5. Report on Community Survey
5.1 Final Report on Community Survey (Sub-contracted survey by NIOPH)

Lao People's Democratic Republic

Peace Independence Democracy Unity Prosperity

Ministry of Health

National Institute of Public Health

Report on

Community Survey

As part of the JICA Data Collection Survey on Health Sector in Lao DPR

Vientiane Capital

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Contents

List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CBHI	Community Based Health Insurance Scheme
CSS	Social Security Insurance Scheme
DHO	District Health Office
EPI	Expanded Programme on Immunization
FGD	Focus Group Discussion
HC	Health Center
HEF	Health Equity Fund
HIV	Human Immunodeficiency Virus
HV	Head of Village
JICA	Japan International Cooperation Agency
KII	Key Informant Interview
Lao PDR	Lao People' Democratic Republic
LWU	Lao Women Union
LYU	Lao Youth Union
MCH	Mother and Child Health
MDG	Millennium Development Goals
MoH	Ministry of Health
NIOPH	National institute of Public Health
OPD	Outpatient Care
PHD	Provincial Health Department
PNC	Postnatal Care
SC	Save to Children
SD	Standard Deviation
SRC	Swiss Red Cross
SBA	Skill Birth Attendants
SSS	Social Security Insurance Scheme
TV	Television
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

VFC	Village Fund Committee
VHC	Village Health Committee
VHV	Village Health Volunteer
VHW	Village Health Worker
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

This report presents the results of the community survey as part of the JICA Data Collection Survey on Health Sector in Lao DPR. The community survey was the responsibility of the survey tem from National Institute of Public Health (NIOPH), Ministry of Health (MoH). The current study aims to find out the actual situation surrounding the health sector and the conditions and perceptions of key stakeholders and beneficiaries at the community level; and to identify bottlenecks and hindering factors in people's access to health services with special focus on maternal, newborn and child health and possible effective approaches to address these challenges. This study was conducted in December 2015and January 2016 in the fourteen districts of nine provinces of Lao PDR, namely Phongsaly, Bokeo, LuangNamtha, Luangprabang, Xiengkhouang, Bolikhaxay, Savannakhet, Sekong and Champasack. The selection of study province, district and village was selected based on the review of community health intervention practices nationwide. Twenty three village heads and 102 key interview informants were interviewed by the research teams. The quantitative and qualitative methods of data collection were used. Face-to-face questionnaires were used to collect quantitative data, with a total of 102 KIIs (65 males and 37 females). Qualitative data were collected through focus group discussion with 14 groups of community representatives, with a total of 102 participants (37 women and 65 men) participating in the discussion.

Results: According to analysis of those data, we could conclude some principle outcomes of this study as follows:

The survey noted that most village leaders were men and attended some years in secondary school. It is noted that community structures were very supportive for the conduction, management and promotion of health activities in community in close collaboration with health center. With the support of village leaders it made the health intervention in community that supported by MoH, non-health sector and international agencies more effective and ensured the achievements. With the integration from different stakeholders like village leaders, health sector, non-health sector and international agencies for implementation of activities related health in communities it made significant changes in communities, for instance, now more people sought health care services at health facilities including ANC, PNC and delivery, more children vaccinated though outreach activities or routine health services. In addition through some supporting system like health insurance (CBHI, SSC) and HEF more poor people in communities accessed to health care services and through free

delivery policy more pregnant women attended the MCH services. There was no gender and ethnicity discrimination in communities and decision making for all household purposes including accessing to health care services and school enrollment was made by both husband and wife. However there were some challenges had been noted as now the CBHI member was very limited, vaccination among target children could not get 100% due to mother perceived side effect of vaccine, and sustainability of intervention in community once the international support was finished.

I. Background

Lao People's Democratic Republic (Lao PDR) has been making progress in achieving the health-related Millennium Development Goals towards 2015, except for nutrition status. However, the country is still faced with the low levels in maternal and child health indicators compared to the surrounding countries, especially with the existing high gaps between urban and rural areas. Under this background, various factors have been noted such as; difficulties in geographical access to health facilities specially in mountainous areas, the inappropriate arrangement of health staff positioning and health facilities not in line with actual needs, limited medical supplies and drugs as well as equipment, lack of awareness and knowledge on health-related matters, and other sociocultural practices and economic factors impeding access to health services as well as lack of trust in public health services.

Under this current situation, the Ministry of Health (MoH) of Lao PDR has shown its commitment in their next 5-year national health development plan (2016-2020) under preparation towards the achievement of Universal Health Coverage (UHC) by 2025, enabling a majority of the population to access basic health services by 2020. Outside of the health sector, various measures and programs have also been considered and developed towards the community development, i.e. infrastructure building, improvement in water supply and sanitation, implementation of district/village development funds, household financial management and livelihood programs specially for women and women empowerment.

In the above challenges in health system as well community development, with the support of JICA, the current study is aimed to gather data and information to grasp the current situation surrounding the health sector with the focus on community level conditions and people's health seeking behaviours, and review issues and existing bottlenecks and hindering factors and identify possible measures and approaches taken towards achieving UHC.

II. Objectives

2.1 General objectives

This current community survey will be under taken as part of the JICA data collection

2.2 Specific objectives

- To find out the actual situation surrounding the health sector and the conditions and perceptions of key stakeholders and beneficiaries at the community level; and
- To identify bottlenecks and hindering factors in people's access to health services with special focus on maternal, newborn and child health and possible effective approaches to address these challenges.

Key Survey Questions to be addressed

The current survey will be undertaken in the targeted areas based upon good practices in community health with special attention on maternal newborn and child and nutrition and through multi-sectoral approach through the review of exiting community interventions in Lao PDR.

Key questions include:

a) People's awareness and knowledge on health matters including health insurance schemes and health seeking behaviours, and utilization of health services.
b) Community conditions, i.e. socio-economic and cultural conditions, community power structure and decision making process, access to information and media, modes of communication and transport, gender relations and household decision making.
d) Barriers and hindering factors in the utilization of health services among community people and facilitating factors and elements of success in identified good practices and successful cases.

III. Methodology of the Survey

The current survey was conducted in December 2015 and January 2016. The quantitative and qualitative methods of data collection were used.

3.1 Survey Target Areas:

The selection of study province, district and village was made based on the review of community health interventions and good practices nationwide (as show in the table 1.

Table 1: List of Survey Sites (9 Provinces, 14 districts, 14 villages)

No	Area	Province	District	Village (Samsang Village)	Implementing/ Supporting Agency
1	North	Phongsaly	Khoua	Thabuk	MOH/WFP
2		Phongsaly	Boun Tai	Namlannoy	MOH/WFP
3		Luang Namtha	Luang Namtha	Namgnene (Samsang village)	MOH/WFP
4		Bokeo	Paktha	Donemixay	Plan Int'l
5		Luang Prabang	Nan	Thongchaleun (Samsang village)	MOH Save the Children
6		Luang Prabang	Xieng-Ngeum	Kiewgna	World Vision
7	Central	Xieng Khouang	Kham	Nagnong (Samsang village)	MOH
8		Xieng Khouang	Nonghad	Khangphanien (Samsang village)	KOFIH/WHO
9		Savannakhet	Kaison Phomvihanne	Phonsim (Samsang village)	MOH
10		Savannakhet	Thapangthong	Xekeu	MOH/UNFPA/ UNICEF
11		Bolikhamxay	Khamkeuth	Khammouane	Lux -Development
12	South	Sekong	Dakcheung	Daklanee	Swiss Red Cross/WFP
13		Sekong	Laman	Namhieng	Swiss Red Cross/WFP
14		Champasack	Pathouphone	Nongboua Yai	MOH

3.2 Qualitative method:

The focus group discussion (FGD) was conducted in every village with key persons (about 6 to 8 persons) such as head or deputy head of village, members of Village Health Committee (VHC), Health Personnel (health staff at Health Center, if exiting), Village Health Volunteer (VHV)/Village Health Worker (VHW), representatives of Women's Union, Youth Union and other key stakeholders who have positions in the community identified. The FGD was conducted in Lao language.

Main items for questions in FDGs:

- Perception towards health care services including social protection scheme (insurance etc)
- Hindering factors for accessing and utilizing of health services
- Access to information and media, means for communication and transportation
- Gender role or family relations including decision-making at the household matters
- Existing community organizations/networks and their roles, and perceptions on existing community interventions (in case of good model cases)

3.3 Quantitative method

Key Informant Interviews (KII)

Intended Interviewees :

Key stakeholders in the designated villages: i.e. head or deputy head of village, members of Village Health Committee (VHC), Health Personnel (health staff at Health Center, if exiting), Village Health Volunteer (VHV)/ Village Health Worker (VHW), representatives of Women's Union, Youth Union and other key stakeholders who have positions in the community identified. If there are more key stakeholders identified, they should be included in this survey.

Main Items for questions in Key Informant Interviews

- Hindering factors for accessing and utilizing of health services
- Status of accessibility of information and media, means for communication and transport
- Existing community organizations and community's decision making process
- Priority issues and challenges, and measures and activities undertaken towards the existing challenges in the community

*Key Informant Interview Guide (semi-structured questionnaire) was prepared.
The survey tools (FGD guide, KII guide) were developed by a survey consultant jointly with the project team in consultation with MoH and JICA, with full consideration of limitations and feasibility.

3.4 Ethical Review

An application was made to the National Ethics Committee for Health Research in Lao PDR with the agreed contents, and its approval was given on November 11, 2015.

3.5 Data collection

The data collection was started from 8th December 2015 to 13th January 2016. Two survey teams were organized to collect the data at the field work. Each team consists of 3 persons (2 persons from the National Institute of Public Health (NIOPH) and one from provincial level). One moderator and one facilitator/note taker was from NIOPH and one data collector from provincial levelwho are responsible for data collection and monitoring all steps of the survey.

3.6 Limitations

- Some sites need to be changed due to the weather conditions and accessibility particularly in the north, Senelat village which was unable to reach during period of survey. So we selected Thabak village instead of Senelat village based on the suggestion from director of Khoua district health office
- Care international village was not visited due to the miss understood of the PHO in selecting site for research team.
- During the survey, some developing agencies were not available for interview

IV. Results

4.1 Findings from Key informant interviews (KII)

4.1.1 Socio-demographic characteristic of respondent

A total, 102 KIIs were interviewed. Males were 65 persons (63.7%). The age ranged from 22 to 68 years of age with the mean of 42.6 years old. Only 1% are illiterate and 19.6% are completed primary school, 31.4% are finished secondary school and also 31.4% were studied in some years in secondary school. Majority of them are married (95.1%). Slightly more than one-third of them (37.3%) are Lao-Tai; 16.7% are Khmu, 4.9% of them are Hmong ethnic group and 46.1% of respondents are belong to other ethnic group such as Phounoy, Talieng, Katang, Yor and Alax. In average, a household ranged from 1-11 members (mean±SD = 5.13±1.88 members).The majority (87.3%) of them are farmers, followed by professional which accounted for 10.8% and only 2.0% of them are tradesman.

Table 1: Socio-demographic characteristic of respondents (n=102)

Variables	Number	Percent
Gender		
- Male	65	63.7
- Female	37	36.3
Age (Mean=42.9, Min=22, Max=68)		
- 20-29	13	12.7
- 30-39	31	30.4
- 40-49	29	28.4
- 50-59	20	19.6
- ≥ 60	9	8.9
Education		
- Illiterate	1	1.0
- Some year in primary school	17	16.7
- Graduate primary school	20	19.6
- Some years in secondary school	32	31.4
- More than secondary level	32	31.4
Marital status		
- Married	97	95.1
- Single	5	4.9

Variables	Number	Percent
Ethnicity		
- Lao-Tai	38	37.3
- Khmu	17	16.7
- Hmong	5	4.9
- Other	47	46.1
Affiliation		
- Head]deputy head of village	24	23.5
- Head]deputy head of Lao Women Union	15	14.7
- Head]deputy head of Youth Union	11	10.8
- Head]deputy head of Lao Front Unit	18	17.6
- Village Health Volunteer	11	10.8
- Others	23	22.5
Occupation		
- Farmer/laborer/domestic worker	89	87.3
- Government employee	11	10.8
- Employed tradesman	2	2.0

4.1.2Existing community organizations/structures

All 102 key informants know that there are seven village authorities including head/deputy head of village, Lao youth union (LYU), Lao women union (LWU), security, defense, village health volunteer (VHV) and Neohom (Senior Unit by the senior residents). All of them know about village health committee (VHC) and head of village is a very important person in their village. Most of them understand the selection of village leader that is from the election of the villagers and then accepted by district governor office. Village leaders were discussed among themselves with villagers to select candidate or responsible in each unit of become to the youth union and women union member including VHV and etc. Then the head of village continued to appoint the head of each unit such as head of LWU, LYU, Senior/Lao front unit, defense unit, security unit, VHV based on the educational level and active manner but under the agreement of villagers and submitted to the district level for approval. In general all units are working together but leaded by head of village.

LWU and LYU are mass organizations in the village. LYU has its role to help the village for any hard works and encourage youngsters to prevent the HIV/AIDS in community. LWU and VHV supports and promotes the mother and child health care services by encouraging women to attend antenatal care, postnatal care, delivery at health facility, bring target children for vaccination, collecting information about reproductive age women and children aged less than five years. All 11 KIs who are VHV reported they ever trained on basic health care and some of them received some training on malaria diagnosis, EPI, diarrhea, health education, hygiene and sanitation practice. A total of 11 VHVs were interviews of which 2 are females. Their ages ranged from 27-59 years old with an average age 41.8 years. All of VHV had attended school and 8 out of 11 attended some year in secondary school. All of them are farmers and half of them belong to Lao ethnic group.

4.1.3 Roles and functions of Village Health Committee

The membership of VHC comes from different seven units within the village but main responsible person is a head of village and VHV. Few female memberships were in the VHC. Any ethnicity and gender could be a membership of VHC. They had a meeting every month but not having exact date of meeting. The VHC was responsible to supervise and promote the implementation of health activities in a village such as health education in community concerning three-hygiene manner like eating, living and clothing cleanly, encouraging community to keep village cleaned such as cleaning around houses, evacuating livestock away from beneath of house, constructing latrine and using it, encouraging pregnant women to attend antenatal care (ANC), delivery in health facility, postnatal care (PNC), prevention of seasonal diseases such as malaria, diarrhea and pneumonia. The VHC was responsible to collect data (death, birth, target children for EPI, reproductive age women), routinely every month to HC with the forms provided by them. After that HC send to DHO and then DHO send to PHD.

4.1.4 Perceptions on health services in the community

Health services in the community were organized by VHV and HC staff under the joining with village organization and village health committee. Most of KIIs perceived that people have a better health, no any children died because their children received vaccination regularly provided by health staff. Half of people reports that the health activities were not so often, only MCH service and EPI were monthly implemented, for village cleaning, health education were depending on situation for instance. However, some of them reported that

there are some international organizations had implemented health interventions in community under the collaboration with health center and district health office with the same aim to improve the access to health care services and community's health. It noted that in three builds villages there were many activities had been implementing in community targeting to improve the socio-economic status and health of community.

Most of participants said that VHV is working well, she/he has a good basic knowledge on health education if some families don't follow the health education she/he go to those families and provide education directly and also she always assist the outreach activities of the health center to announce the villager to come to receive the services.However, there are one village (Namgnen village in Luangnamtha province) VHV do not function as before because now health centre is located in the village and there are five health centre staff so that most of health activities in village the health centre staff is responsible instead of VHV.

Most of them said there is no problem on food availability and nutrition in their villages. However, there are some women who practice on food taboo after delivery, but now most of women access to ANC and delivery in health facility and tries to give up the food taboo unlike before more women followed the food taboo from their old generation and delivered at home. Women are more aware of health due to accessing to health messages in villages during the visit of health staff in the village, their visit to health facility during the use of health care services, and TV concerning the risk of pregnancy and delivery if not attending health services in hospital and benefit of eating properly. Women also learned from each otherduring practice in their village. Source of food in community is agriculture and keep live stocks. Some people grow corn and keep live stocks as a main activity. In general people in village have good nutrition status.

4.1.5 Access and utilization of health services

Most of KIIs reported that the accessibility to health services was very convenient because health centre located not so far from village. Most of them, when their family member get sick they go to health center first to get the advice and services, if in severe case they were referred to the hospital to get better treatment. So far there is no emergency preparedness plan of the village. Most of people said that they can easily access to the health service like MCH, EPI that were routinely served in this village. Very few of them are the members of insurance schemes (CBHI, CSS, HEF) that make better access to the health service without economic

burden and also free MCH is also covered in all village.

Those who are sick and could not go to hospital due to having no money, the village authority will assist by issuing a certification for him/her as the poor family for fee exemption for treatment. Another option head of village will ask the village fund to advance some cashes to them and they have to refund later with no interest except for the member of village fund they will receive certain amount of cash support from the fund without refunding.

4.1.6 Access to information, means of communication and transportation

Most KIIs were connected to the main road and could be accessed by car and motorbike in both seasons. They can used their own transports for accessing to health facilities except for some villages that located close or along the main road people could access to buses that passed by villages but they were very limited number in a day. For those village that are not accessible by car during rainy season, they mainly visit VHV or HC which near by to get the health services.

Regarding to the communication in communities, mobile phone was very popular for communicating as all of KIIs possessed of it. Now it is very easy for communication in all villages in this survey, mostly 80 to 90% of households have mobile phone. The signal for mobile phone is available at anywhere. Television is very common in these villages but the coverage is not certain. Some of them used satellite TV, equipment instalment for satellite TV is about 400,000LAK and no charge for monthly fee. We like watching police and Lao star channel because they talk about everything and we get to know about situation in Lao PDR and also about health though the health programme is given very short time. Some people missed health programme because they are still working outside the village while the health programme is broadcasting. The information sources are most useful in obtaining health related information is village media (village speaker). The internet is available but access/using is very limited.

Concerning to the access to health related information in villages, most of them said that people could access to health related information through the health program in television however the health program was broadcasting in very short time so that many people easily missed that program. Only Lao Star and police channels were available in communities.

Beside the television people could access to health related information through posters and health staff during outreach activities. Thus the health staff was the most important and useful source of health related information in communities because people appreciated the reliability of the information, followed by loudspeakers and posters as people could understand the content by images particularly illiterate people.

4.1.7 Gender roles and family relations

All KIIs reported on the gender issue is not problem in the village. There is no social limitations/barriers for women and ethnic minorities in access to income generation, health services, education. As now both male and female mutually decided for all household purposes like accessing to health care, enrolling children to school and household income generation as discussed by most KII men. Most KII women sad that can decide by themselves to go to health facility for ANC visit without making decision with their husband.

Most of them reported that in their community they have the same right and value in accessing to any activities in communities such as health services, education, income generations and status of village leaders. Gender is good in all villages. No any gender discrimination both wife and husband mutually decide for any households purposes.

4.2 Findings from focus Group discussion

4.2.1 General characteristics FGD participants

There were 14 focus group discussions conducted in 9 provinces. Regarding to the general characteristics of FGD participants in the community structures, of the total FGD participants 102, 37 were women (36.3%). The average age was 42.2 years and age ranged was 22 – 68 years. More than half of participants had attended some years in secondary school (55.9%) and more than a quarter had attended some years in primary school (28.4%). The majority of participants were farmers (85.3%). Most of them were head or deputy head of village (23.5%), followed by head or deputy head of senior unit (Neohom) or Lao front unit (15.7%) and head or deputy head of Lao Women Union (14.7%, Annex 1).

4.2.2 Existing community organizations/structures

4.2.2.1 Organizations or structures exist in community

Of 14 FGDs 12 of them had discussed that there are seven units existing in the village such as head or deputy head of village, Lao Women Union (LWU), Lao Youth Union (LYU), senior unit, defense unit, security unit, village health volunteer (VHV). Only two FGDs or two villages had discussed that they have five community organizations such as party committee, mass organization (LWU and LYU), socio-cultural unit, economic unit and administrative unit (cited by 2 FGDs out of 14 FGDs). It is noted that a mass organization includes two units LWU and YU and the socio-cultural unit includes VHV and education units.

Regarding to the gender and ethnicity of membership of community organizations, the survey discovered as the following: most of members in each unit are men except for the LWU all of them are women. Of 102 total FGD participants only 37 were women, of 24 heads or deputy heads of village, 5 of them were women and of 16 members of senior unit/Lao front only 2 of them were women. Ethnicity is not an issue in the community. Community can be a membership of any community organizations. As in this survey observed FGD participants were from different ethnic groups such as Lao, Khmu, and Hmong. An example given in Thabuk village the head of village was from Khmu and deputy head of village was from Lao group. In addition, the village health committee (VHC) was established in all villages while village drug kit and village fund committee (VFC) were established in some villages. Village fund is established in the village and kept in villages, mostly manage fund by head of the village and LWU. The management of village fund depends on village leader or VFC. For example, in the North region, interest is free for the poor and members, non-members can borrow/for medical purposes in emergency without interest. In the South region: people deposit and become members and borrow money, those who are not members, they cannot borrow. However, in Khammouane village, Bolikhamxay province get supported by Lux, the villages maintain the VDF, anybody can borrow and deposit. The membership of each committee comes from different seven units but mainly head of village or deputy head of village must be presented in all committees in the villages because usually a head of village is a secretary village's party committee and a deputy head of village is a vice-secretary village's party committee.

4.2.2.2 How to establish the community organizations?

First the head of village was elected by villagers and approved by district governor office. Then the head of village continued to appoint the head of each unit such as head of LWU, YU, Senior/Lao front unit, defense unit, security unit, VHV based on the educational level and active manner but under the agreement of villagers and submitted to the district level for approval.

Concerning to the establishment of VHC and village drug kit, head of village had appointed the committees but they had to be approved by secretary village's party committee and the district health office (DHO). In contrast the VFC was established and got approved by secretary village's party committee or head of village.

4.2.2.3 The role and function of community organizations

The role and function of each unit was discussed. Head of village (HV) supervise and involve in all activities in the village and has an authorization to appoint a head of each unit in the village based on their educational levels and active manners but under the agreement of villagers before submission to the district level for approval. In general all units are working together but leaded by head of village.

LWU and LYU are mass organizations in the village. The survey observed that LYU has its role to help the village for any hard works and encourage youngsters to prevent the HIV/AIDS in community. LWU supports and promotes the mother and child health care services by encouraging women to attend antenatal care, postnatal care, delivery at health facility, bring target children for vaccination, collecting information about reproductive age women and children aged less than five years. LWU also provide help on the day of health staff working in the village. In one village LWU was working instead of VHV (in Namgene village)

4.2.2.4 Challenges

Some challenges had noted: 1) Low payment for village leaders and now asking for more salary so that it is challenging for the local authorities, 2) Few female memberships present in each community organization in the village particularly in rural areas. As we observed

women have low education, household workload and culture as women cannot go very far alone, 3) Limited knowledge among village leaders but workload in community such as since the three builds ideas have been implementing there were many activities exist in the village at the same time, an example given the management of village fund, economic-financing, working with different sectors: bank as some banks lent money to community for improving agriculture products for selling, supervising and implementing health activities in the village, agriculture activities and education activities, 4) Concerning to village fund, it is very difficult to get refund from villagers once they borrowed from the village fund, 5) Management of garbage in the village is not in line with the suggestion of district environment office. Villagers do not throw garbage in the village garbage bin due to they do not want to pay for it so that they burn it. Burning of garbage is prohibited in community.

4.2.3 Roles and functions of village health committee

The VHC was established in each village by the secretary of village's party community and get approved by the DHO. The membership comes from different seven units within the village but main responsible person is a head of village and VHV. Few female memberships were in the VHC. Any ethnicity could be a membership of VHC. They had a meeting every month but not having exact date of meeting.

The VHC was responsible to supervise and promote the implementation of health activities in a village such as health education in community concerning three-hygiene manner like eating, living and clothing cleanly, encouraging community to keep village cleaned such as cleaning around houses, evacuating livestock away from beneath of house, constructing latrine and using it, encouraging pregnant women to attend antenatal care (ANC), delivery in health facility, postnatal care (PNC), collecting health statistics for health center, prevention of seasonal diseases such as malaria, diarrhea and pneumonia. Beside that VHC reported any outbreak happened in the village to its own technical line health center and through health center to DHO and informed community in the village concerning outbreak and health activities that received from health center or DHO. In addition, they communicated with and provided a support to the DHO and health center team when working in community such as during EPI day, routine vaccination (arranging target community for the vaccination), deworming, distribution of vitamin A, health education and other health intervention or project that takes place in the village. They also supported other health intervention

implementing in the village such as nutrition among children under 2 years and schoolchildren.

Some challenges were observed: 1) Vaccination cannot get 100% due to some family moved to stay in rice filed particularly during the rice plantation so that VHC had to work hard in order to get them for vaccination, 2) Evacuation of livestock away from home is difficult because villagers do not give a good collaboration, 3) Workload to some members of VHC. Most of the time only VHV is working as a representative of VHC due to other members thought that this health work is related to VHV. VHC will involve when the campaign take place in the village. However VHV can consult with head of village at any time needs and 4) No incentive for VHC or VHV

4.2.4 Perception of health services in community

4.2.4.1 Health services exist in community

Health activities existed in the village was described by FGD participants. There are three stakeholders implementing activities related with improving health in communities such as community, health sector and international organizations.

From community side, VHC leaded community to clean around houses, destruct the breeding site of mosquito, evacuate the livestock away from houses, encourage community to construct latrine and use it and drink boiled water; in addition VHC particularly VHV collected data on death, birth, target population for vaccination and reproductive age women. They also reported to health center for any outbreak of diseases in community.

As for health sector the health center provided health services to its catchment areas and at the same time implemented outreach activities in the catchment areas monthly or three monthly. The outreach activities included vaccination to target children, providing MCH services, deworming, distribution of vitamin A, follow up of the child nutrition status and health education to mothers of the malnourished child, health education concerning seasonal diseases and outbreak of any diseases. The organizations that implement the health activities in community were mainly health center and community themselves but under the supervision of DHO.

There are some international organizations which have provided assistance in implementing health interventions in community under the collaboration with health center and district health office with the same aim to improve the access to health care services and community's health. The external coordinators had mutually developed plan for health activities in community with health center and DHO staff. Fund was issued based on the planned activities. Plan International intervention took place in Bokeo province and it focused on the improvement of the access to improve health by providing the financial support to routine activities of health center, supporting medical equipment and construct and renovate health center, and support water and sanitation in communities and encourage community to construct latrine with aiming to reach to open defecation free in each village. WFP supported food stuff to community like rice, flour, oil, fish can, sugar to primary school children with aim to improve the nutrition status of primary schoolchildren of two villages, this was discussed in FGD of two villages in Phongsaly province; in addition WFP supported 10 kg of rice to target women in order to encourage them to attend ANC, PNC and delivery at health facilities and supplementary food to children under five years of age in Namgene village in Louangnamtha province. In Nan district, Louangprabang province, the Save the Children, focusing on MCH activities, provided support to building and strengthening SBAs, construction and renovation of health facilities, provision of medical equipment, training on management and administration, organizing health day, monitoring and supervision, through joint planning for health activities in communities by DHO and Save the Children. While the PT company had provided a complete support to a village that had an impact of dam construction, the company construct houses, school with dormitory for teacher, health center with dormitory for health staff, temple for community, support food to community like 20 kg of rice for each household member, and an egg per day per student or instant noodle. World Vision intervention took place in Xiengeun district, Louangprabang province, supported the integrated MCH services, nutrition including food demonstration, medical equipment, construction of health center and renovation of the MCH room at district hospital, organizing training course for VHV and VHC.

It noted that in three builds villages there were many activities had been implementing in community targeting to improve the socio-economic status and health of community. In addition village leaders were very active to working with local agriculture sector, bank and health sector. As observed in Namgene village

4.2.4.2 Perception of village health volunteer/village health worker

Village health volunteer is a volunteer to work in community and unpaid. VHV represents as one unit in the village authorities. He/she was selected by head of village based on educational level and active manner and get approved by DHO.

Village health volunteer served as a health network in community and communicate directly with health center in case of needs. He/she was responsible for all activities concerning health in the village. Provision of health education in community concerning practicing three-hygiene (eating, living and clothing cleanly), keeping livestock away from home, constructing latrine and its use, destroying breeding site of mosquito, encourage pregnant women to attend ANC ad delivery in hospital and talk about the benefits of ANC, PNC and delivery in health facility. VHV also served as primary health care in the village like provide consultation to sick people to seek health care and on certain diseases (malaria and diarrhea), distributing of mosquito net and its retreatment. Some villages VHV helped delivery in case a pregnant woman could not reach to health facility in time.

Beside that VHV supported health center and DHO staff when they conducted outreach activities or other health purposes in village.

4.2.4.3 Food consumption and nutrition

Regarding the access to food in community, the source of food is different. In rural areas people normally accessed to forest products: vegetables, bamboo, mushroom, and games like rats, deer etc, fishing in nearby river and household garden. In community nearby city the household food relied on both market and forest or pond/river.

In some village food taboo after delivery was still strongly practiced in community due to mothers perceived that if they eat strong smell food like fermentage fish *Pa Deak*, pickle vegetables and fishes, meat of white baffaloes, beef, games, and some forest vegetables like bamboo and mushroom, and fruits and vegetables they could be in toxic 'PhitKam'. So that by the first week after delivery mothers ate only salt with gangers and some did add

grilled/boiled traditional species of chicken. The food taboo had been practicing since generation. Now some women tried to ignore this practice.

4.2.4.4 Challenges regarding health in community and its solutions

When asking for the three biggest challenges regarding health in community, the survey discovered that 1) vaccination could not reach to 100% of target children due to two reasons a child got fever after vaccination which causes mother did not like to bring a child to vaccinate in the next time or family temporary moved to stay in rice field during the plantation, 2) food taboo after delivery is still strongly practiced by some women due to they perceived that if they eat certain kind of food like food with strong smell such as fermentage fish and vegetables, meat of white buffaloes, beef, games, fruits, vegetables and etc. they could get toxicity called 'PhitKam' and children could get abdominal sick so that in the first week after delivery mothers preferred to eat only salt with ginger, 3) villagers dislike to subscribe as members of CBHI scheme due to they could not afford for monthly payment such as the ceiling for household with ≤ 7 people was 25,000 kips (3.1 USD) and with > 7 people was 28,000 kips (3.5 USD) per month, many did not yet understanding about the policy of the CBHI scheme and some complained that health providers prescribed only cheap medicine to them, 4) sustainability of health activities in community once the international support is finished, and 5) outbreak of seasonal diseases like dengue fever in community particularly in southern Laos.

Regarding to the three challenges mentioned above community leaders tried to address the problem. In order to increase number of target children attended the vaccination the VHV or LWU or head of village strongly encourage mothers to bring their children to get vaccination, for those mothers who do not understand about the side effect of vaccination like fever the VHV had explained to them, and VHV had to inform mothers one or two days before the vaccination took place in the village. VHC or VHV did explain to mothers to not practicing food taboo by explaining about the health of women after delivery and the proper food for lactated mothers. In addition health staff provided health education mothers during the ANC visit and after delivery in health facility.

4.2.5 Access and utilization of health services

Regarding to the access to health care services, the community preferred to seek health care services at health center or district hospital/provincial hospital as discussed by all FGDs. The place of seeking health care depended on the level of sickness. When they got not severe sickness they sought health care service at health center in contrast when they had severe sickness they went to district or provincial hospital directly. No any FGD participants mentioned about seeking health care with traditional healer or private practitioners.

It is noted that if the villages located close to health facilities, to main road and easily accessed to public transport that passed by the village, availability of international organizations' health interventions in communities (annex 2), the access to health services was better. More people sought care at outpatient care (OPD), MCH services like family planning, attending to ANC and PNC, getting delivery in health facilities, target children accessed to vaccination, deworming and vitamin A. An example given in Namgene village, a "three Builds" village, Louagnamtha province where WFP provided a support of 10 kg of rice per each time to those pregnant women who attended to ANC and delivery at health facility and women who visited PNC and brought target children for vaccination as appointed, most women utilized the health services at health center, and in addition to that the health center is located in the village.

How do you pay for health services

If people have difficulties in accessing to health care services, there are some systems existed in community to support the access to health care services such as community based health insurance scheme (CBHI), health equity fund (HEF), village fund and free delivery policy (see Table 2). So far the number of CBHI members was very limited due to villagers could not afford the monthly payment as minimum 25,000 kips (3.1 USD) if household members $\leq$ 7 people and maximum 28,000 kip (3.5 USD) if household members per household per month, in addition, more health services requirement than the actual needs, complaining about the quality of health services and place for health care services. An example given in Thongchaleun more villagers wanted to utilize the health services in the hospital of nearby province if the CBHI allowed them they would subscribe in it (this community located in the border which is close the other province). Moreover, poor people could utilize the HEF for

health care services after submission of letter for certification that issued by a head of village. Beside that the village fund was available in some villages and people can borrow it with low interest or without interest if they need to spend for health care services. Free delivery policy was implemented in many provinces since two years ago, villagers appreciated it because it supported pregnant women to attended ANC and PNC and delivery in health facility for free of charge.

Although there were some supporting systems to support the health care services in community like mentioned above CBHI, HEF and free delivery policy, people still need to pay for non-medical equipment from their own pocket money such as costs for transportation and food for both patient and caregiver.

In case of emergency cases, there was no any emergency preparedness plan in the communities to access to health services.

4.2.6 Access to information, means of communication and transportation

- Most villages were connected to the main road and could be accessed by car and motorbike in both seasons. Only few villages were difficult to access or sometime were disconnected during the rainy season.
- No any public transport was available in villages and most people used their own transports for accessing to health facilities except for some villages that located close or along the main road people could access to buses that passed by villages but they were very limited number in a day.
- Regarding to the communication in communities, mobile phone was very popular for communicating as all household possessed of it. There were different telecom companies network functioning.
- Concerning to the access to health related information in villages, all FGD participants discussed that people could access to health related information through the health program in television however the health program was broadcasting in very short time so that many people easily missed that program. Only Lao Star and police channels were available in communities. Beside the television people could access to health related information through posters and health staff during outreach activities. Thus the health staff was the most important and useful source of health related information in communities

because people appreciated the reliability of the information, followed by posters as people could understand the content by images particularly illiterate people.

4.2.7 Gender role and family relations

The gender in community is getting better since LWU or other non-health sector disseminated the information related gender role, and health sector provided health education concerning the risk of pregnancy and delivery. As now both male and female mutually decided for all household purposes like accessing to health care, enrolling children to school and household income generation as discussed by most FGDs, though one FGD discussed that men were the main person to make decision in household but still after discussion with wives. In addition men supported wives to attend ANC visit and delivery at health facility and some even accompanied wives to hospital. Some men supported women to be head of village.

Only one FGD, men stated that both men and women still perceived that if pregnant women worked hard they would give birth easily. So that pregnant women in this village were still working hard until giving birth. They discussed that women would have responsibility for housework, rice plantation, taking of children while men would be responsible for cutting timber and look for food for the household like hunting animal.

All ethnicity in community have the same right and value in accessing to any activities in communities such as health services, education, income generations and status of village leaders. An example given in one village, a head of village was from Khamu group whereas the deputy head of village was from Lao group.

V. Conclusions and recommendations

A community survey in order to gain insight into condition and practices regarding health in the community with the purpose of exploring effective measures and approaches to improve the health status of community was conducted in nine provinces, 14 districts and 14 villages (14 FGDs). Qualitative data were collected through the conduct of FGD among village leaders and in-depth interviews with key informants.

The survey noted that most village leaders were men and attended some years in secondary school. It is noted that community structures were very supportive for the conduction, management and promotion of health activities in community in close collaboration with health center. With the support of village leaders it made the health intervention in community that supported by MOH, non-health sector and international agencies more effective and ensured the achievements.

With the integration from different stakeholders like village leaders, health sector, non-health sector and international agencies for implementation of activities related health in communities it made significant changes in communities, for instance, now more people sought health care services at health facilities including ANC, PNC and delivery, more children vaccinated though outreach activities or routine health services for all health facilities. In addition through some supporting system like health insurance (CBHI, CSS) and HEF more poor people in communities accessed to health care services and through free delivery policy more pregnant women attended the MCH services.

There was no gender and ethnicity discrimination in communities and decision making for all household purposes including accessing to health care services and school enrollment was made by both husband and wife.

However there were some challenges had been noted as now the CBHI member was very limited, vaccination among target children could not get 100% due to mother perceived side effect of vaccine, and sustainability of intervention in community once the international support was finished.

Based on the findings it is recommended that:

1) More women should be prioritized to be members of any community structures at least 40% of all village leaders because in our survey indicated that of 102 FGD participants only 37 of them were women. In addition, we observed that LWU members had been working sufficiently and productively in health intervention implemented in communities.
2) Three builds ideas is very supportive and affective for the complete development in communities, this implementation should be continued
3) International agencies should prolong the support for conducting of health intervention in communities if it is possible because the international assistance contributed to significant impact to community's health
4) More health education concerning the effectiveness of vaccination particularly to mothers of target children should be considered in order to warranted the high vaccination coverage among target children
5) Dissemination of CBHI policy in communities should be urgently made by concerned DHO staff and the access to health facility of CBHI members should be flexible not obligated only to certain hospital particularly for those people who stay close to other hospitals.

Annexes:

Annex 1: General characteristic of FGD participants (n = 102)

Items	Number	%
Gender:		
Male	65	63.7
Female	37	36.3
Average age	42.2 years	
Age range	22 – 68 years	
Educational level:		
No schooling	1	0.9
Informal primary school (Pasaseuksa)	2	1.9
Attended some years in primary school	29	28.4
Graduate primary school	3	2.9
Attended some years in secondary school	57	55.9
More than secondary school level	10	9.8
Occupation:		
Farmer	87	85.3
Business	2	1.9
Government staff	12	11.8
Housewife	1	0.9
Representative of community structures:		
Head/deputy head of village	24	23.5
Head/deputy head of Lao Women Union	15	14.7
Head/deputy head of Youth Union	10	9.8
Head/deputy head of senior unit or Lao front unit	17	16.7
Village health volunteer	11	10.8
Head of/deputy head of defense unit	4	3.9
Head of/deputy head of security unit	5	4.9
Party member	2	1.9
District health staff/ Health center staff	12	11.7
Teacher	1	0.9
Peer educator	1	0.9

Annex 2: Challenges in community

Challenges in community	
A lot of activities to perform but the work experiences are limited once the village becomes 3 builds	
Health center lack of medicine	
Village is far from HC so it is difficult to access during night time people went to rice field only during the cultivated season.	
Village is far from HC, Outbreak of dengue fever every year , Latrine construction is not yet reaching to 100%, People do not yet understand about health	
Outbreak of dengue fever so that every year before rainy season VHV leads the destroying the breeding site of mosquitoes, - insurance coverage is not stable particularly CBHI	
No village emergency preparedness plan to support the payment burden	
Villagers do not give a good collaboration in implementing the preventive measures in community like cleaning around houses, destroyed breeding site of mosquitoes and other activities.	
Household food relied on the nature and pond around village Food taboo still practiced after delivery	
Food taboo is still practiced by some women but most of them gave up after listening to health education	
• So far there are some mothers (about 20%) still not bring their children to vaccinate during the vaccination in a village due to they are afraid that the child would get sick of that however to solve this problem the village authorities tried to explain about the benefits of vaccination in order to encourage them to bring the child for vaccination • Few women do not understand the benefits of preparing proper food for children, they still say that 'even mother cook proper food for children the children would still remain the same as before' • Few women still perceive that taking deworming drug would cause infect with worm infection again	

• Only half of households in the village are members of CBHI, some people resigned from the CBHI members however some return to be member of CBHI when they understand well about its policy, so that village leaders tried to educate them concerning the benefits of CBHI • Some women still practice food taboo after delivery because they inherit from their old generation however the TBA tried to address this issue by introducing then the food that needed for women during this period such as explaining about the food that rich of vitamin and protein such as meat, chicken, vegetable and fruits.	
• Health problems faced in this village: people are sick of diabetes, gastritis and kidney diseases, grippe, but no dengue fever occurred in this village • Children under five years get grippe during the cold season due to in this area the weather is quite cold • The road condition from the village to the main road is muddy and pumpy so it is difficult to access to hospital particularly for pregnant women to travel to health facility, so they also need support for the road construction, the length of road is about 2 km. • People still use unsafe water because the tank is very old and mad by non-Need cement water tank for the village. The village has gravity fed water (Namlin) since long time but they have no tank to keep water so that they want to have a support to construct a tank. • We would like the district office to supervise us in arranging the houses because now the houses are dispersed and no road within the village. They need the power from the district level otherwise villagers might have problem between them.	
• The sustainability of the international support in community	
• Half of household are not yet becoming member of CBHI because head of households heard that many people complain about hospital that prescribing only cheap medicine and obligating to a certain hospital only. If the CBHI allow community to utilize other neighboring hospital all people in the village will apply for it. However concerning this issue, village leaders will try to encourage them to be members of CBHI. ○ The ceiling of CBHI payment per household per month:	

- More than 7 people 28,000 kips - Less than 7 people 25,000 kips • The PT company support will be over this year so that it is highly concern for the sustainability on the nutrition in household • Exclusive breastfeeding to 6 months is still challenging because mothers started to give masticated rice to children at 3 months old and some a week after delivery	
- Community are not yet well understand about the CBHI so that only half of households 20% of HH involved in the CBHI - 10% of mothers do not bring their children for vaccination due to they are afraid that children would be of that sick and do not bring children for deworming - More community have no money to buy food and they mainly consume what is available in villages - After delivery some women still practice food taboo	
In this village VHV do not function as before because now health centre is located in the village and there are five health centre staffs so that most of health activities in village the health centre staff is responsible instead of VHV. Head of LWU just help to collect some information related to child birth, death, children under five years for head of village and head of village continues to submit these information to health centre.	
Suggestions from participants	
• Requesting construct of health center, strengthening capacity of health center staff and VHV • Request some incentive for VHV • Request water supply in a village because they have only 3 wells are available now	
Request latrine for a village, Request water supply for a village	
Request some emergency medicine Request some incentive for VHV when travelling to work or training Request water supply for a village	
We want to have support for making a fence for the school	

• Salary for village leaders is too small. If it is possible they wish the government to increase the salary for them. • Concerning to the village garbage basket, now no any car came to collect it because many times when the car comes the basket was empty, when it is empty the village will not pay for that service, people in this village prefer to burn the garbage so that is why the basket is empty. Village leaders must address this problem by encouraging people to throw garbage in the village basket but not burning it anymore because the district advice the village to contribute some for garbage management.	

Annex 3: Characteristics of surveyed villages and systems support in accessing to health care services

No	Province	District	Village	Type of Village	Availability of HF	Access to Main Road	Health Insurance	HEF	VDF	Free MCH	Implementing Agency/ Supporting DPs
1	Phongsaly	Khoua	Thabuk	MHV	2km to DH	Perfect RC	X	✓	✓	✓	MHO/WFP
2	Phongsaly	Boun Tai	Namlannoy	MHV Development	8km to DH	2km to main road with poor RC	X	✓	✓	✓	MOH/WFP
3	Luang Namtha	Luang Namtha	Namgnene	Samsang MHV	HC in village	Perfect RC	X	✓	✓	✓	MOH/WFP
4	Bokeo	Paktha	Donemixay	MHV	3km to DH	Along the main road	X	✓	X	✓	Plan International
5	Luang Prabang	Nan	Thongchaleun	Samsang	HC in village	8km to main road Good RC	CBHI	✓	✓	✓	MOH, PT company Save the Children
6	Luang Prabang	Xieng-Ngeum	Kiewgna	MHV	HC in village	Close to main road Good RC	CBHI	✓	✓	✓	World Vision, Cornardo Assn./Switzerland
7	Xieng Khouang	Kham	Nagnong	Samsang MHV	HC in village	Perfect RC	X	✓	✓	✓	MOH
8	Xieng Khouang	Nonghad	Khangphanien	Samsang MHV	HC in village	Perfect RC	X	✓	X	✓	KOFIH/WHO

9	Savannakhet	Kaison Phomvihanne	Phonsim	Samsang	Close to HC	Perfect RC	SSS/CSS CBHI	X	✓	✓	MOH
10	Savannakhet	Thapangthong	Xekeu		Close to HC	Accessible only dry season with poor RC	CBHI	✓	X	✓	MOH/UNFPA / UNICEF
11	Bolikhamxay	Khamkeuth	Khammouane	MHV	HC in village	Poor RC	X	✓	✓	✓	Lux-Development
12	Sekong	Dakcheung	Daklane		12 km from HC	Main road with poor RC	X	✓	X	✓	Swiss Red Cross/WFP
13	Sekong	Laman	Namhieng		5km from HC	Main road with poor RC	CBHI	✓	X	✓	Swiss Red Cross/WFP
14	Champasack	Pathouphone	Nongboua Yai	MHV	8km to HC	Perfect RC	X	✓	✓	✓	MOH

MHV: Model Healthy Village; HF: Health Facility; HC: Health Center; DH: District Hospital; RC: Road Condition; VDF: Village Development Fund

Annex 4: Summary of Characteristics in the Study Sites

No. 1	Province: Phongsaly	District: Khoua	Village: Thabuk
Thabuk village is located close to DH, so there is no problem on road access. All people can access to the health services, particularly MCH, nutrition, health education, etc. The Swedish project has been supporting school meals (primary school P1, P2 and P3) since to 2012, which, has contributed the improvement of the nutrition status of children. Head of the Village, VHV, LWU, LYU have received training regarding nutrition, hygiene and sanitation, school meals, village fund management, solidarity and child right.			
No. 2	Province: Phongsaly	District: Boun Tai	Village: Namlannoy
Namlannoy village is located about 8 km far from the urban areas so that the access to health facilities is not an issue, and the accessibility to the health services, in particular MCH, EPI are widely accessible. DHO supports supplementary food to children under 5 years old such as soya milk, salt and eggs. In addition, WFP supports flavor, sugar and oil to primary school children every quarter and women in villages take turn to be cookers in the school. The community observed that the child malnutrition had decreased largely with the more than 10-year WFP program. The challenges in the village are that the access to the safe water is an issue and the food taboo after delivery is still a common practice. The village is certified as MHV and Development Village.			
No. 3	Province: Luang Namtha	District: Luang Namtha	Village: Namgnene
HC staff, village authorities and community people have a good cooperation. All people can access to the health services, especially ANC and delivery at health facility are all accessible. Food taboo is not a common practice in this village. In this village VHV do not function as before because now health centre is located in the village and there are five health centre staffs so that most of health activities in village the health centre staff is responsible instead of VHV. Head of LWU just help to			

collect some information related to child birth, death, children under five years for head of village and head of village continues to submit these information to health centre. District health staff often come to our village to provide vaccination to target children, distribution of vitamin A and deworming to children under five and women, and sometime provide health education to us concerning to the seasonal diseases and keeping good three-hygiene. World Food Program (WFP) in collaboration with DHO particularly with health center provided supports of supplementary food to reproductive age women and children under five years through the health center services in order to encourage targeted women and children to access to health services such as ANC/delivery/PNC/vaccination among children.

No. 4	Province: Bokeo	District: Paktha	Village: Donemixay

From village to DH is about 3 km, Plan International in close collaboration with Paktha District Health Office and health center provided support to all villages in this district. So that village leaders of this village have received several training on how to encourage community to construct latrine with the purpose to get open defecation free, how to manage and sustained the intervened activities, provide health education concerning MCH activities and nutrition such as encourage women to attend ANC visit, PNC visit, and delivery at health facility, food demonstration and learn about gender. However the food taboo for postpartum is still a common practice in this village. Regarding the health activities in the village now we have district health staff often come to our village to provide vaccination to target children, distribution of vitamin A and deworming to children under five and women, and sometime provide health education to us concerning to the seasonal diseases and keeping good three-hygiene. They also encourage pregnant women to attend antenatal care, delivery and attend postnatal care in hospital. They also talk about the benefit of delivery in hospital. In addition they encourage people to seek care in hospital when they get sick. Beside the health staff the VHV together with LWU and head of village inform us and lead us to clean around houses, evacuate any animal from the village and keep them far from house, destroying the breeding site of mosquito in every month particularly during the rainy season. VHV often talk about the benefits of attending antenatal care, delivery and postnatal care in hospital. In addition the Plan

International in collaboration with district health staff provide health activities in the village and they encourage us to construct latrine (pit latrine).			
No. 5	Province: Luang Prabang	District: Nan	Village: Thongchaleun
The village is quite a big community with easy road access, there are availability of HC, and school. This village has both TBA and VHV together with the active VHC which make a community intervention is quite working well and also there is a support from PT company for health activities like MCH, nutrition, health education activities including training for health staff, etc. however, some of postpartum women are keeping food taboo practiced.			
No. 6	Province: Luang Prabang	District: Xieng-Ngeum	Village: Kiewgna
Social protection, CBHI and HEF are available for the unemployed and poor respectively. VHC is working well since also there is a support from World Vision project which support for the training and activities. However the food taboo is still commonly practiced in this village. World Vision (WV) in close collaboration with DHO and health center they support the provision of health activities in communities which focuses on integrated MCH activities and nutrition in 25 villages before but now due to combining small villages into one village then it is becoming 18 villages.			
No. 7	Province: Xieng Khouang	District: Kham	Village: Nagnong
The HC located in the village which make people easier to access to the health services. ANC and delivery at health facility and other MCH are the most accessible and nutrition status of the child is good. The village has no any insurance schemes available. there was no water supply in a village, there were only three wells existing in the village, in addition there is no any canal to drain waste water from village so that it might cause some diseases, some people are not yet aware of health education due to health centre has no any LCD to make visualized health education in community.			

No. 8	Province: Xieng Khounag	District: Nonghad	Village: Khangphanien
This is a Samsang village. The HC located in the village, since the village is a mountainous area the safe water supply is lacking. While the general health services are mostly available. after a villages declared as three builds village there were a lot of activities to perform but the work experience is limited such as economic-finance facing problem for instance collecting money from villagers is very difficult because they do not understand about it, in addition VHV has no any support from other units			
No. 9	Province: Savannakhet	District: Kaison Phomvihanne	Village: Phonsim
This village is Samsang village, there are school, Healt center located in this village with the population of laolum ethnics. The village is quite developed in terms of education, road access, social protection, health access, and community interventions. The seasonal disease outbreak is a challenge particularly a dengue fever which, has outbreak every year during rainy season. The villagers start campaigning early before rainy to destroy the breeding site of the mosquitoes			
No. 10	Province: Savannakhet	District: Thapangthong	Village: Xekeu
It's a remote area with poor road access, the majority of the people are Katang ethnics. This village has no village development fund, and according to the discussion with the village authorities we found that the villagers are not aware of health issue, don't understand a health, that make a health intervention is not easy. During the discussion many people mention that there is no gender issue, while the key informant interview found that the women have less opportunities for education, decision making, etc. Since the HC located in the village, the Drug kit is not functioning well while the food taboo practice for postpartum is still existing in the village.			

No. 11	Province: Bolikhamxay	District: Khamkeuth	Village: Khammouane
HC is located in the village which make the people easily access to the health services and Lux-development project is also implementing in the village providing the VDF and other activities. The taboo is not a common practice, health activities working well. All pregnancy have delivered at the health facility and access to MCH service like ANC, EPI, etc.			
No. 12	Province: Sekong	District: Dakcheung	Village: Daklane
The village is a mountainous area, about 12 km far from the HC, no electricity, lack of safe water supply. This village is red cross covered by HEF(Swiss). Villagers have a difficulty to access to the HC, when sickness they first visit VHV ,therefore they request VHV to have more training.			
No. 13	Province: Sekong	District: Laman	Village: Namhieng
Village is a Samsang village, and mountainous area about 3 km for from the HC. village are covered by HEF(Swiss red cross). The cooperation of the villager to health activity is not so well, when MCH outreach come to the village villagers are not coming to get the service even HC staff put more effort to provide the health education. The health education in local language is needed.			
No. 14	Province: Champasack	District: Pathouphone	Village: Nongboua Yai
The distance from the village to HC is about 8 km, the village health committee is not functioning well, and has a meeting every 6 month. The gender issue is not a problem in this village. In this village the accessibility to the health services is quite good for example the EPI coverage, ANC, delivery at health facility, health education, etc. But, some of them are still follow the taboo practices.			

Annex 5: Village Health Volunteers Backgrounds

No	Province	District	Village	Attending FGD	Age	Gender	Education	Occu.	Ethnicity
1	Phongsaly	Boun Tai	Namlannoy	✓	46	M	Non-formal education	Farmer	Phounoy
2	Bokeo	Paktha	Donemixay	✓	30	M	S2	Farmer	Khmu
3	Luang Prabang	Nan	Thongchaleun	✓	37	F	S3	Farmer	Lao
4	Luang Prabang	Xieng-Ngeum	Kiewgna	✓	40	M	S3	Farmer	Khmu
5	Xieng Khouang	Kham	Nagnong	✓	52	M	P5	Farmer	Lao
6	Savannakhet	Kaison Phomvihanne	Phonsim	✓	38	F	Completed high school	Farmer	Lao
7	Savannakhet	Thapangthong	Xekeu	✓	56	M	S3	Farmer	Katang
8	Bolikhamxay	Khamkeuth	Khammouane	✓	59	M	S3	Farmer	Lao
9	Sekong	Dakcheung	Daklane	✓	36	M	S4	Farmer	Talieng
10	Sekong	Laman	Namhieng	✓	27	M	S4	Farmer	Alak
11	Champasack	Pathouphone	Nongboua Yai	✓	28	M	P5	Farmer	Lao

S: secondary school; P: primary school

Annex 6: Result from KII implementing agencies

World Food Program (WFP)

- Implementation structure

  - World Food Program(WFP) has the main office in Vientiane and also their own office in Sekong province working closely with government in particular is Provincial health department to implement the project in local villages. The implementers are the government authorities (provincial, district, Health center, village and VHV.), WFP is providing technical and financial support

- Key characteristics and major achievement
  - World Food Program (WFP) has been working in Sekong province since 2002 on providing food to the school children (corn power, vegetable, rice and sugar, can fish) to the contract school that school/village promising to provide the cooker to prepare the food for the student, one cooker is responsible for 50 student. After the implementation of the project the realized that they could not sold the main cause of malnutrition, thus in 2011 the WFP start Mother and child nutrition project by providing the supplement food (nutri-batter) and to the pregnancy and lactating.
  - Major achievement: the children who were involved in the project had a better health status and growth rate are good

- Funding source and support from outside

  All activities are funded by WFP. The activities is implemented by the government, particularly provincial health department who managed all work like planning, implementing, monitoring and reporting for both activity and finance. The budget are provided to the provincial health department (PHD) in advance based on the plan.

- Strengths and challenges of the current project
  - The project get fully support from the government to implement the project activities
  - The perception and participation of the communities and local people to the project are the main challenges.

- Lessons learned from the current project

The key success are

- The support from the government
- The understanding and participating of the local communities to the project

Care international

- Implementation structure

  - Care international is a NGO had the office in Sekong province working with government authorities. In district level there is a implementation and monitoring committee that consist of women union, Health, education, agriculture, and rural development chaired by deputy district governor to monitor the project and have quarterly meeting at the district level. In the provincial level called steering committee chaired by deputy governor had meeting every 6 months to report the progress of the project and planning.

- Key characteristics and major achievement

  Care international has implemented many activities like UXO, livelihood improvement in supporting income generation by agriculture, training in nutrition for the targeted village, food security in Dakcheung district by providing technical and financial support to agriculture activity to produce food source for the villagers. In addition, there were the funding from Luxembourg to support mine risk education on UXO, EU to support Care Int' then add nutrition education activity, Care Australia support hygiene and diseases prevention (latrine, water). EU is currently support partnership women empowerment and poverty reduction project covered 35 villages incorporate with care international project.

  Major achievement are women development has been significantly improve such as women have more right, agriculture production increased and high income, and the people have more knowledge on nutrition

- Funding source and support from outside

  Care international, Care Australia, MoFA of Luxembourg, EU.

- Strengths and challenges of the current project
  - Strengths: Good participation from the government
  - Challenges: Accessibility(some village could access only 4 months during the dried season, UXO is still the threat in implementing of the project , Ethnicity is also a barrier to access to the local people therefore the staff 50% should be local people to ensure the information provided is delivered. There is not enough government staff to support the activities

Swiss Red Cross

- Implementation structure

  Swiss Red Cross had the office in Sekong province working with government authorities and have the office at the provincial health office

- Key characteristics and major achievement

  Swiss Red Cross has been implemented health equity fund in Sekong since 2009 then pilot of free MCH was implemented in 2010. In 2014 has launched the new pilot project which focusing on universal health coverage (UHC). The health insurance coverage in Sekong is 69% for all scheme. Swiss Red Cross is piloting the implementation of health insurance scheme in particular CBHI, health equity fund and free delivery in collaboration with the government. Normally, health equity fund is identifying the poor first before recruit the poor to be member. Since Kaleum and Dakcheung district majority of the population are poor, the HEF cover all population except capital village the district which need to identify the poor before recruit them as HEF member.

- Funding source and support from outside

  Swiss Red Cross is assisting the provincial health insurance bureau to create the mechanism to manage the funding integrating the pilot project into existing system of the government by putting budgets from different sources to the same basket including government budget to be used for the UHC , making internal audit, fund management, improving the CBHI, and payment mechanism

- Strengths and challenges of the current project
  - Strengths: Good participation from the government and local people
  - Challenges: perception of people to the policy, insurance or benefit package. The facility or system is not yet ready for the pilot project. Health management, quality of health services, accessibility, integration services and information are not so good and budget from the government delay.

Annex 7: Surveys Tools

Community Survey

Focus Group Discussion (FGD) Guide

Detailed Questions:

Objective:

To gain insight into conditions and practices regarding health in the community with the purpose of exploring effective measures and approaches to improve the health status of community people.

Procedure

Participants:

One FGD in each village with key persons (about 6 to 8 persons), such as; Head or deputy head of village, members of Village Health Committee (VHC), Health Personnel (health staff at Health Center, if existing), Village Health Volunteer (VHV)/Village Health Worker (VHW), representatives of Women's union, Youth Union and other key stakeholders who have a position in the community identified.

Procedure:

1) Explain briefly the objectives of the discussion
2) Obtain the participants' informed consent
3) Introduce each other and obtain background information
4) Conduct FGD

Each FGD session will take 60 minutes in due consideration of the participants' availability.

Discussion Questions :

1. Existing community organizations/structures
    - What kind of organizations and committees exist in the community?

- Membership (males/females/ethnicity background) & selection process
- Roles and responsibilities?
- How often do they meet and how do they make decisions on community affairs?
- Any constraints/challenges they are faced with?
    - What are the roles and functions of Village Health Committee?

- Membership (males/females/ethnic background)?
- Roles and responsibilities?
- Any constraints/challenges they are faced with in their functions?
- Do they receive any support from outside (the provincial/district level/external donors) If yes, what support do they receive?

2. Perceptions on health services in the community
    - What kind of health services / health-related activities exist in the community?
        - What types of health services and activities are available? (both curative/preventive)
        - How often do you have such services and activities?
        - Which organizations are working for these health services / activities?
        - Who are providing these health services/activities?

- What more health services/activities do you think the community needs?
    - What do you think of the work of Village Health Volunteers(VHVs)/Village Health Workers (VHWs) or any other community workers?

*e.g. various VHVs, community-based distributers (CBDs), VHWs (full-time paid)

- How are they selected/recruited? Their background (female/male/ethnic background)
- What health activities are they currently doing in the community?
- What more health services/activities do you think the VHV/VHW could do?
    - What are the biggest challenges regarding health in the community?

- The biggest challenges faced currently (three biggest ones)?
- How is the community addressing such challenges? Any actions taken by the community?
    - Are there any issues regarding food availability, food consumption and nutrition?

- Are there any dietary taboos?
- Are there any measures / actions taken by the community to address such issues?

(e.g. school meals, school / home gardening, nutrition education)?

3. Access and utilization of health services
    - In case of sickness (requiring medical treatment), where do yougo for consultation/treatment?

-Where do you go and why?

(e.g. provincial/district hospitals, health center, private practitioners, traditional

medicine/healers, etc.)

- In case of emergency (emergency in delivery, severe sickness, accidents), where do you go for consultation/treatment? Why?
- If community people have difficulty to go to health facilities (hospitals/health centers) for receiving consultation and treatment, is there any support available in the community?

- Any support from the community (financial, transport, etc.)
- In case of emergency, are there any community emergency preparedness plan?

- How do you pay for health services?

- How much do you spend in comparison with other important matters, such as food consumption and education?
- Are there any support systems for people who cannot pay for health services?
- Do the community people have access to social health protection? (e.g. free MCH, health equity fund, community based health insurance, any other schemes)

4. Access to information, means of communication and transportation

- What is the community's physical accessibility by road and transportation?

- Road availability and means of transportation available in the community

- What means of communication are available in the community?

- Availability of mobile phone, radio/TV, internet, access to mass media?

- Which information sources/channels are most useful in obtaining health related information?

5. Gender roles and family relations

- Who usually makes decisions at the household level?

- For family affairs, e.g. income generation, marriage, child birth, child rearing and education?
- Are there any difficulty for women to make decisions about health care themselves?

- Are there any existing social limitations/barriers for women and ethnic minorities in access to income generation, health services, education?

Community Survey

Key Informant Interview(KII) Guide

Detailed Questions:

Objective:

To gain insight into conditions and practices regarding health in the community with the purpose of exploring effective measures and approaches to improve the health status of community people.

Procedure

Interviewees:

Key stakeholders in the designated villages: i.e. Village Head, members of Village Health Committee (VHC), Health Personnel (health staff at Health Center, if exiting), Village Health Volunteer (VHV)/Village Health Worker (VHW), representatives of Women's Union, Youth Union and other key stakeholders who have positions in the community identified.
Approximately 8 interviewees in each village. If there are more key stakeholders identified, they should be included in this survey.

Procedure:

1) Explain briefly the objectives of the discussion
2) Obtain the participants' informed consent
3) Obtain background information
4) Conduct KII

Discussion Questions :

1. Existing community organizations/structures

- What kind of organizations and committees exist in the community?

- Membership(males/females/ethnicity background) & selection process
- Roles and responsibilities?
- Any constraints/challenges they are faced with?
- Do they receive any training or support from outside (government/external donors)?

- What are the roles and functions of Village Health Committee?

- Membership (males/females/ethnic background)?

- Roles and responsibilities?
- Any constraints/challenges they are faced with in their functions?
- Do they receive any support from outside (the provincial/district level/external donors)?

If yes, what support do they receive?

- Does your community receive any support from outside (national/provincial/district government/external donors)?

- What kind of support? (funding, in kind, technical support, etc.)

- Have you had any changes in community organizations/structures since the community received support from outside? (including the creation of new organization/structure)

- How this change has made any impact in dealing with community affairs?

2. Perceptions on health services in the community

- What kind of health services / health-related activities exist in the community?
  - What types of health services and activities are available? (both curative/preventive)
  - How often do you have such services and activities?
  - Which organizations are working for these health services / activities?
  - Who are providing these health services/activities?

- What more health services/activities do you think the community needs?

- What do you think of the work of Village Health Volunteers(VHVs)/Village Health Workers (VHWs) or any other community workers?

*e.g. various VHVs, community-based distributers (CBDs), VHWs (full-time paid)

- How are they selected/recruited? Their background (female/male/ethnic background)
- What health activities are they currently doing in the community?
- What more health services/activities do you think the VHV/VHW could do?

- (For VHVs and VHWs / CBDs)

- How have you become a VHV/VHW/CBDs?
- What strengths and challenges have you experienced being a VHV/VHW/CBD?
- What support does the community provide to you?

- What are the biggest challenges regarding health in the community?

- The biggest challenges faced currently (three biggest ones)?
- How is the community addressing such challenges? Any actions taken by the community?

- Are there any issues in the community regarding food availability, food consumption and nutrition?

- Are there any dietary taboos?

- Are there any measures / actions taken by the community to address such issues? (e.g. school meals, school / home gardening, nutrition education)?

3. Access and utilization of health services
    - In case of emergency (emergency in delivery, severe sickness, accidents), where do the community people will go to? Why?
    - If community people have difficulty to go to health facilities (hospitals/health centers) for receiving services, are there any support available in the community?
    - How do the community people pay for health services?

- Are there any support systems for people who cannot pay for health services?

- Do the community people have access to social health protection? (e.g. free MCH, health equity fund, community based health insurance, any other schemes)

4. Access to information, means of communication and transportation
    - What is the community's physical accessibility by road and transportation?

- Road availability and means of transportation available in the community
    - What means of communication are available in the community?

- Availability of mobile phone, radio/TV, internet, access to mass media?
    - Which information sources/channels do you think are most effective in obtaining health related information?

5. Gender roles and family relations
    - Are there any existing social limitations/barriers for women and ethnic minorities in access to income generation, health services, education?

6. Lessons learned and facilitating factors in good practices
    - In the progress the community has made, what are key facilitating factors?
    - What are the lessons learned you have experienced in the process?

Community Survey

Key Informant Interview (KII): Topic Guide For Implementing Agencies

Interviewees:

- Local government authorities (Provincial / District)
- Provincial Health Office / District Health Office
- Other agencies identified as important
- Representative of implementing agencies (e.g. NGO field managers, technical persons)

Interview Topics

***Regarding the project / good examples the survey is to study**

- Implementation structure
  - Linking with existing provincial/district/community structure?
  - New structure/system created?
- Key characteristics and major achievement
- Funding source and support from outside
  - From central government and/or other donors
  (e.g. model healthy village, district/village development fund, health equity fund, free MCH, or other donor support, etc.)
  - How the fund is managed
- Any support provided from the province/district to the community
  - Financial and technical (monitoring & supervision)
- Any multi-sectoral approach taken
  - Any examples of collaboration among different sectors (e.g. health/sanitation, education, agriculture, etc.)
- Strengths and challenges of the current project
- Lessons learned from the current project.

5.2 List of Local NGO in Lao P.D.R.

Local NGOs in Lao P.D.R. summaried and explained as main local NGOs in "The Directory of Civil Society Organisations (CSOs) in 2014, Lao PDR" are listed as follows.

1. Association for Community Development
2. Aid Children with Disability Association
3. Association for Community Training and Development
4. Association to Support the Development of Peasant Societies
5. Association for Development of Women and Legal Education
6. Association for Autism Agro-Forestry and Development Consultant Co. Ltd
7. Association For the Deaf
8. Bolaven Plateau Coffee Producers Groups Association
9. Association for Patient with Epilepsy
10. Association of People Living with HIV/AIDS Association for Poor People
11. Association Rural Mobilisation and Improvement
12. The Association for Vulnerable Children and Community Development
13. Clean Agriculture Development & Food Processing Association
14. Community Association for Mobilizing Knowledge In Development
15. Community Development and Environment Association
16. Community Knowledge Support Association
17. Community Development Association
18. Disadvantaged children and Youth capacity development Association
19. Dongsavath Children and Youth Development Association
20. Development Environment for Community Association
21. Environment Conservations and Community Development Association
22. The Education for Development Fund
23. Equal Education For All
24. Farmer Development Association
25. Friends of PhaTadKe Association
26. Fair Trade Laos
27. Green Community Alliance
28. Green Community Development Association
29. Gender and Development Association
30. Huam Jai Asasamak / United in Volunteer Association
31. Hed Yu Tham Kin / Working for Living Association
32. Join Moral Foundation
33. Kong Community Development Association
34. Lao Association of the Blind
35. Lao Association for Disadvantaged People
36. Lao Bar Association
37. Lao Positive Health Association
38. Lao Biodiversity Association
39. Lao Bio-Diesel Research and Development Association
40. Lao Coffee Association
41. Lao Coffee Association
42. Lao Community Sustainable Development Promotion Association
43. Learning House for Development
44. Lao Disabled People's Association
45. Lao Disabled Women's Development Centre
46. Lao Handicraft Association
47. Lao Institute for Renewable Energy
48. Lao Library Association
49. Love Natural Resource Association
50. Labour and Professional Promotion Association Life Skills Development Association

51. Microfinance Association
52. Maeying Houamjai Pathana / Women Participating in Development Association
53. Participatory Development Training Center
54. Population Education and Development Association
55. Promotion of Family Health Association
56. Promote Sustainable Natural Resource Use Association
57. Quality of Life Association
58. Rural Research and Development Promoting Knowledge Association
59. Sustainable Agriculture and Environment Development Association
60. Sisterhood for Development Association
61. Samakom Gounka Lao / The Worth of Laos
62. Social Development Alliance Association
63. Vulnerable Women and Children Foundation
64. Vulnerable Youth Development Association
65. The Wildlife Conservation Association
66. Youth to youth Peer Workers in Health Education and Development Association

6. Detailed Information on the Financial Status of the Central Hospitals and the Provincial and District Hospitals in the Four Southern Provinces

The detailed information for Chapter 2.3 “Financial Status and Issues of the Three Central Hospital Facilities” and Chapter 3.3.5 “Financial Status of the Hospitals in the Southern Region” of the report is provided on the following pages.

Appended Table 1 Income Statements of the Three Central Hospitals (2013/2014 – 2014/2015)

1-1 Mahosot Hospital 2013/2014 (Unit: Million LAK)

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	67,799.8
		Government subsidy revenue	25,324.6
		RF revenue (mainly medical practice revenue)	42,475.2
	Expenditure	Total expenditures	63,750.9
1		Personnel cost (10, 11)	21,662.4
		Personnel cost covered by government subsidy (10, 11)	20,074.7
		Personnel cost covered by RF (11)	1,587.7
2		Expenses (12, 16)	41,140.9
		Expenses covered by government subsidy (12, 13, 16)	4,302.3
		Expenses covered by RF (12, 13)	36,838.7
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	25,627.4
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	22,500.1
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	3,753.5
	*	Buildings as included in the above (repeated) (12-02-2-1)	799.5
	*	Vehicles as included in the above (repeated) (12-02-2-2)	69.0
	*	Instruments as included in the above (repeated) (12-02-2-3)	2,885.0
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	579.9
3		Capital investment cost (covered by government subsidy) (17)	947.6
	Profit and loss	Based on total revenues (including government subsidy)	4,048.9
		Based on RF revenues (mainly medical practice revenue)	(21,275.7)

(Source) Settlement of accounts report provided by Mahosot Hospital (2013/2014)

1-2 Mahosot Hospital 2014/2015 (Unit: Million LAK)

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	82,033.3
		Government subsidy revenue	32,896.8
		RF revenue (mainly medical practice revenue)	49,136.5
	Expenditure	Total expenditures	78,928.2
1		Personnel cost (10, 11)	26,304.3
		Personnel cost covered by government subsidy (10, 11)	25,213.8
		Personnel cost covered by RF (11)	1,090.5
2		Expenses (12, 16)	52,623.9
		Expenses covered by government subsidy (12)	7,683.0
		Expenses covered by RF (12, 13)	44,940.9
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	23,756.0
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	20,894.2
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	6,289.3
	*	Buildings as included in the above (repeated) (12-02-2-1)	1,192.3
	*	Vehicles as included in the above (repeated) (12-02-2-2)	17.4
	*	Instruments as included in the above (repeated) (12-02-2-3)	5,079.5
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	2,498.6
3		Capital investment cost (covered by government subsidy) (17)	0.0
	Profit and loss	Based on total revenues (including government subsidy)	3,105.1
		Based on RF revenues (mainly medical practice revenue)	(29,791.8)

(Source) Settlement of accounts report provided by Mahosot Hospital (2014/2015)

Note 1) Numbers in parentheses in the column of "Revenues and Expenditure" are article numbers designated by the government.

Note 2) The accounting year of Laos is October to September of the next year. For example, 2014/15 refers to October 2014 to September 2015.

2-1 Mittaphab Hospital 2013/2014 (Unit: Million LAK)

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	51,085.2
		Government subsidy revenue	15,504.0
		RF revenue (mainly medical practice revenue)	35,581.2
	Expenditure	Total expenditures	40,605.9
1		Personnel cost (10, 11)	12,426.5
		Personnel cost covered by government subsidy (10, 11)	11,979.3
		Personnel cost covered by RF (11-4-6)	447.2
2		Expenses (12, 16)	27,155.8
		Expenses covered by government subsidy (12)	2,501.1
		Expenses covered by RF (12, 16)	24,654.7
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	19,897.1
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	15,389.7
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	1,561.4
	*	Buildings as included in the above (repeated) (12-02-2-1)	1,299.0
	*	Vehicles as included in the above (repeated) (12-02-2-2)	76.9
	*	Instruments as included in the above (repeated) (12-02-2-3)	185.5
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	196.5
3		Capital investment cost (covered by government subsidy) (17)	1,023.6
	Profit and loss	Based on total revenues (including government subsidy)	10,479.3
		Based on RF revenues (mainly medical practice revenue)	(5,024.7)

(Source) Settlement of accounts report provided by Mittaphab Hospital (2013/2014)

2-2 Mittaphab Hospital 2014/2015 (Unit: Million LAK)

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	58,890.4
		Government subsidy revenue	18,659.0
		RF revenue (mainly medical practice revenue)	40,231.4
	Expenditure	Total expenditures	89,548.6
1		Personnel cost (10, 11)	14,901.8
		Personnel cost covered by government subsidy (10, 11)	14,566.8
		Personnel cost covered by RF (11-4-6)	335.0
2		Expenses (12, 16)	73,647.3
		Expenses covered by government subsidy (12)	3,092.8
		Expenses covered by RF (12, 13)	70,554.5
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	36,756.9
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	22,771.1
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	5,935.7
	*	Buildings as included in the above (repeated) (12-02-2-1)	5,739.0
	*	Vehicles as included in the above (repeated) (12-02-2-2)	140.8
	*	Instruments as included in the above (repeated) (12-02-2-3)	4.9
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	16,989.2
3		Capital investment cost (covered by government subsidy) (17)	999.5
	Profit and loss	Based on total revenues (including government subsidy)	(30,658.2)
		Based on RF revenues (mainly medical practice revenue)	(49,317.2)

(Source) Settlement of accounts report provided by Mittaphab Hospital (2014/2015)

Note 1) Numbers in parentheses in the column of "Revenues and Expenditure" are article numbers designated by the government.

Note 2) The accounting year of Laos is October to September of the next year. For example, 2014/15 refers to October 2014 to September 2015.

3-1 Setthathirath Hospital 2013/2014 (Unit: Million LAK)

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	31,926.0
		Government subsidy revenue	14,526.4
		RF revenue (mainly medical practice revenue)	17,399.6
	Expenditure	Total expenditures	30,950.9
1		Personnel cost (10, 11)	15,356.9
		Personnel cost covered by government subsidy (10, 11)	9,946.2
		Personnel cost covered by RF (11-4-6, 11-7-6)	5,410.6
2		Expenses (12, 13, 16)	15,594.0
		Expenses covered by government subsidy	0.0
		Expenses covered by RF (12, 13, 16)	15,594.0
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	10,228.5
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	8,564.3
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	1,043.1
	*	Buildings as included in the above (repeated) (12-02-2-1)	186.0
	*	Vehicles as included in the above (repeated) (12-02-2-2)	96.9
	*	Instruments as included in the above (repeated) (12-02-2-3)	760.2
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	107.9
3		Capital investment cost (covered by government subsidy) (17)	0.0
	Profit and loss	Based on total revenues (including government subsidy)	(975.1)
		Based on RF revenues (mainly medical practice revenue)	(13,551.2)

(Source) Settlement of accounts report provided by Setthathirath Hospital (2013/2014)

3-2 Setthathirath Hospital 2014/2015 (Unit: Million LAK)

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	38,440.4
		Government subsidy revenue	18,598.7
		RF revenue (mainly medical practice revenue)	19,841.8
	Expenditure	Total expenditures	38,440.4
1		Personnel cost (10, 11)	15,309.5
		Personnel cost covered by government subsidy (10, 11)	14,661.1
		Personnel cost covered by RF (11-4-6, 11-7-6)	648.4
2		Expenses (12, 16)	23,131.0
		Expenses covered by government subsidy (12)	3,937.6
		Expenses covered by RF (12, 13)	19,193.4
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	13,040.0
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	9,646.1
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	2,369.7
	*	Buildings as included in the above (repeated) (12-02-2-1)	820.9
	*	Vehicles as included in the above (repeated) (12-02-2-2)	288.1
	*	Instruments as included in the above (repeated) (12-02-2-3)	1,260.7
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	107.9
3		Capital investment cost (covered by government subsidy) (17)	0.0
	Profit and loss	Based on total revenues (including government subsidy)	0.0
		Based on RF revenues (mainly medical practice revenue)	(18,598.7)

(Source) Settlement of accounts report provided by Setthathirath Hospital (2014/2015)

Note 1) Numbers in parentheses in the column of "Revenues and Expenditure" are article numbers designated by the government.

Note 2) The accounting year of Laos is October to September of the next year. For example, 2014/15 refers to October 2014 to September 2015.

Appended Table 2 Income Statements of Four Southern Provincial Hospitals

① Champasak Provincial Hospital 2013/2014 Unit: Million LAK

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	29,955.6
		Government subsidy revenue	15,386.2
		RF revenue (medical practice revenue)	14,569.3
	Expenditure	Total expenditures	27,529.5
1		Personnel cost (10, 11)	12,830.8
		Personnel cost covered by government subsidy (10, 11)	12,798.8
		Personnel cost covered by RF (11-1-6, 11-4-6)	32.0
2		Expenses (12, 16)	14,698.7
		Expenses covered by government subsidy (12, 13, 16)	2,587.4
		Expenses covered by RF (12, 13)	12,111.3
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	8,613.4
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	7,604.3
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	476.6
	*	Buildings as included in the above (repeated) (12-02-2-1)	236.6
	*	Vehicles as included in the above (repeated) (12-02-2-2)	1.2
	*	Instruments as included in the above (repeated) (12-02-2-3)	238.8
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	721.8
3		Capital investment cost (covered by government subsidy) (17)	0.0
	Profit and loss	Based on total revenues (including government subsidy)	2,426.0
		Based on RF revenues (mainly medical practice revenue)	(12,960.2)

Source) 1. Champasak Provincial Health Office "Revenue/Expenditure Status of Champasak Provincial Hospital 2013/2014"
2. Champasak Provincial Health Office "Budget-Implementation Status of Government subsidy of Champasak Provincial Hospital 2013/2014"

② Salavan Provincial Hospital 2014/2015 Unit: Million LAK

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	12,679.9
		Government subsidy revenue	7,619.2
		RF revenue (mainly medical practice revenue)	5,060.8
	Expenditure	Total expenditures	12,343.8
1		Personnel cost (10, 11)	7,619.2
		Personnel cost covered by government subsidy (10, 11)	7,619.2
		Personnel cost covered by RF (11-1-6, 11-4-6)	0.0
2		Expenses (12, 16)	4,724.6
		Expenses covered by government subsidy (12-1,2, 13-1,3,4, 16-2)	555.0
		Expenses covered by RF (12, 13)	4,169.6
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	3,265.6
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	2,880.1
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	198.0
	*	Buildings as included in the above (repeated) (12-02-2-1)	34.1
	*	Vehicles as included in the above (repeated) (12-02-2-2)	50.4
	*	Instruments as included in the above (repeated) (12-02-2-3)	0.0
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	0.0
3		Capital investment cost (covered by government subsidy) (17)	0.0
	Profit and loss	Based on total revenues (including government subsidy)	336.2
		Based on RF revenues (mainly medical practice revenue)	(7,283.0)

Note 1) The following sources list the government subsidy revenue/expenditure as total values of Salavan Provincial Health Office and Provincial Hospital.

(Source) 1. Salavan Provincial Health Office "Status of Revenue/Expenditure from Government subsidy, Donations, and Revolving Funds 2014/2015"
2. Salavan Provincial Hospital "Status of Revenue/Expenditure from Revolving Funds 2014/2015"

③ Sekong Provincial Hospital 2014/2015 Unit: Million LAK

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	10,181.2
		Government subsidy revenue	8,116.5
		RF revenue (mainly medical practice revenue)	2,064.7
	Expenditure	Total expenditures	10,185.5
1		Personnel cost (10, 11)	7,211.0
		Personnel cost covered by government subsidy (10, 11)	7,211.0
		Personnel cost covered by RF (11-1-6, 11-4-6)	0.0
2		Expenses (12, 16)	2,974.6
		Expenses covered by government subsidy (12-1,2, 13-1,3,4, 16-2)	905.5
		Expenses covered by RF (12, 13)	2,069.1
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	1,908.0
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	1,888.1
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	2.4
	*	Buildings as included in the above (repeated) (12-02-2-1)	0.0
	*	Vehicles as included in the above (repeated) (12-02-2-2)	2.4
	*	Instruments as included in the above (repeated) (12-02-2-3)	0.0
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	0.0
3		Capital investment cost (covered by government subsidy) (17)	0.0
	Profit and loss	Based on total revenues (including government subsidy)	(4.3)
		Based on RF revenues (mainly medical practice revenue)	(8,120.8)

Note 1) Source 1 below excludes the basic pays (10-1) from the government subsidy revenue/expenditure. Therefore, they were added to the government subsidy revenue/expenditure based on the data of interview with the person in charge of finance.

(Source) 1. Sekong Provincial Health Office "Status of Revenue/Expenditure from Government subsidy 2014/2015
2. Sekong Provincial Hospital "Status of Revenue/Expenditure from Revolving Funds 2014/2015"

④ Attapeu Provincial Hospital 2014/2015 Unit: Million LAK

№	Revenues and Expenditures		Amount
	Revenue	Total revenues	12,515.3
		Government subsidy revenue	7,900.0
		RF revenue (mainly medical practice revenue)	4,615.3
	Expenditure	Total expenditures	11,065.3
1		Personnel cost (10, 11)	4,858.0
		Personnel cost covered by government subsidy (10, 11)	4,710.5
		Personnel cost covered by RF (11-1-6, 11-4-6)	147.5
2		Expenses (12, 13, 16)	6,207.3
		Expenses covered by government subsidy (12-1,2, 13-1,3,4, 16-2)	1,592.0
		Expenses covered by RF (12, 13)	4,615.3
	*	Cost of supplies (repeated) (12-01-4-2/3/4)	NA
	*	Cost of medicines as included in the above (repeated) (12-01-4-4)	NA
	*	Maintenance cost of facilities, equipment and instruments (repeated) (12-02-2)	NA
	*	Buildings as included in the above (repeated) (12-02-2-1)	NA
	*	Vehicles as included in the above (repeated) (12-02-2-2)	NA
	*	Instruments as included in the above (repeated) (12-02-2-3)	NA
	*	Purchasing cost of new equipment, instruments, etc. (repeated) (16)	NA
3		Capital investment cost (covered by government subsidy) (17)	1,600.0
	Profit and loss	Based on total revenues (including government subsidy)	1,450.0
		Based on RF revenues (mainly medical practice revenue)	(6,450)

Note 1) Source 1 below excludes the capital investment (17) from the revenue/expenditure from the government subsidy. However, it was incorporated into the calculation because it is included in Source 2.

(Source) 1. Attapeu Provincial Health Office "Status of Revenue/Expenditure from Government subsidy 2014/2015"
2. Attapeu Provincial Hospital "Status of Revenue/Expenditure from Revolving Funds 2014/2015"

Appended Table 3 Income Statements of District Hospitals in the Four Southern Provinces

① Champasak Province 2013/2014 (partly 2014/2015) Unit: Million LAK

Hospital name	Sanasomboun DH	Bachiang-chaleunsouk DH	Phonthong DH	Paksong DH	Pathoumphone DH
Item	Amount	Amount	Amount	Amount	Amount
Total revenues	3,161.0	–	–	–	–
Government subsidy revenue	2,761.3	2,834.6	2,283.1	2,716.9	3,059.3
RF revenue	399.7	NA	NA	NA	NA
Gross expenditure	3,674.7	–	–	–	–
Government subsidy expenditure	3,333.0	2,834.6	2,283.1	2,716.9	3,059.3
*Related to personnel cost	2,767.8	2,154.1	1,619.8	2,034.6	2,344.0
*Related to expenditure	565.3	680.5	663.2	682.4	715.3
*Related to capital expenditure	0.0	0.0	0.0	0.0	0.0
RF expenditure	341.7	NA	NA	NA	NA
*Related to personnel cost	0.0	NA	NA	NA	NA
*Related to expenditure	341.7	NA	NA	NA	NA
Profit and loss	(513.7)	–	–	–	–

Hospital name	Champasak DH	Soukouma DH	Mounlapamok DH	Khong DH	
Item	Amount	Amount	Amount	Amount	
Total revenues	–	–	–	–	
Government subsidy revenue	2,617.9	2,664.6	2,573.6	3,534.3	
RF revenue	NA	NA	NA	NA	
Gross expenditure	–	–	–	–	
Government subsidy expenditure	2,617.9	2,664.6	2,573.6	3,534.3	
*Related to personnel cost	1,958.2	2,026.0	1,742.8	2,788.7	
*Related to expenditure	659.7	638.6	830.9	745.6	
*Related to capital expenditure	0.0	0.0	0.0	0.0	
RF expenditure	NA	–	–	–	
*Related to personnel cost	NA	NA	NA	NA	
*Related to expenditure	NA	NA	NA	NA	
Profit and loss	–	–	–	–	

Note 1) The PHOs have only the government subsidy revenue/expenditure data by district (DHO, DH and HC). The Phonthong District Hospital that the Survey Team visited had only incomplete monthly data. The only data that allowed us to confirm the statuses of revenue/expenditure from government subsidy and RFs was the FY2014/2015 data of the Sanasomboun District Hospital.

(Source) Champasak Provincial Health Office "Budget-Implementation Status of Government Subsidy" (2013/2014)
Sanasomboun District Hospital "Status of Revenue/Expenditure from Government Subsidy and Revolving Funds" (2014/2015)

② Salavan Province 2014/2015 Unit: Million LAK

Hospital name	Laongam DH	Khongsedone DH	Vapi DH	Lakhonepheng DH	Toumlan DH
Item	Amount	Amount	Amount	Amount	Amount
Total revenues	–	5,641.1	–	–	–
Government subsidy revenue	NA	3,568.5	NA	NA	NA
RF revenue	842.3	2,072.6	1,087.1	544.6	482.2
Gross expenditure	–	5,339.7	–	–	–
Government subsidy expenditure	–	3,568.5	–	–	–
*Related to personnel cost	NA	2,900.2	NA	NA	NA
*Related to expenditure	NA	668.3	NA	NA	NA
*Related to capital expenditure	NA	0.0	NA	NA	NA
RF expenditure	814.0	1,771.2	728.2	541.2	324.7
*Related to personnel cost	0.0	0.0	0.0	0.0	0.0
*Related to expenditure	814.0	1,771.2	728.2	541.2	324.7
Profit and loss	–	301.4	–	–	–

Hospital name	Ta-Oy DH	Samuoi DH			
Item	Amount	Amount			
Total revenues	–	–			
Government subsidy revenue	NA	NA			
RF revenue	600.5	417.7			
Gross expenditure	–	–			
Government subsidy expenditure	–	–			
*Related to personnel cost	NA	NA			
*Related to expenditure	NA	NA			
*Related to capital expenditure	NA	NA			
RF expenditure	705.5	364.2			
*Related to personnel cost	0.0	0.0			
*Related to expenditure	705.5	364.2			
Profit and loss	–	–			

Note 1) The PHOs have the financial data by DH only regarding RF revenue/expenditure. The government subsidy revenue/expenditure of the PH and HO have been totaled so that the details of them are unknown. The data for each of them can be viewed only in FY2014/2015 data of the Khongsedone District Hospital that the Survey Team visited. The data of the Vapi Hospital, another hospital that the Survey Team visited, cannot be read because arbitrary expense items were used in it.

(Source) Salavan Provincial Health Office "Financial Statuses of Provincial Health Office, Provincial Hospitals, and District Hospitals" (2014/2015), Khongsedone District Hospital "Status of Revenue/Expenditure from Government Subsidy and Revolving Funds" (2014/2015)

③ Sekong Province 2014/2015 Unit: Million LAK

Hospital name	Tha Teng DH	Kaleum DH	Dakcheung DH		
Item	Amount	Amount	Amount		
Total revenues	–	–	–		
Government subsidy revenue	3,435.0	2,915.9	3,122.3		
RF revenue	NA	NA	NA		
Gross expenditure	–	–	–		
Government subsidy expenditure	3,435.0	2,915.9	3,122.3		
*Related to personnel cost	2,965.1	2,555.4	2,731.8		
*Related to expenditure	469.9	360.5	390.5		
*Related to capital expenditure	0.0	0.0	0.0		
RF expenditure	–	–	–		
*Related to personnel cost	NA	NA	NA		
*Related to expenditure	NA	NA	NA		
Profit and loss	–	–	–		

Note 1) The financial data owned by the PHO shows only the government subsidy revenue/expenditure for each district (DHO, DH and HC). No data is available to show the revenue/expenditure of each DH. The PHO does not have the data on the RF revenue/expenditure of each DH, nor does the Tha Teng District Hospital that the Survey Team visited have any data sorted into expense items compliant with the accounting standards of the national government.

(Source) Sekong Province "Status of Revenue/Expenditure from Government Subsidy by District" (2014/2015)

④ Attapeu Province 2014/2015 Unit: Million LAK

Hospital name	Phouvong DH	Xaysetha DH	Sanamxay DH	Sanxay DH	
Item	Amount	Amount	Amount	Amount	
Total revenues	–	3,483.9	–	–	
Government subsidy revenue	2,281.0	3,404.5	3,190.0	3,750.0	
RF revenue	NA	79.4	NA	NA	
Gross expenditure	–	3,491.6	–	–	
Government subsidy expenditure	2,281.0	3,398.4	3,190.0	3,750.0	
*Related to personnel cost	1,531.0	2,554.5	2,290.0	2,900.0	
*Related to expenditure	750.0	843.8	900.0	850.0	
*Related to capital expenditure	0.0	0.0	0.0	0.0	
RF expenditure	–	93.3	–	–	
*Related to personnel cost	NA	0.0	NA	NA	
*Related to expenditure	NA	93.3	NA	NA	
Profit and loss	–	(7.7)	–	–	

Note 1) The financial data owned by the PHO shows only the government subsidy revenue/expenditure for each district (DHO, DH and HC). No data is available to show the revenue/expenditure of each DH. The PHO does not have the data on the RF revenue/expenditure of each DH. Only the Xaysetha District Hospital that the Survey Team visited had the government subsidy revenue/expenditure and RF revenue/expenditure of each DH, which the Team confirmed.

(Source) Attapeu Province "Status of Revenue/Expenditure from Government Subsidy by District" (2014/2015), Xaysetha District Hospital "Status of Revenue/Expenditure from Government Subsidy and Revolving Funds" (2014/2015)

7. Existing Medical Equipment in Setthathirath Hospital

The list of existing medical equipment provided by Setthathirath Hospital is shown as follow.

Setthathirat Hospital
Medical Equipment check list

No	Equipment name	QTY	Purchase year	User			Maintenance			Reason of out order			Repairing			Renewal			Remark
				Dr	Nurse	engineer	Dr	Nurse	engineer	Aging	No spare parts	consumable	user	agent	manufacturer	Government budget	Hosp budget	donation	
1	CT	1	2011	+			+			+				+				+	
2	Fluoro	1	2013	+			+			+			+					+	
3	X-ray	1	2014	+	+		+	+					+					+	
4	Mobile-X ray	3	1998	+	+		+	+					+					+	
5	CTG	1	2014	+	+		+	+			+			+			+		
6	CTG	1	2015	+	+		+	+						+			+		
7	Delivery set	10	2001	+	+		+	+		+							+		
8	Delivery set	10	2015	+	+		+	+											
9	Ultrasound	1	2001	+			+	+		+								+	
10	Ultrasound	2	2012	+			+											+	
11	Ultrasound	2	2013															+	
12	Ultrasound 4D	2	2015	+			+											+	
13	warmer	1	2001	+	+		+	+										+	
14	warmer	1	2013	+	+		+	+										+	
15	Colposcopy	1		+			+											+	
16	Anesthesia	1	2001	+	+		+	+		+								+	
17	Anesthesis	1	2014	+	+		+	+									+		
18	Anesthesis	1	2015	+	+		+	+										+	
19	Anesthesis	1	2015	+	+		+	+									+		
20	Operation table	3	2001	+	+		+	+										+	
21																			

Source: Setthathirath Hospital, as an answer to questionnaire of the JICA Survey Team.