictability of development aid. Aid volumes received by Laos have fluctuated over the period from 1950-2000, as have the sectors receiving support. McIllivray *et al* found in their 2012 study that development assistance to Laos was less predictable than that provided to all other developing nations in the period 1960-2008.[8] Furthermore, Laos has at times resorted to asking many countries for similar assistance, unsure of which nation/s would oblige.

While the political motivations and impacts of development assistance have been exposed, the a-historical framework in which such assistance has been provided and implemented has remained largely obscured and unexplored. In fact, the 'anti-history machine' would be as fitting a label for the international development sector as Ferguson's 'anti-politics machine'. Development assistance has been provided within an a-historical, decontextualised framework, often implementing efforts and initiatives that resemble those of previous or even concurrent donors in seeming oblivion. Moreover, a key 'lesson learned' by development agencies and recipients has

[7] NARA, RG 59, Box 3323: 'RLG's principles of accepting foreign aid', 12 April 1963.
[8] McIllivray *et al*, *Evaluation Study*, p.50.

been that meaningful, sustainable change takes time. Ironically, predictable, consistent support over decades has proved to be an element the development sector has been unable to guarantee. The lack of time and the unpredictability of international assistance have frequently resulted in the provision of limited doses rather than full courses of development assistance in the Lao context.

Limited doses of health development for the Lao health system

International development assistance has played an influential role in the development of the Lao health sector. This study has shown that Laos' biomedical health system has developed over a period of more than one hundred years, in large part enabled by the provision of external support, initially from the French colonial administration and later from international development assistance donors. As in other socio-economic sectors of Laos, much of the external assistance to support health infrastructure, professional education and training and service delivery has been politically motivated, of unpredictable duration, highly diverse and/or poorly coordinated. This situation has resulted in health sector development proceeding in fits and starts, as funding and/or technical advisors became available, overlapping in some areas and entirely absent in others. Moreover, the various channels of assistance have not always been complementary, confusing and at times obstructing the limited development opportunities.

The Lao health sector has contended with a number of issues limiting the effectiveness of the external assistance provided. Problems engendered by distance, division, doctrine and donor proliferation have accumulated, presenting Laos and its donors with additional challenges to the development

of its health infrastructure, personnel, and service delivery. Limitations of geographic, cultural and administrative distance were initial obstacles encountered in the colonial period. The rudimentary transportation and telecommunications networks effectively isolated Laos from the larger, more dynamic centres of French Indochina, as well as the rural population it was intended to serve, resulting in administrative decision-makers having a poor understanding of Laos' development needs and capacities. Many French doctors working in Laos were frustrated to observe that the colonial framework of health and medical assistance was formulated with the Vietnamese territories or even France in mind, and was inappropriate in the Lao environment.

Independence and a Vientiane-based national government did not resolve the problem of distance, even as transportation and telecommunications improved, and the cultural gap between colonial staff and local patients was removed. Decisions affecting the health sector and other sectors continued to be made outside Laos, or by Lao-based foreigners serving distant masters, as the nation was dependent on international assistance for its national development, as well as for support to the burgeoning war effort.

The country's involvement in the Second Indochina War effectively split its fledgling health service into three parallel civilian services: the RLG, the USAID-OB and the NLHX, and two military services, creating a debilitating technical division for such a young health system. Distance and division continued to dog the sector, even after the 1973 ceasefire. Division played one more decisive hand in the post-1975 reunification of the health sector, as many staff from the former RLG and USAID-OB health services

joined the refugee exodus. A further wave of staff left the sector although not the country in the early 1990s, in search of a living wage as government workers struggled to make ends meet.

Doctrine, or ideology, emerged as an additional instrument of limitation in the early Lao PDR period, when the emphasis on political training and proficiency seemingly eclipsed the requirement for technical skills. Assistance from nations such as the Soviet Union, Vietnam and Cuba, bolstered Laos' application of socialist doctrine, in particular its attempt to transform the newly re-united health service into a socialist system offering free healthcare nationwide, staffed by a workforce well-versed in socialist theoretical principles.

The proliferation of international donors in the post-socialist 1990s is one of the more recent development limitations with which the Lao health sector has had to grapple. The volume of aid, and the diversity of donors, has added complexity and created a large burden of management and coordination for Ministry of Health staff, most of whom are doctors and not trained managers and administrators. The Ministry's weak management capacity has resulted in slow, and sometimes poor, decision-making and weak oversight, causing lost opportunities and frustration among donors and Lao government staff alike.

By 2000 the limitations of division and doctrine within the health sector had largely subsided, although they sometimes lurk beneath the surface. Healthcare is provided by civilian and military branches of the government health services, alongside a private sector of after-hours government health workers, and private services in neighbouring countries of Thailand, Vietnam

and China. The distraction of doctrine has yielded to a more pragmatic, market-oriented form of socialism. However, many decisions concerning financial and/or technical assistance to the Lao health sector continue to be made overseas in the headquarters of the main international donors. In this respect, securing international assistance has become recognised as an achievement in itself for Lao government staff.

The political and financial dependency of the Lao health sector, reinforced by reliance on assistance from international donors, has been compounded by the a-historical approach of the development sector. Donors and technical advisors working in Laos in the pre-1975 period often displayed no acknowledgement of colonial health programs, or of the ways in which distance had operated to determine the latter's success or sustainability in the medium to longer-term. Despite the colonial legacy of health facilities and staffing, donors often operated as if health development had begun in the 1950s. A similar situation emerged post-1975, when health programs of the former regime were swept from view, unable to be acknowledged by the Lao PDR because they had been implemented by political opponents. This situation extends to the present day. Within Laos it remains awkward to discuss in an informed manner the efforts of the French colonial administration, or the RLG and USAID-OB health services, despite some senior Ministry staff being trained by those services. This reticence has produced a younger generation of Lao health workers uncertain of their professional heritage, many of whom feel it is wiser to accept the political pretence that Lao health sector development began after 'Liberation' in 1975.

Concluding comments

Biomedical health services in Laos have undoubtedly developed since their modest origins in Luang Prabang in 1895. There is a nationwide network of central, provincial and district hospitals and village health centres (*souksala*). There is a cadre of trained health staff, ranging from medical specialists, doctors, pharmacists, dentists, midwives, nurses and other para-medical professions. There is a University of Health Sciences (the former Royal School of Medicine, later the Faculty of Medicine), and a number of provincial health colleges training medical and health staff in-country. Numbers of health facilities, staff and patients have all increased, as have the sophistication of most facilities, and the training levels of most staff. There are government budget lines for the construction and maintenance of health facilities, the salaries for health staff and the partial funding of provision of health services to the Lao population (patients also pay fees towards the cost of medical care).

However, the impermanent nature of international development assistance, and the limited doses in which it dispenses doses of technical transfer, has resulted in a national health sector that sports the structure but not necessarily the substance of a comprehensive system, and that remains reliant on external funding and support. The international development sector's tendency towards decontextualisation and a-historicity has led to a situation where it is difficult to identify actual medium and longer-term developments as opposed to stagnation and/or backsliding, because each project is presented as a 'new' opportunity, and previous efforts are obscured or forgotten.

Let us finally return to the initial questions of this thesis. Why was the Lao health sector unable to help Am's three infant children in Ta-Oy district in the late 2000s? The thesis argues that the answer lies in a combination of Laos' colonial, international and even intra-country marginality, and its long-term, heavy reliance on diverse sources of external assistance. These two characteristics have created a complex web and distance, division, doctrine and donor deluge, factors which have been at times obscured by poverty, weak human resources, and lack of attention to Laos' past, but also by the a-historical and unpredictable characteristics of international development assistance. In Laos' experience, assistance from all major donors, whether it be the French colonial administration, the US or the Soviet Union, has ended relatively abruptly as those nations disengaged with Laos or the wider Southeast Asian region, leaving Laos to find its development path with new partners.

The international development sector has repeatedly emphasised the absence of strong foundations, staffing and standards in the Lao health sector, and the lack of progress and results desired by its various donors. It has side-stepped the politicised nature, the unpredictability, and/or the incompleteness of previous support, and has rarely attempted to build on the existing albeit modest foundations of the Lao health sector. Nor has it offered explanations of the deeper limitations to development explored in this study. Instead, the international development sector has employed a narrative of perpetually unmet expectations and under-performance, adrift from time and devoid of any strong sense of place, which feeds its 'anti-history machine' and leaves the Lao health sector without context or explanation of why it struggles to develop.

An acknowledgement and understanding of Laos' marginality and long-term dependence on external assistance over many decades helps make sense of the obstacles and development limitations currently encountered in the Lao health sector.

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