Concept Paper

Project Number: 47137-003
June 2015

Proposed Programmatic Approach, Policy-Based Loan, and Technical Assistance Loan and Grant for Subprogram 1
Lao People's Democratic Republic: Health Sector Governance Program

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Asian Development Bank

CURRENCY EQUIVALENTS
(as of 1 May 2015)

Currency unit	–	kip (KN)
KN1.00	=	$0.0001235
$1.00	=	KN8,096.00

ABBREVIATIONS

ADB	–	Asian Development Bank
HEF	–	Health Equity Fund
HSR	–	health sector reform
HSRS	–	Health Sector Reform Strategy
Lao PDR	–	Lao People's Democratic Republic
MDG	–	Millennium Development Goal
MNCH	–	maternal, neonatal, and child health care
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
TA	–	technical assistance

NOTES

(i) The fiscal year (FY) of the Government of the Lao People's Democratic Republic ends on 30 September. "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2015 ends on 30 September 2015.

(ii) In this report, "$" refers to US dollars.

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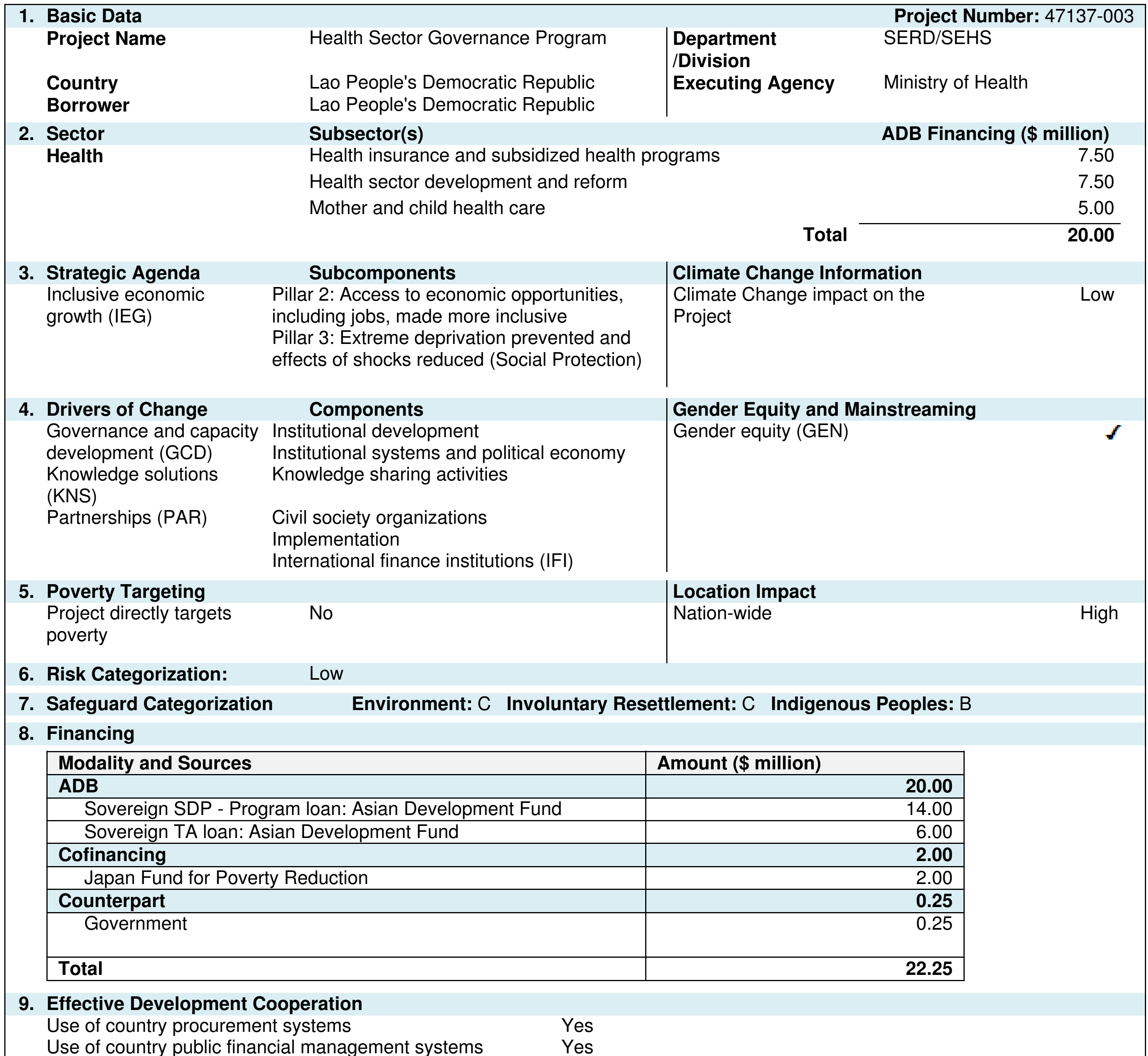
PROGRAM AT A GLANCE



1. Basic Data — **Project Number:** 47137-003

Project Name	Health Sector Governance Program	**Department /Division**	SERD/SEHS
Country	Lao People's Democratic Republic	**Executing Agency**	Ministry of Health
Borrower	Lao People's Democratic Republic		

2. Sector

Sector	Subsector(s)	ADB Financing ($ million)
Health	Health insurance and subsidized health programs	7.50
	Health sector development and reform	7.50
	Mother and child health care	5.00
	Total	**20.00**

3. Strategic Agenda

Strategic Agenda	Subcomponents	Climate Change Information	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive Pillar 3: Extreme deprivation prevented and effects of shocks reduced (Social Protection)	Climate Change impact on the Project	Low

4. Drivers of Change

Drivers of Change	Components	Gender Equity and Mainstreaming	
Governance and capacity development (GCD)	Institutional development Institutional systems and political economy	Gender equity (GEN)	✓
Knowledge solutions (KNS)	Knowledge sharing activities		
Partnerships (PAR)	Civil society organizations Implementation International finance institutions (IFI)		

5. Poverty Targeting

Poverty Targeting		Location Impact	
Project directly targets poverty	No	Nation-wide	High

6. Risk Categorization: Low

7. Safeguard Categorization — **Environment:** C **Involuntary Resettlement:** C **Indigenous Peoples:** B

8. Financing

Modality and Sources	Amount ($ million)
ADB	**20.00**
Sovereign SDP - Program loan: Asian Development Fund	14.00
Sovereign TA loan: Asian Development Fund	6.00
Cofinancing	**2.00**
Japan Fund for Poverty Reduction	2.00
Counterpart	**0.25**
Government	0.25
Total	**22.25**

9. Effective Development Cooperation

Use of country procurement systems	Yes
Use of country public financial management systems	Yes

Source: Asian Development Bank

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I. THE PROGRAM

A. Rationale

1. In the Lao People's Democratic Republic, improved management of health services is critical in ensuring better health service delivery. The proposed programmatic approach for the Health Sector Governance Program will support the implementation of the Health Sector Reform Strategy (HSRS) by the Lao People's Democratic Republic, which aims to (i) improve access to basic health care by 2020, and (ii) achieve universal health coverage by 2025.[1] It includes a policy-based loan to the government for subprogram 1, which will have a capacity development component, provided by a technical assistance (TA) loan and grant. The program will support the following key elements of the HSRS: (i) strengthening the health sector reform process; (ii) securing sufficient financial resources for basic health services provision (particularly for the poor, women, and children); (iii) strengthening human resources; and (iv) improving financial management of health services. The capacity development will support both the Ministry of Health (MOH) and provincial health offices to implement the HSRS. The design and monitoring framework is in Appendix 1.

2. **Health sector performance and access to health services.** Lao PDR has made notable achievements in health outcomes since the 1990s. However, significant challenges remain to meet key Millennium Development Goal (MDG) targets. Maternal mortality ratio decreased from 405 maternal deaths per 100,000 live births in 1995 to 357 per 100,000 live births in 2012, but the country is off track to attain the MDG target of 260 maternal deaths per 100,000 live births. Utilization of health services in Lao PDR is relatively low – ambulatory care visits per capita per year have been below 1 in most areas of the country. Poor utilization of health services is partly due to high user fees,[2] poor quality of health facilities, lack of staff, and low operational budget for outreach services.[3]

3. **Key governance challenges.** The National Commission for Health Sector Reform guides implementation of the reform process,[4] and its secretariat needs support to implement and monitor the reforms. While the number of health workers has increased significantly in 2013–2014, primary health care facilities often lack health staff. In 2013, 33% of the health centers had a community midwife (against a target of 100%). The provinces lack information on skills, health workforce development and deployment plans. There is no functioning regulatory system for licensing and registration of health professionals. The financial management systems do not capture the revenues generated by the sale of medicines and the fees for services, which constitute about 50% of total revenues in the health facilities (Footnote 3) The development budget, including all budgets from aid-financed projects, is not disaggregated, and there is no institutionalized system of national health accounts. Better financial management will improve system transparency and accountability as well as efficiency.

4. **Governments efforts supported.** The government has introduced policies and strategies since 2000 to implement health sector reforms aimed at achieving the Millennium Development Goals, improving health financing and systems, setting standards, and strengthening coordination within the sector. The government's Seventh National Socio-Economic Development Plan, 2011–

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[1] Ministry of Health. 2013. *Health Sector Reform Framework, 2013 to 2025.* Vientiane.

[2] Out-of-pocket expenditures remain high at $37 per capita per year, almost half of total health expenditures.

[3] Ministry of Health. *National Health Accounts for 2011–2012.* Unpublished.

[4] The National Commission for Health Sector Reform Strategy is chaired by the Deputy Prime Minister and co-chaired by the Minister of Health, the Vice-Minister of Finances, and the Vice-Minister of Planning and Investment. The Secretariat of the Commission is led by the Director of the Planning and Investment Department, Ministry of Health, and co-led by the Deputy Director of Cabinet.

2015 reflects its commitment to improve human development outcomes.[5] The HSRS five priority areas are (i) health human resources development; (ii) health financing; (iii) organization and management; (iv) services delivery, with emphasis on maternal and child care; and (v) information, monitoring, and evaluation. To make health services financially accessible to the poor, the government, with the technical and financial support of development partners, has financed Health Equity Fund (HEF) schemes.[6] The government is also implementing free delivery of maternal, neonatal, and child health care (MNCH), using its own revenues and external assistance financing. However, those schemes operate under different implementation, financial management, and monitoring mechanisms. Moreover, the coverage of the schemes is also incomplete.[7]

5. **ADB strategy implemented.** The midterm review of the Asian Development Bank (ADB) Strategy 2020 recommends expanding operations in the health sector to 3%–5% of its annual approvals.[8] ADB's country partnership strategy, 2012–2016 includes support to public financial management capacity in the health sector.[9] The program is included in the country operations business plan, 2015–2017.[10] It is aligned with the operational plan for health, 2015–2020.[11] ADB has provided significant support to public sector management through several TA projects and programs focusing on governance and public financial management.[12] Health sector governance has been strengthened through the implementation of two projects focusing on budget and financial management development. Lessons from previous health projects show that it is critical to move away from investment in health infrastructure and shift support to capacity development measures to enable the sector to better manage the increasing budgetary resource flows. The HSGP will support the government's HSRS, in particular reforms intended to (i) increase financial access to health services; (ii) strengthen the health human resources management; and (iii) improve the health sector financial management.

6. **Development coordination.** Major development partners in the health sector are the World Bank; the Japan International Cooperation Agency; the Luxembourg Development Agency; the Global Fund for Malaria, AIDS, and Tuberculosis; and the World Health Organization. The World Bank has a long and ongoing engagement in the health sector through the Health Sector Service Improvement Project, which focuses on four provinces in the south, and will also support the HSRS through the proposed Health, Governance, and Nutrition Development Program nationwide. The World Bank program will coordinate with ADB's program and will focus on health service delivery, including (i) strengthening the district health information system, (ii) operational and/or budget support for service delivery (basic package of services), and (iii) village-based nutrition improvements. Linkages between ADB and World Bank interventions are in Appendix 2.

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[5] Ministry of Planning and Investment. 2011. *The Seventh National Socio-Economic Development Plan 2011–2015.* Vientiane.

[6] The Health Equity Fund (HEF), established in 2007, is a social protection scheme that provides free public health care services for the poor by removing major barriers to health facilities and/or access to health services, such as transportation and the cost of pharmaceuticals and other health care costs paid by those seeking care.

[7] By 2013, HEF covered 45% of poor households, with free maternal care provided in 80 out of 143 districts.

[8] ADB. 2014. *Midterm Review of Strategy 2020: Meeting the Challenges of a Transforming Asia and Pacific.* Manila.

[9] ADB. 2011. *Country Partnership Strategy: Lao People's Democratic Republic, 2012–2016.* Manila.

[10] ADB. 2014. *Country Operations Business Plan: Lao People's Democratic Republic, 2015–2017.* Manila.

[11] ADB. 2015. *Operational Plan for Health, 2015–2020*. Manila.

[12] ADB. 2007. *Technical Assistance to the Lao People's Democratic Republic for Improved Public Financial Management Systems.* Manila; ADB. 2012. *Report and Recommendation of the President to the Board of Directors: Proposed Programmatic Approach, Policy-Based Loan and Grant, and Grant Assistance for Subprogram 1 to the Lao People's Democratic Republic for the Governance and Capacity Development in Public Sector Management Program.* Manila. ADB. 2007. *Report and Recommendation of the President to the Board of Directors: Proposed Grant to the Lao People's Democratic Republic for the Health System Development Project.* Manila; and ADB. 2009. *Report and Recommendation of the President to the Board of Directors: Proposed Sector Development Program and Project—Asian Development Fund Grants to the Lao People's Democratic Republic for the Health Sector Development Program.* Manila.

7. The proposed programmatic modality comprises two subprograms: subprogram 1 to be implemented from August 2013 to July 2015, and subprogram 2 from August 2015 to July 2018. The proposed policy matrix in Appendix 3 includes reforms completed prior to consideration of subprogram 1, and indicative triggers for subprogram 2 to facilitate continuous dialogue with the government. The ADB Board of Directors is expected to consider subprogram 1 in September 2015. Subprogram 2 will be processed sequentially upon completion of subprogram 1 and submitted to the ADB Board of Directors approximately 36 months later, based on progress achieved. The policy-based modality has been assessed to be more relevant as it provides more flexibility in the HSRF implementation support and fosters government ownership of the reforms.

B. Impact, Outcome, and Outputs

8. The impact will be universal health coverage achieved by 2025.[13] The outcome will be improved health services delivery, particularly for the poor, women, and children. The outputs will be (i) an improved health sector reform process, (ii) improved implementation of the HEF and free MNCH schemes, (iii) strengthened health human resources management capacity, and (iv) a strengthened health sector financial management system. These outputs will be key policy pillars under the program. The problem tree is in Appendix 4, and the initial poverty and social analysis is in Appendix 5.

C. Development Financing Needs

9. The financing needs required to support the government reform initiatives outlined in the HSRS have been estimated at $141 million (for FY2016–FY2018). The government has requested a single tranche loan of $14 million from ADB's Special Funds resources to finance subprogram 1. The amount of the loan has been included in the government's external borrowing program for FY2015, which totals $290 million. Financing of subprogram 2 will also be via a loan and is tentatively estimated at $15 million, to be confirmed by the government and ADB in 2017. In 2015, the World Bank is providing $26 million in the form of a loan and grant. The government budget for health (including foreign assistance) has increased from $134 million in FY2011 to $210 million in FY2014. The government has pledged further budget increases, which will significantly exceed the amount of ADB financing over the medium term.

D. Indicative Implementation Arrangements

10. The MOH, through its Department of Planning and International Cooperation, is proposed to be the executing agency for the program. Three MOH departments (Finance, Training and Research, and Personnel) and 18 provincial health departments will be the implementing agencies. An MOH steering committee—chaired by the minister of health and comprising vice ministers and representatives of MOH departments, including the cabinet, which is responsible for oversight of health sector reform implementation—will provide overall guidance on program implementation.

11. The policy-based loan for subprogram 1 will be released in a single tranche, following loan effectiveness. The local currency counterpart funds generated by the policy-based loan will be used to finance program expenditures and associated costs of reform, specifically those relating to (i) implementation of free MNCH and HEF schemes; (ii) strengthening health human resources management and financial management, and (iii) improvement of health service delivery. The proposed fund flow mechanism under the policy-based program is in Appendix 6.

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[13] The universal health coverage is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

II. TECHNICAL ASSISTANCE LOAN AND GRANT FOR CAPACITY DEVELOPMENT

12. A TA loan estimated at $6 million is proposed for subprogram 2 implementation and capacity development of MOH and provincial health departments. The TA loan will be implemented from October 2015 to September 2020. A $2 million attached TA grant has been requested from a trust fund to be implemented from October 2015 to September 2018. Both the loan and grant will support reform implementation, which will require technical inputs and targeted on-the-job support to equip selected MOH departments and provincial health offices with the required knowledge and skills to ensure reform results are sustained. The description of the TA loan and grant is in Appendix 7. The proposed fund flow mechanism is in Appendix 8.

III. DUE DILIGENCE REQUIRED

13. Due diligence includes (i) financial and procurement management and anticorruption assessments; (ii) program impact assessment; (iii) institutional capacity assessment; (iv) gender analysis to inform specific gender-related policy actions; and (v) review of impacts on the environment, involuntary resettlement, and indigenous peoples. Proposed safeguard categories are C for involuntary resettlement and environment, and B for indigenous people. Safeguard documents will follow the requirements of ADB's Safeguard Policy Statement (2009).

IV. PROCESSING PLAN

A. Risk Categorization

14. The program is categorized as low risk because (i) the total loan amount is less than $50 million; (ii) the MOH has considerable experience implementing specific investment programs and projects financed by ADB, and considerable capacity in project procurement activities, financial reporting, and the general management and oversight of project implementation; and (iii) the safeguards categorizations are B and C.

B. Resource Requirements

15. The program is being prepared through policy and advisory TA to the MOH.[14] No additional resources are envisaged for the proposed program preparation. Four international staff members from ADB's headquarters (9 person-months) and three national staff from the Lao Resident Mission (4 person-months) will work in close collaboration with the sector division.

C. Processing Schedule

16. The major processing milestones are in Table 2.

Table 2: Proposed Processing Schedule

Milestones	Expected Completion Date
Management review meeting	June 2015
Loan negotiations	July 2015
Board consideration	September 2015
Loan effectiveness	November 2015

Source: Asian Development Bank.

V. KEY ISSUES

17. Key issues include (i) slow implementation of reforms, and (ii) human resources and financial management capacity constraints in remote provinces.

[14] ADB. 2013. *Technical Assistance to the Lao People's Democratic Republic for Health Sector Governance*. Manila.

DESIGN AND MONITORING FRAMEWORK

Impacts the Health Sector Governance Program is aligned with:

Universal health coverage achieved by 2025 (Health Sector Reform Strategy)[a]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks
Outcome Health services delivery, particularly for the poor, women, and children, improved	a. By June 2019, 80% of the poor are covered by HEF scheme (2014 baseline: 43% of the poor covered by HEF scheme) b. By June 2019 80% of health centers will have at least one midwife (2013 baseline: 33%)	a. Annual report of the Health Insurance Bureau b. Annual provincial health human resources plans	The government does not allocate sufficient financial and human resources to the health sector.
Outputs 1. Health sector reform process improved	1a. National Commission on Health Sector Reform approves health sector reform annual implementation plans for FY 2017 and FY 2018 (Baseline: NA) 1b. By June 2016, the MOH endorses the road map for implementation of human resources management reforms and financial management reforms. (Baseline: Not applicable)	1a. Minutes of meeting issued by commission's secretariat 1b. MOH decree	Shift in government's focus takes attention away from health sector reform.
2. Implementation of the HEF and free MNCH schemes improved	2a. By June 2018, at least 131 districts have implemented the HEF program under the national policies and guidelines (2014 baseline: 88 districts) 2b. By June 2018, at least 131 districts apply the free MNCH policy under the national policies and guidelines (2014 baseline: 110 districts) 2c. By June 2018, the MOH has conducted an evaluation of the inclusiveness, efficiency, and impact of the HEF and free MNCH program (Baseline: Not applicable)	2a–b. Annual report of the Health Insurance Bureau 2c. Evaluation report	Provinces and districts do not allocate sufficient human resources for proper management of the schemes.
3. Health human resources management capacity strengthened	3a. During fiscal year 2018, at least 13 provinces have submitted timely yearly updates of their health staff skill database, including data on gender and ethnicity (Baseline: Not applicable)	3a. Annual provincial reports	Provinces and districts do not allocate sufficient human resources for proper management of health human resources.

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks
	3b. By June 2018, at least 13 provinces formulate annual health human resource workforce plans, which include gender and ethnicity dimensions (2013 baseline: 0 provinces) 3c. By June 2018, MOH has issued a decree for the licensing of health professionals.	3b. Annual provincial health human resource workforce plans 3c. MOH decree	
4. Health sector financial management system strengthened	4a. System established to account for sources and application of funds, by August 2018 (Baseline: system not established) 4b. By June 2018, at least 13 provinces produce quarterly financial reports, according to national guidelines, and integrate all sources of funds (2013 baseline: 0) 4c. NHA FY2013 and FY2014, published by June 2018 (Baseline: NHA FY2011 and FY2012 published)	4a. Published reports by MOH Finance Department on facility collection of revenues and use of funds 4b. Provincial quarterly financial reports 4c. MOH DOF annual report on NHA	Financial management capacity at provincial level is inadequate. Corruption and vested interest might oppose the introduction of financial accountability mechanisms.

Key Activities with Milestones (not applicable)

Inputs
Subprogram 1
ADB:
Program ADF Loan: $14 million
TA ADF Loan: $6 million

Subprogram 2
ADB:
Program ADF loan: estimated at $15.0 million (To be confirmed in 2017)

Technical Assistance
Trust Fund: $2.0 million

Government:
$0.25 million in-kind

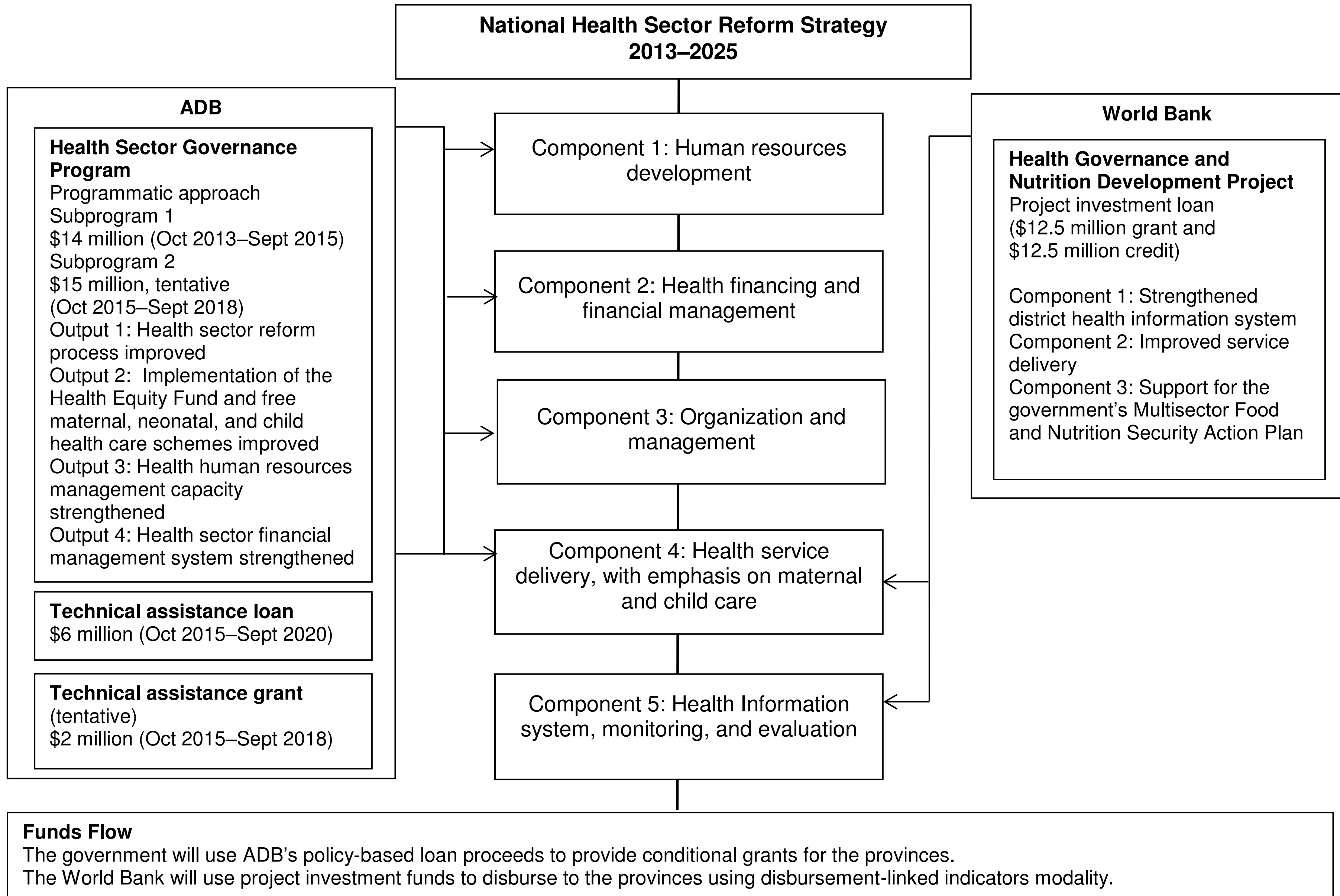
Assumptions for Partner Financing

Outputs necessary to reach design and monitoring framework outcome that are not administered by ADB include World Bank Group, Lao Health Governance and Nutrition Development Project. Components of the World Bank project include (i) MOH information management system improved; (ii) reproductive, MNCH, and nutrition services strengthened; and (iii) nutrition and health-related social and behavior change communication activities implemented.

ADB = Asian Development Bank, ADF = Asian Development Fund, DOF = Department of Finance, FY = fiscal year, GCD = governance and capacity development, HEF = Health Equity Fund, MNCH = maternal, neonatal, and child health care, MOH = Ministry of Health, MOF = Ministry of Finance, NHA = National Health Account, Q = quarter, TA = technical assistance.

[a] MOH. 2013. *Strategy Health Sector Reform Framework, 2013–2025*. Vientiane.

Source: Asian Development Bank.



ADB = Asian Development Bank
Source: Asian Development Bank.

POLICY MATRIX

Subprogram 1 Policy Actions (August 2013 to July 2015) (Triggers in bold)	**Indicative Policy Actions for Subprogram 2 (August 2015 to July 2018) (Triggers in bold)**	**Medium-Term Objectives of the Health Sector Reform Framework (phase 2016–2020)**
1. Health sector reform process improved		
1.1 The government to establish the National Commission on Health Sector Reform (HSR) to steer and to facilitate implementation of the Health Sector Reform Strategy. **1.2 The government to endorse the Health Sector Reform Framework (HSRF), describing the reform implementation process for 2013–2025.** 1.3 The government to draft and initiate internal review of the roadmap describing key reforms in strengthening health human resources and health system financial management, including their sequencing, and technical assistance and capacity development requirements.	**1.1 The National Commission is functioning through periodic meetings and approves annual HSR implementation plan, as part of MOH implementation plan** **1.2 MOH to approve the roadmap for reforms in strengthening health human resources and health system financial management, and to establish monitoring mechanism of the reforms for the period 2015–2025.**	The phase 2016–2020 of the HSR aims to ensure that essential services of reasonably good quality are accessible and utilized by majority of the population.
2. Implementation of the health equity fund (HEF) and free maternal, neonatal, and child health care (MNCH) schemes improved		
2.1 The government to establish the principles, rules, and measures for implementation of the policy on free delivery of maternal, neonatal, and child health care (MNCH).	**2.1. The government to increase financial resources for scaling up free MNCH and HEF through joint funding (government and official development assistance), with the goal of all MNCH services free of charge to users, nationwide[a] and 75% of the poor families covered by HEF in 135 districts by June 2018.**	The Government will (i) by 2020, increase coverage of the social health protection schemes to 80% through effective implementation of the national decree on health insurance; and (ii) by 2015 ensure that all MNCH services are free of charge to users nationwide. *(HSRF Priority area 2: Health financing)*
2.2 By September 2014, the government to roll out the free MNCH program in 88 districts for maternal care and in 35 districts for children care (out of 146 districts); and to extend the coverage under the health equity fund (HEF) safety net program to 109,000 poor families in 110 districts (43% of poor families).[b]	2.2 MOH to continue improving governance arrangements and strengthening management and financial capacity of the HIB and its provincial branches, including training of staff.	The out of pocket expenditures is 35% of the total health expenditure. *(HSRF Priority area 2: Health financing)*
2.3 The MOH to clarify the role of the Health Insurance Bureau (HIB) under MOH Department of Finance, and its branches.[c]	**2.3 MOH to assess financial management, monitoring and health provider payment mechanisms of the existing free MNCH and HEF schemes and develop recommendations for improvements of the existing schemes and/or prepare revisions of relevant implementation**	

Subprogram 1 Policy Actions (August 2013 to July 2015) (Triggers in bold)	Indicative Policy Actions for Subprogram 2 (August 2015 to July 2018) (Triggers in bold)	Medium-Term Objectives of the Health Sector Reform Framework (phase 2016–2020)
	guidelines.	
2.4 MOH to strengthen capacity of the HIB on financial management, processing and verification of claims, including training of HIB staff on costing; and to establish HIB branches in 2 pilot provinces. **2.5 To streamline uniformity of HEF and free MNCH schemes, the MOH to harmonize their implementation guidelines for nationwide application.**		
3. Health human resources management capacity strengthened		
3.1 The MOH to continue nationwide roll-out of the computerized Health Personnel Management Information System (HPMIS) in the provinces, to facilitate provision of annually updated information on number, allocation and skills of the health staff. **3.2 The government to increase the quota for health staff by at least 4,000 to ensure availability of adequate health personnel staffing in the provinces, including the increase of community midwives from 747 in 2013 to 1,020 in 2014.** 3.3 The MOH to continue enhancing regulatory framework, certification standards, accreditation and registration for licensing nurses (including midwives), dentists, and medical doctors.	3.1 MOH to continue improvement of the HPMIS, including data related to skills, training, gender and ethnicity, and to strengthen capacity of the provincial health offices in utilizing the HPMIS data for planning and management purposes. **3.2 To ensure appropriate staffing level of health facilities with emphasis on deployment of staff in remote and hard to reach areas, each provincial health office to formulate and implement its workforce plan (including, gender and equity policies and appropriate staff incentives).** **3.3 To ensure quality of MNCH care, the MOH to staff at least 70% of the health centers with one midwife.** 3.4 MOH to ensure allocation and provision of adequate financial and human capital resources, as well as expertise and management, to the Health Professional Council and its boards to enable their delivery of mandated function and responsibilities as stipulated in the Health Law. **3.5 To further enhance skills and qualification of health care professionals, MOH to issue decree defining certification standards, accreditation, licensing, and registration system for health professionals.**	
4. Health sector financial management system strengthened		
4.1 MOH to continue strengthening staff capacity to adopt multi-year budgeting	**4.1 To ensure sufficient funding of the health sector, the government to**	Domestically financed health expenditures are not less than

Subprogram 1 Policy Actions (August 2013 to July 2015) (Triggers in bold)	Indicative Policy Actions for Subprogram 2 (August 2015 to July 2018) (Triggers in bold)	Medium-Term Objectives of the Health Sector Reform Framework (phase 2016–2020)
and budget framework, and trained 188 staff (of which 106 were female) in 2014.	**allocate at least 9% of general government expenditures (including ODA expenditures) to the health sector in FY2016–2017 and FY2017–2018.**	9% of General Government Expenditure (GGE) from 2015 and rise to 13% by 2025
4.2 To improve transparency and accountability of public finances, the government to approve rules and regulations for the collection, accounting and utilization of the money collected from service charges by publicly owned health facilities. **4.3 MOH to issue Implementation Guidelines for the collection, accounting and utilization of the money collected from health service charges.** **4.4 To improve health expenditures transparency, MOH to prepare and publish National Health Accounts (NHA) for FY2011, and FY2012 detailing health sector funding, its sources, and utilization at national and sub-national levels.** 4.5 MOF and MOH to initiate dialogue on establishing efficient and sustainable mechanism for adequate allocation and timely funding support to provincial health offices and MOH relevant departments for free MNCH, HEF and health service delivery.	**4.2 To enhance monitoring of public finances in the health facilities, MOH to adopt and implement a system to account for sources and application of all funds at the health facility level.** 4.3 MOH to initiate implementation of the system to account for sources and application of funds for selected facilities with an initial focus on district and provincial level hospitals in at least five provinces. 4.4 MOH to continue to publish NHA for FY 2013 and FY 2014. **4.5 To improve budget planning and to facilitate its execution, MOH to establish an expenditure monitoring system to document annual and quarterly expenditure reports of provinces and central level health departments together with reports on budget disbursements.** 4.6 MOH to adopt a new system and set of procedures to align development partner financing with government plans and budget, consistent with Government chart of accounts.[d] **4.7 To improve financial sustainability of health sector operations; MOF to adopt a mechanism for adequate allocation and timely funding support to provincial health offices and MOH key departments for free MNCH, HEF and health service delivery.**	

[a] With the exception of provincial capitals.

[b] The Health Equity Fund, established in 2007, is a social protection scheme which provides free public health care services for the poor by removing major barriers to health facilities and/or health services access such as transportation and costs of pharmaceuticals and other health care costs paid by those seeking care.

[c] The Prime Minister Decree on Health Insurance (470/GO October 2012) mandates that the Health Insurance Bureau will administer the five existing social health protection schemes [three health insurance schemes: (i) State Authority for Social Security (SASS) for civil servants, (ii) Social Security Organization for private sector employees (SSO), and (iii) Community Based Health Insurance (CBHI) - and two safety nets arrangements (HEF and Free MNCH)].

[d] In fiscal year 2014, 35% of the total government health expenditure has been financed through Chapter 17 budget category as either foreign or domestically financed projects. However, the budget and accounting system only monitors budgets and expenditures by aggregate project totals with no breakdown of how the money is spent by inputs or program (as with the rest of the government budget). It is known that many of these projects (development partner- and government-financed) include significant recurrent costs and are not just of a capital nature.

Source: Asian Development Bank.

PROBLEM TREE

Effect

Insufficient access to affordable and quality health services

Core Problem

Poor health services delivery

Root Causes

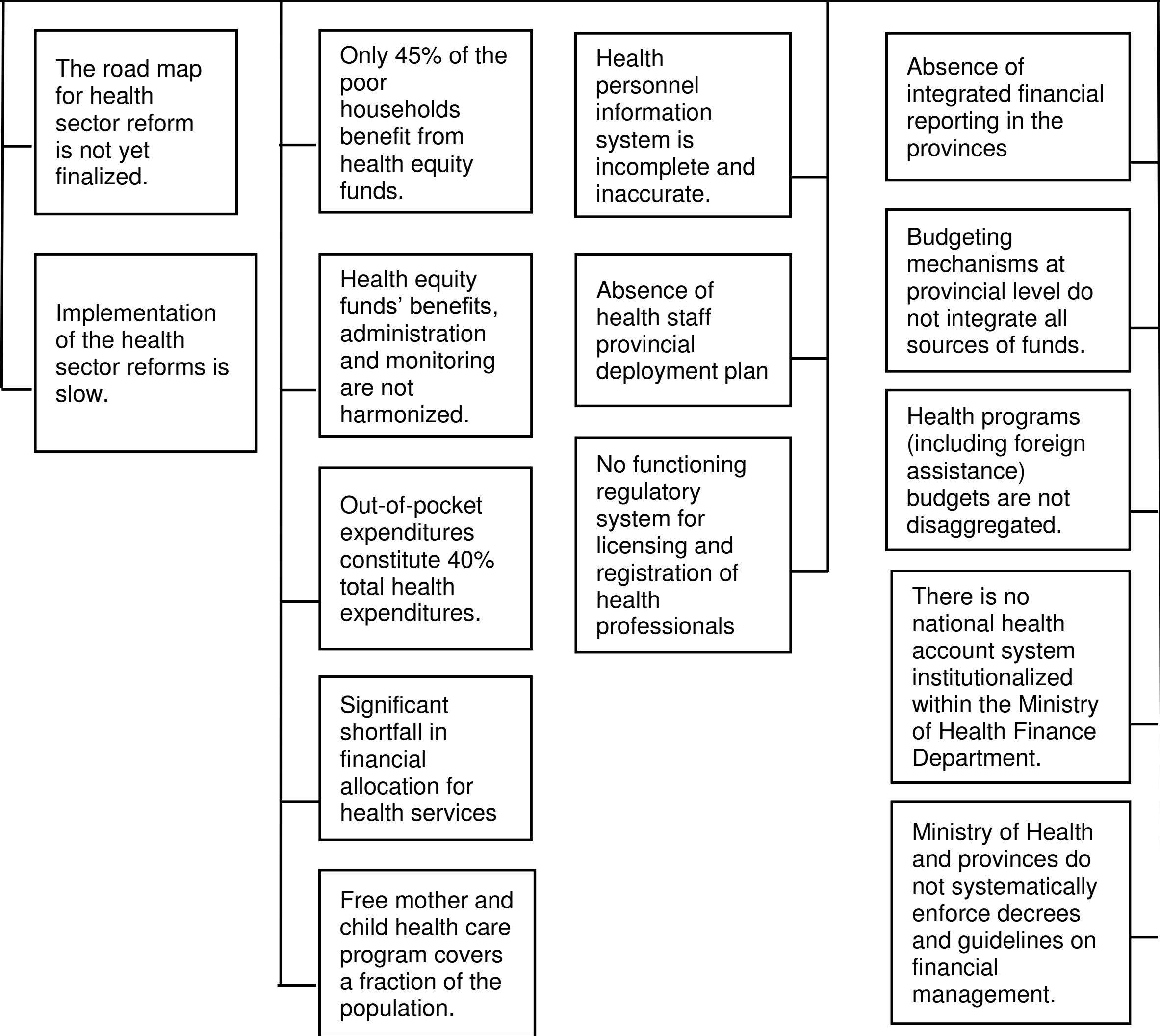
The planning and monitoring of the health sector reform strategy need to be strengthened.

Financial barriers to health service access, particularly for the poor, mothers, and children

Health staff allocation, particularly in remote areas, is inadequate.

Resources are not efficiently allocated. Financial management is not transparent.

Inadequate financing of the health sector; inadequate financial protection of the poor, weak governance



Source: Asian Development Bank.

INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	Lao People's Democratic Republic	Program Title:	Health Sector Governance Program
Lending/Financing Modality:	Health sector Policy-based loan	Department/ Division:	Southeast Asia Department/ Human and Social Development Division

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

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

Poverty reduction, graduation from least-developed country status by 2020, and achievement of the MDGs are government priorities. The NSEDP7, 2011–2015 aims to achieve annual economic growth of at least 8%; decrease poverty to less than 19% by 2015; and achieve other significant improvements in the social sectors, such as increased primary school enrolment, reduced infant and child mortality, reduced maternal mortality, and improved access to clean water.

B. Poverty Targeting

☒General Intervention ☐Individual or Household (TI-H) ☐Geographic (TI-G) ☐Non-Income MDGs (TI-M1, M2, etc.)

The Health Sector Governance Program is aimed at improving the health and nutrition of the population, in particular the poor, women and children, and ethnic groups on a national basis, with priority on the poorer provinces and districts. The program will be implemented nationally and at all levels including provincial and district hospitals, health centers, and at village level. Poor and isolated communities will benefit from improved access to health services with expanded free delivery and MNCH, and free treatment under the extension of the HEF.

C. Poverty and Social Analysis

1. Key issues and potential beneficiaries.

The gross domestic product per capita has grown by more than 7.5 % from 2006 to 2013. The country has made progress in rural development and has made advances in poverty reduction. The basic poverty headcount ratio declined from 33.5% in 2002–2003 to 20.5% in 2012–2013, against a 7th NSEDP target of less than 19%.[a] The ethnic groups have a higher poverty incidence. The poor lack land, labor resources, and money for investment. Food security is a major issue for the rural poor, and is most pronounced in isolated upland rural areas. Food deficits are common in the poorest households, with deficits of up to 9 months in the worst cases. The poorest areas are inland and along the border with Viet Nam, and include midland and highland communities Key issues of concern include (i) high MMR; (ii) limited access to reproductive health services; (iii) gender disparity at all levels of education; and (iv) limited access to training, employment, finance, and opportunities for economic advancement. The Lao PDR's MMR remains among the highest globally (357 deaths per 100,000 live births).[b] Access to and quality and uptake of emergency obstetric and skilled birth attendant care at delivery pose major challenges for the country. The under-5 mortality rate remains high at 79 per 1,000. Health service quality and access vary widely, particularly between rural and urban areas.

2. Impact channels and expected systemic changes.

Health science learning institutions will have improved curricula and better-trained teaching staff. Health service staff will receive improved training, including sensitivity to gender and ethnic minority needs. Outreach health services for isolated areas and poor communities will be strengthened, as will a network of trained birth attendants and village health workers.

3. Focus of (and resources allocated in) the project preparatory (TA) or due diligence.

Financial reform and the transparency of process in the provision of free delivery and MNCH services as well as operation of the HEF are critical to ensuring coverage and full inclusion, and program sustainability. Beneficiaries must receive accurate and timely information as to program entitlements and how they can access program benefits. Information must be available in formats understood easily by those with limited literacy, as many ethnic minority people cannot read Lao PDR script. The program design must include a grievance channel for people who are entitled to but are refused benefits. Additional staffing categories for ethnic minority trainees may be needed to ensure ethnic minority language capacity within outreach teams and at health centers.

4. Specific analysis for policy-based lending.

The program represents the beginning of a long-term initiative to reform and improve the national health service, with a focus on rural areas. Improvements to health science education curricula, better in-service human resource development and training, and improved provincial, district, and health center facilities will improve institutional-levels service delivery. Improved outreach services and village-based trained birth attendants and health workers will improve basic services in isolated areas and provide improved early detection of problem cases.

II. GENDER AND DEVELOPMENT

1. What are the key gender issues in the sector/subsector that are likely to be relevant to this program?

Significant inequalities and disparities persist along rural–urban lines, and among geographic areas (north, center, and south) and ethnic groups. Access to and quality and uptake of emergency obstetric and skilled birth attendant care at delivery pose major challenges to achieve the MDG goal of an MMR of 260 per 100,000, but the MMR has improved from

the 1995 baseline of 796 per 100,000. Access is difficult for women in isolated rural areas and particularly for ethnic minority women, as a result of topography and social factors. Rural women need better physical and financial access, improved and safer birthing and pre- and post-natal services, and more women-to-women service providers.

2. Does the proposed program have the potential to make a contribution to the promotion of gender equity and/or empowerment of women by providing women's access to and use of opportunities, services, resources, assets, and participation in decision making? ☒ Yes ☐ No Expanding and improving the provision of services at the village level, increasing the availability of women-to-women services. The GAP recommends gender-based staffing ratios at both operational and management levels. Measures are recommended for consultations with women, particularly ethnic minority women, to enhance planning and participatory decision-making. Program components specifically target the health of women and children. Women's representation ratios in community management bodies are also specified.

3. Could the proposed program have an adverse impact on women and/or girls or widen gender inequality?
☐ Yes ☒ No The program will improve gender sensitivity, include a gender focus in all initiatives, and reduce gender inequality.

4. Indicate the intended gender mainstreaming category:
☒ GEN (gender equity) ☐ EGM (effective gender mainstreaming)
☐ SGE (some gender elements) ☐ NGE (no gender elements)

III. PARTICIPATION AND EMPOWERMENT

1. Who are the main stakeholders of the program, including beneficiaries and negatively affected people? Identify how they will participate in the program design.

The main stakeholders include the health educational facilities, central ministry and technical departments, provincial and district health agencies, and health centers and communities, especially rural women of reproductive age and children under 5 year of age. Stakeholder consultation will occur at all levels to identify strategic and practical needs. Participatory capacity, human resource development, and training needs assessments will be conducted at the institutional level.

2. How can the program contribute (in a systemic way) to engaging and empowering stakeholders and beneficiaries, particularly, the poor, vulnerable, and excluded groups? What issues in the program design require participation of the poor and excluded?

Capacity building and funding will support outreach teams and training of village-based health workers, health volunteers and trained birth attendants. The selection and training of more women in these roles will result in improved access to better primary health care at the grassroots level and increased availability of women-to-women health services. Women will be consulted on selection of village-based health trainees and separate women's discussion groups with local translators will ensure engagement occurs in all villages, with all women able to participate. The program has specific staffing targets under the GAP and IPDP that will increase sensitivity to gender and ethnic minorities.

3. What are the key, active, and relevant civil society organizations in the program area? What is the level of civil society organization participation in the program design?

M Information generation and sharing M Consultation L Collaboration L Partnership

Desk reviews were made of the many nongovernment organizations operating within the health sector nationally, which are under the auspices and control of the Ministry of Health. There are also several health sector projects supported by ADB and the World Bank with which the policy and advisory TA consulted extensively. The proposed program is anticipated to be implemented in partnership with the World Bank through the Ministry of Health and provincial and district-level health agencies.

4. Are there issues during program design for which participation of the poor and excluded is important? What are they and how shall they be addressed? ☒ Yes ☐ No Increased use of health services by poor households (and particularly ethnic minorities) at hospitals, health centers, and village levels is essential for program success. This includes increased use of trained birth attendants and delivery services at health facilities. Dissemination of information in text and non-text media that can be understood by women and men in literate and illiterate households is essential. Local translators, use of non-text IEC/BCC materials and local minority health center staff and assistants are recommended, as is the use of separate men's and women's groups for information dissemination and discussion at the village level.

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C ☐ FI

1. Does the program have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☐ Yes ☒ No There will be no new construction under the program. Some facility improvements will be undertaken, but these will be within existing facility footprints, and most likely involve installation of waste incinerators. No additional land is needed, but a resettlement framework has been prepared if land acquisition is needed.

2. What action plan is required to address involuntary resettlement as part of the project preparatory TA or due diligence process? ☐ Resettlement plan ☒ Resettlement framework ☒ Social impact matrix
☐ Environmental and social management system arrangement ☐ None

B. Indigenous Peoples Category ☐ A ☒ B ☐ C ☐ FI

1. Does the program have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☒ Yes ☐ No
Better health, and lower maternal and child death rates will add to improved dignity of local families.

2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No
Program interventions are aimed at providing improved health services to local rural and ethnic minority communities. Communities will benefit from improved outreach services, more skilled health staff at health center and hospital levels, more and better trained village health workers and volunteers, and more trained delivery attendants. The poor, most of whom are ethnic minorities, will also benefit from free MNCH and other services under the expanded HEF.
3. Will the program require broad community support of affected indigenous communities? ☐ Yes ☒ No
Their participation and increased use of the health services being provided is essential, and includes willingness to participate in the healthy village initiative. The program, however, does not involve activities that will trigger the requirement of ascertaining the consent of indigenous peoples communities.
4. What action plan is required to address risks to indigenous peoples as part of the project preparatory TA or due diligence process? ☒ Indigenous peoples plan ☐ Indigenous peoples planning framework ☒ Social Impact matrix ☐ Environmental and social management system arrangement ☐ None

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the program design?
L Creating decent jobs and employment ☐ Adhering to core labor standards ☐ Labor retrenchment
☐ Spread of communicable diseases, including HIV/AIDS ☐ Increase in human trafficking ☐ Affordability
☐ Increase in unplanned migration ☐ Increase in vulnerability to natural disasters ☐ Creating political instability
☐ Creating internal social conflicts ☐ Others, please specify ___________________
2. How are these additional social issues and risks going to be addressed in the program design?
The GAP and IPDP have staffing targets for both women and ethnic minorities. There are recommendations to employ more ethnic minority people as assistants at health centers, and offer health science scholarships for minority students. There is a risk that few scholarship candidates will be identified in the short term. Program funding will need to be earmarked for both initiatives.

VI. PROJECT PREPARATORY TECHNICAL ASSISTANCE OR DUE DILIGENCE RESOURCE REQUIREMENT

1. Do the terms of reference for the project preparatory TA (or other due diligence) contain key information needed to be gathered during project preparatory TA or due diligence process to better analyze (i) poverty and social impact, (ii) gender impact, (iii) participation dimensions, (iv) social safeguards, and (v) other social risks. Are the relevant specialists identified? ☒ Yes ☐ No

2. What resources (e.g., consultants, survey budget, and workshop) are allocated for conducting poverty, social and/or gender analysis, and participation plan during the project preparatory TA or due diligence?
International and national gender and social safeguards specialists were engaged under the policy and advisory TA, with previous experience on ADB–Lao PDR health sector projects such as the Communicable Disease Control and Health Sector Development projects.[c] The safeguard specialists conducted a social analysis of gender and ethnic minority issues, particularly those related to health. Due diligence will confirm the relevance of the GAP, indigenous people's development plan, and other safeguard documents such as the resettlement framework and the environmental assessment.

ADB = Asian Development Bank, BCC = behavioral change communication, GAP = gender action plan, HEF = Health Equity Fund, IEC = information, education, and communication, IPDP = indigenous peoples development plan, Lao PDR = Lao People's Democratic Republic, MDG = Millennium Development Goal, MMR = maternal mortality rate, MNCH = maternal, neonatal, and child health care, NSEDP7 = Seventh National Socio-Economic Development Plan, TA = technical assistance.

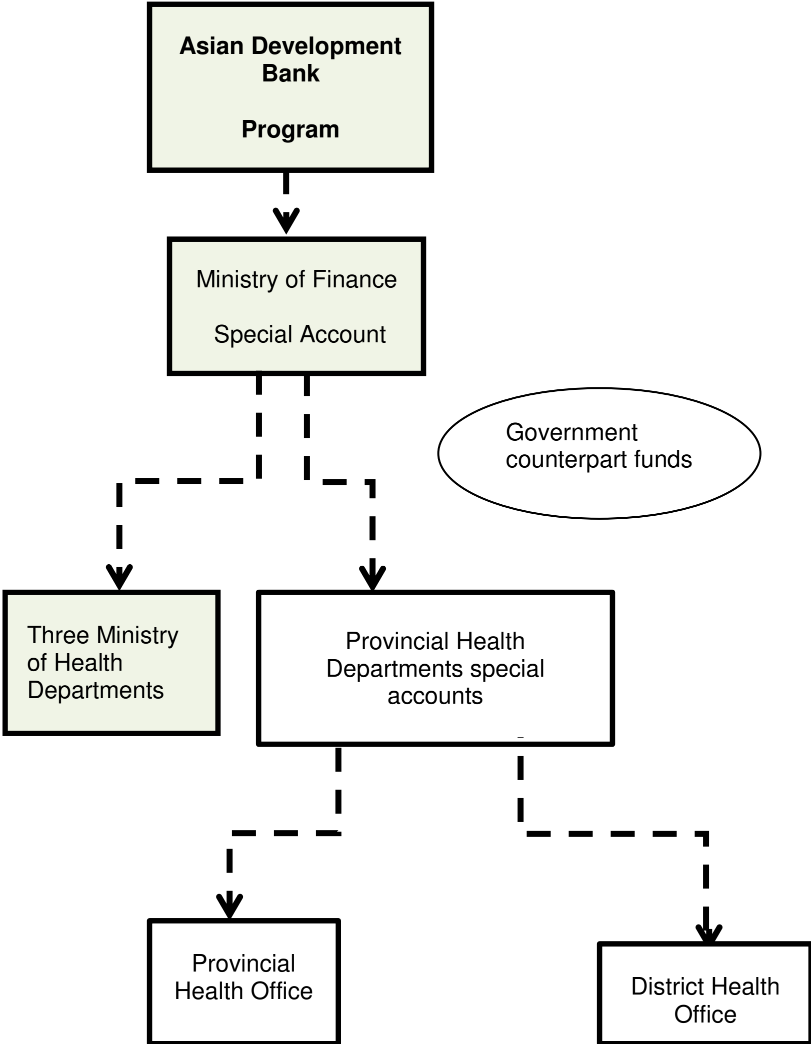
[a] Ministry of Planning and Investment. 2011. *The Seventh National Socio-Economic Development Plan 2011–2015.* Vientiane.

[b] Ministry of Health and Lao Statistics Bureau. 2012. *Lao Social Indicator Survey 2011–12.* Vientiane.

[c] ADB. 2005. *Report and Recommendation of the President to the Board of Directors: Proposed Grants to the Kingdom of Cambodia, the Lao People's Democratic Republic, and the Socialist Republic of Vietnam for the Greater Mekong Subregion Communicable Disease Control Project.* Manila; ADB. 2010. *Report and Recommendation of the President to the Board of Directors: Proposed Grants to the Kingdom of Cambodia, the Lao People's Democratic Republic, and the Socialist Republic of Vietnam for the Second Greater Mekong Subregion Communicable Disease Control Project.* Manila; ADB. 2009. *Report and Recommendation of the President to the Board of Directors: Proposed Loan to the Lao PDR for the Health Sector Development Program.* Manila.

Source: Asian Development Bank.

PROPOSED FUND FLOW ARRANGEMENT UNDER THE POLICY-BASED LOAN



Source: Asian Development Bank and Ministry of Health.

TECHNICAL ASSISTANCE LOAN AND ASSOCIATED TECHNICAL ASSISTANCE GRANT

1. The Government of the Lao People's Democratic Republic has requested a $6 million technical assistance (TA) loan from the Asian Development Bank (ADB) and ADB has requested a $2 million grant from a trust fund on behalf of the government to finance the TA and other resources necessary to support health sector reform (HSR) implementation, including assisting the MOH to achieve the policy triggers agreed for subprogram 2. The TA loan will provide information and communication technology, office equipment, and vehicles for MOH and the provinces; capacity development measures (including scholarships); program administrative costs; and consultant support. The associated TA grant will provide consultant support associated with the four project outputs. The implementation period of the TA loan will be from 1 October 2015 to 30 September 2020. The implementation period of the associated TA loan and grant will be from 1 October 2015 to 30 September 2018. The mission has proposed that government provide an in-kind counterpart contribution (office space for consultants and civil servant salaries), estimated at a total of $250,000. The impact of the TA loan and grant will be universal health coverage achieved by 2025. The outcome will be improved health services delivery, particularly for the poor, women, and children. The outputs will be (i) an improved health sector reform process; (ii) improved implementation of the Health Equity Fund (HEF) and free maternal, neonatal, and child health care (MNCH) schemes; (iii) strengthened health human resources management capacity; and (iv) a strengthened health sector financial management system.

2. **Output 1: Health sector reform process improved.** Under this output, the proposed project will assist the department of cabinet in managing the implementation of the HSR program, with support from development partners, through an emphasis on the following activities:

(i) assist the cabinet in developing the strategy, phasing the HSR process, and establishing a system to monitor progress and effectiveness of the HSR program. The project will provide TA (through an international expert for 6 persons-months) and funding for meetings, study tours, short-term leadership training, and recurrent costs;

(ii) joint development by MOH departments and development partners of a plan that selects the provinces and districts in which to pilot HSR implementation, and determines available resources;

(iii) assist senior officials and management responsible for the HSR program gain experience in other Association of Southeast Asian Nations countries that have undertaken similar health sector reform programs; and

(iv) support national forums for senior management and key staff from the provinces and districts in which they can share knowledge and experiences with colleagues at the national level and from other provinces, as well as development partners. This will support implementation of HSRs and the HSR road map.

3. **Output 2: Implementation of the Health Equity Fund and free maternal, neonatal, and child health care schemes improved.** The program will undertake the following:

(i) support demand-side interventions to reduce financial barriers to health program access in the form of the HEF for the poor and free MNCH for priority areas of the country as an initial step towards universal coverage, including by (a) harmonizing existing schemes under MOH leadership, (b) strengthening MOH capacity to support the provinces and monitor implementation of the schemes, and (c) strengthening provincial capacity to implement and monitor the schemes;

(ii) support the Health Insurance Bureau under the MOH Department of Finance, with a focus on four key implementation functions of the HEF and MNCH: membership management, provider management, benefits and provider payment design and management, and information management. The support will include a training program for key National Health Insurance Bureau and other MOH technical staff, an international individual health information technology consultant, national individual consultants, staff incentives, and related expenses;

(iii) contract an information management consultant to review and provide information system architecture to support membership, provider and benefits management, including advice on data standards, inter-operability and other standards that would facilitate electronic data capture and transfer. The consultant will be supported by two national consultants (programmers) who will develop or customize application and other information and communication technology systems as recommended; and

(iv) undertake coordination through provincial HEF coordinators, who will receive incentives to improve coordination and supervision. Three provincial HEF coordinators will be designated mentors for the other 15 coordinators (and receive higher incentives) to further improve implementation of the schemes.

4. **Output 3: Health human resources management capacity strengthened.** The proposed project will assist MOH to strengthen health human resource governance and management systems to improve staff capacity in planning and managing human resources of the health system at all levels, with an emphasis on:

(i) supporting development of health human resource plans in each province to identify specific local human resource needs and priorities, and aggregate these to determine national-level priorities;

(ii) strengthening staff supervision and support by establishing an incentive and recognition system to improve staff morale and productivity, linking performance assessment to the reward system and opportunities for career advancement; and

(iii) strengthening health human resources governance and organization management systems, and ensuring that the professional council for health professionals and its boards have sufficient resources to meet the responsibilities stipulated in the Health Law.

5. **Output 4: Health sector financial management system strengthened.** This key output will assist MOH and the Ministry of Finance to develop improved financial systems as part of the financial structural reform program. These will consist of:

(i) enhancements to the provincial planning and annual budget process and the introduction of a rolling 3-year planning framework. These plans and budgets would form the basis of agreements on provincial financing, including program support;

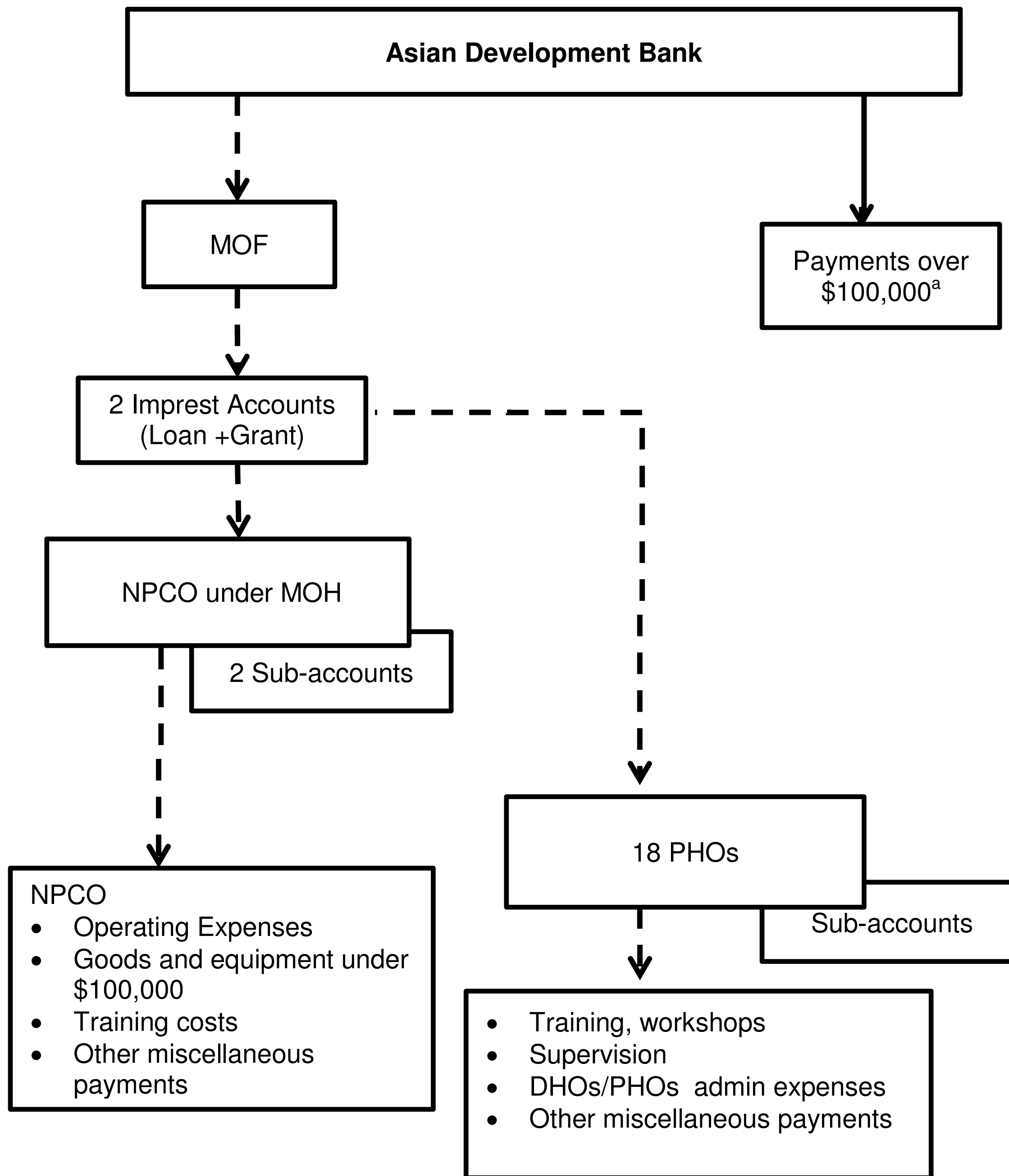
(ii) development of a computerized system to document the sources and application of funds collected and used at the health facility level—including out-of-pocket expenses, and government- and development partner-financed activities—as a basis for improved health facility management and to document the collection and use of out-of-pocket expenses. The system would also provide new information for analysis of the costs of health facility units and their variation nationwide; and

(iii) development of a new and revised budget and expenditure reporting format and process for MOH at the central and provincial levels that meets the technical needs of the Ministry of Finance and Ministry of Planning and Investment, and

documents both budgets and expenditures in a standard format for all domestic and development partner-financed projects.

6. The executing agency of the investment project will the MOH Department of Planning and International Cooperation, while implementing agencies will be (i) the Department of Finance (including the Health Insurance Bureau), (ii) the Department of Organization and Personnel, (iii) the Department of Training and Research, and (iv) 18 provincial health offices.

PROPOSED FUND FLOW ARRANGEMENT UNDER THE TECHNICAL ASSISTANCE LOAN AND GRANT



DHO = district health office, MOF = Ministry of Finance, MOH = Ministry of Health, PHO = provincial health office, NPCO = National Project Coordination Office, SAO = State Audit Organization,

[a] If necessary, payments less than $100,000 may also be made by direct payment.

Source: Asian Development Bank and Ministry of Health.