SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Kingdom of Bhutan	Project Title:	Health Sector Development Program
Lending/Financing Modality:	Sector development program	Department/ Division:	South Asia Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Poverty targeting: targeted poverty intervention – Sustainable Development Goals 3 and 5

A. Links to the National Poverty Reduction and Inclusive Growth Strategy, and Country Partnership Strategy

The sector development program (SDP) is in line with the government's long-term vision for Bhutan, in which gross national happiness is the ultimate objective and the crux of Bhutan's development philosophy.[a] Within this vision, the government recognized health as one of the nine critical domains for gross happiness and committed to establishing a relevant and cost-effective health care delivery system based on the primary health care (PHC) approach, which the SDP supports. The SDP also supports the agenda as set forth in the National Health Policy, which promotes achieving self-reliance and sustainability through more efficient delivery of health services, and the realization of universal health coverage through PHC.[b] The program is included in the country operations business plan for Bhutan, 2016–2018 of the Asian Development Bank (ADB)[c] and reinforces ADB's increasing investments in health systems and health security, acknowledged as critical for inclusive growth in the Midterm Review of Strategy 2020.[d]

B. Results from the Poverty and Social Analysis during Project Preparation or Due Diligence

1. **Key poverty and social issues.** Bhutan is in the medium human development category and has transitioned to a lower middle-income country status. From 2012 to 2017, the poverty rate fell from 12.0% to 8.2% (national poverty lines), and gross domestic product per capita increased from $560 (1990) to $2,655 (2015). Poverty continues to be largely a rural phenomenon in Bhutan—11.9% in rural and 0.8% in urban areas.[e] While Bhutan made significant investments in health care and achieved remarkable progress in key health outcomes over the past several decades, rural–urban disparities in health status remain. For example, the under-5 mortality rate is 81 deaths per 100,000 live births in rural areas and 41 deaths per 100,000 live births in urban areas; 98.5% of urban women gave birth in a health facility but only 89.8% of women living in rural areas did so; and teenage pregnancy is 3.6 times higher outside the urban areas.[f] Differences also exist in the use of health services by wealth profile—the richer use hospitals more than the poor. For example, most poor people (58.9%) use basic health units compared with only 27% of the non-poor.[g] Bhutan is also rapidly urbanizing, i.e., the urban population is growing at twice the rate of the national population. The cities of Thimphu and Phuentsholing have the highest concentrations of urban populations in the country. Rapid urbanization and rural–urban migration have opened new gaps in health service coverage, so urban migrants are underserved. Regional health security risks are also increasing because of direct air connectivity with large regional hubs and reliance on a large number of expatriate workers. Cross-border public health risks arising from Bhutan's highly porous borders with India are significant but do not receive sufficient attention. This generates a corresponding need to improve disease surveillance and response mechanisms, especially at major points of entry.

2. **Beneficiaries.** Health services are constitutionally guaranteed and provided free of charge to all citizens. The SDP investments in measures to strengthen the overall health system and health security will directly or indirectly benefit the entire Bhutanese population (officially about 760,000), and especially those in underserved areas. As regards PHC improvements, urban peripheries (Thumphu and Phuentsholing) and eight rural districts (Dagana, Mongar, Pemagatshel, Samdrup-Jongkhar, Trashigang, Trashiyangtse, Trongsa, and Zhemgang) were given priority based on their poverty levels. The SDP's support for the Bhutan Health Trust Fund (BHTF) will further ensure that essential drugs and vaccines are sustainably funded, bringing benefits to both the general population and those that are most vulnerable to vaccine-preventable diseases.

3. **Impact channels.** The SDP will contribute to government efforts to reduce poverty and disparities through (i) investments to strengthen PHC services in both rural and urban peripheries to meet the needs of the poor and underserved, which will also result in overall sustainability and efficiency gains for the sector; and (ii) support for immunization, disease surveillance, and other health security measures, which will benefit the poor, who may be disproportionately vulnerable to infectious diseases.

4. **Other social and poverty issues.** Bhutan's multidimensional poverty rate in 2017 is estimated at 5.8% of the population, with urban poverty at 1.2% and rural poverty at 8.1%. Deprivations in the health dimension constitute 34% of overall multidimensional poverty. This suggests the need for strategic health investments to close the large regional disparities in health deprivation.

5. **Design features.** The SDP will help improve equity, efficiency, and sustainability of Bhutan's health system. It will strengthen (i) primary health service delivery, focusing on expanding quality and coverage of services in peripheral areas; (ii) strengthen the BHTF to boost sector financing; and (iii) improve health sector management and disease surveillance through a strong national health information system (HIS).

C. Poverty Impact Analysis for Policy-Based Lending

1. **Impact channels of the policy reforms.** The SDP will support sustainable health financing and a modernized HIS. The health financing policy actions include measures to make the distribution of benefits from public health financing more equitable through a benefit-incidence analysis; and to develop the legal basis that governs equitable, efficient, and sustainable health financing. The HIS policy actions will facilitate Bhutan's move to an interoperable national HIS, which will also result in better capture of equity differentials.
2. **Impacts of policy reforms on vulnerable groups**. The SDP will support the BHTF in sustainable financing of essential drugs and vaccines, which will be provided free of charge to all citizens, and to improve disease surveillance and the HIS. This support for immunization, disease surveillance, and other health security measures will particularly benefit the poor, who may be disproportionately vulnerable to infectious diseases and public health risks.
3. **Systemic changes expected from policy reforms.** The policies under the SDP are expected to result in more progressive and pro-poor distribution of benefits from public health financing, and related improvement in service delivery, which will help close disparities in health outcomes and access, and contribute to multidimensional poverty reduction. The SDP will contribute to achieving targets related to universal health coverage under Sustainable Development Goals 3 and 5, by expanding access to essential health services for all, including universal access to reproductive health.

II. PARTICIPATION AND EMPOWERING THE POOR

1. **Participatory approaches and project activities.** The project includes support for more extensive communication on public health advocacy and behavioral change through partnerships with civil society organizations (CSOs). The SDP will also improve the interpersonal counseling skills of health staff, to ensure that every contact with a health professional is respectful and that information provided is useful, accurate, and communicated in a way that is understood. The SDP will support the rollout of operational standards for PHC facilities, which include standards for ensuring community participation in health and measuring client satisfaction.
2. **Civil society organizations.** The SDP plans to engage with CSOs to communicate with the poor and excluded communities in the eight districts on public health advocacy and behavior change.
3. The following forms of CSO participation are envisaged during project implementation, rated as high (H), medium (M), low (L), or not applicable (NA):

☒ Information gathering and sharing = H ☒ Consultation = H ☒ Collaboration = H ☒ Partnership = H

4. **Participation plan.** A participation plan will not be prepared because the needs and concerns of the poor and other vulnerable people in Bhutan are already reflected in the various outputs of the SDP, as described above.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: effective gender mainstreaming

A. Key issues. The maternal mortality ratio per 100,000 live births improved from 777 in 1984 to 86 in 2012, and skilled birth attendance rose from 11% in 1994 to 75% in 2012. Despite impressive gains, rural–urban disparities in health status and access to child and reproductive health services remain. Health outcomes and service coverage vary wildly across districts. There is also a need to monitor morbidity trends and effects of different health conditions and diseases by sex and by age group. For example, in 2014, more males than females aged 1–4 and over 65 years fell ill. However, in the reproductive age group (aged 15–49), more women than men experienced illness episodes, resulting in a higher overall share of women (52.8%) falling ill.[h] More women (13.5%) are generally susceptible to sickness and injury than men (10.4%), and two-thirds of people affected by gender-based violence are women.[i] Among the noncommunicable diseases, significant gender differences are observed in certain noncommunicable disease risk factors. For example, 8.2% of females are obese compared with 4.2% of males. [j] However, more men (61%) than women (39%) suffer from cancer. [k] There are also imbalances in the health workforce, with a shortage of women health workers. The government plans to ensure that every health facility has at least one female health worker, but at present the ratio is two male health workers to every female one.

B. Key actions. A gender action plan (GAP) was prepared. It will support the delivery of the SDP by integrating gender across the output areas and program management. For project-based output 1, the GAP would ensure that all construction and renovation works at health care facilities are gender-sensitive, with adequate provision for patient privacy. It would also encourage female health workers to participate in gender-sensitive interpersonal counseling training, and female community members to participate in behavior-change activities. At the management level, the GAP would ensure capacity building for project management staff on gender mainstreaming. For policy-based output 2, the GAP will ensure that the work on health financing equity reflects the differential impacts on men and women, and that the draft Health Bill considers the distribution of health benefits among a range of different population groups by income, socioeconomic status, gender, and geographical factors. Additionally, it will ensure that the BHTF and Ministry of Health (MOH) staff recruitment reflects the national effort for gender-redistributive policies. For policy-based output 3, the GAP will ensure that the HIS collects sex-disaggregated data and monitors gender-related trends over time, focusing on the analysis in the MOH Annual Health Bulletin. The GAP will be implemented by the MOH and closely monitored through the MOH's gender focal person. Progress of the GAP will also be monitored through the Gender Equality Monitoring System of the National Commission for Women and Children.

☒ Gender action plan ☐ Other actions or measures ☐ No action or measure

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. **Key impacts**. The project will not involve any land acquisition. New construction will be limited to five small urban satellite clinics on vacant government land with no productive use. Neither physical nor economic displacement will occur. Of the five clinics, two sites are yet to be selected (Debsi and Phuentsholing). The initial sites offered by the municipal authorities were not accepted by the MOH because of their less than optimal location and size, and negotiations with the authorities continue. The two satellite clinics for which the land has yet to be identified will be built on vacant government land, and no safeguard impacts are therefore anticipated. Necessary assurances are included in the grant agreement.
2. Strategy to address the impacts. – None.
3. Plan or other actions. ☒ No action

B. Indigenous Peoples **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. There are no indigenous peoples in project areas as per ADB's Safeguard Policy Statement (2009). Is broad community support triggered? ☐ Yes ☒ No
2. Strategy to address the impacts. N/A
3. Plan or other actions. ☒ No action

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. **Relevance of the project for the country's or region's or sector's labor market.**
☒ Unemployment = L, ☒ underemployment = L, ☒ retrenchment = L, ☒ core labor standards = L
2. **Labor market impact.** Employment will be provided by the civil works at fair wages that are equal for men and women for the same type of work. Contractor bidding documents will include core labor standards.

B. Affordability. PHC services will be strengthened and will reduce the out-of-pocket expenditures on transport to health facilities. Basic health services are constitutionally guaranteed in Bhutan, and the government provides a comprehensive range of free health care to all citizens, including referrals of patients abroad for treatments beyond the clinical capacity of Bhutan.

C. Communicable Diseases and Other Social Risks

1. **The impact of the following risks are rated as high (H), medium (M), low (L), or not applicable (NA):**
☒ Communicable diseases = L ☐ Human trafficking = NA
Construction workers involved in civil works under the project will be informed of the availability of HIV/sexually transmitted infection-testing centers and related services.
2. **Risks to people in project area.** NA

VI. MONITORING AND EVALUATION

1. **Targets and indicators.** Gender-related targets in the GAP and design and monitoring framework (DMF) will be monitored and reported to the government and to ADB. Where possible, data on the DMF baselines and targets will be obtained from the MOH's regular information systems. Key gender targets to be monitored are training of health workers, construction, BHTF staffing, and better analysis of sex-disaggregated health data.
2. **Required human resources**. No additional resources are needed. The MOH's gender focal point will monitor the GAP activities, and the National Commission for Women and Children will monitor the GAP indicators.
3. **Information in the project administration manual.** Monitoring of the GAP, DMF, and safeguards are included.
4. **Monitoring tools.** These will include health service statistics, project reports, and GAP monitoring reports. Third-party monitoring of the GAP activities and indicators will be undertaken through the Gender Equality Monitoring System.

[a] Government of Bhutan, Planning Commission. 1999. *Bhutan 2020: A Vision for Peace, Prosperity and Happiness.* Thimphu.
[b] Government of Bhutan, Ministry of Health. 2011. *National Health Policy*. Thimphu.
[c] ADB. 2015. *Country Operations Business Plan: Bhutan, 2016–2018.* Manila.
[d] ADB. 2014. *Midterm Review of Strategy 2020: Meeting the Challenges of a Transforming Asia and Pacific.* Manila.
[e] Government of Bhutan, National Statistics Bureau. 2017. *Bhutan Poverty Analysis Report 2017.* Thimphu
[f] Government of Bhutan, National Statistics Bureau. 2010. *Bhutan Multiple Indicator Cluster Survey*. Thimphu.
[g] Government of Bhutan, National Statistics Bureau. 2017. *Bhutan Living Standards Survey Report 2017.* Thimphu.
[h] Footnote f. This trend is likely because of child birth and reproductive health issues.
[i] United Nations Entity for Gender Equality and the Empowerment of Women. 2016. *Gender Responsive Planning and Budgeting in Bhutan: From Analysis to Action.* New Delhi.
[j] World Health Organization. 2017. *Bhutan Sustainable Development Goals 3 Profile*. New Delhi.
[k] Government of Bhutan, Ministry of Health. 2017. *Annual Health Bulletin.* Thimphu.
Source: Asian Development Bank.