Indigenous Peoples Planning Framework: Ethnic Group Development Plan

January 2018

Lao PDR: Health Sector Governance Program

Prepared by the Ministry of Health, Lao People's Democratic Republic for the Asian Development Bank.

CURRENCY EQUIVALENTS
(as of 14 December 2017)

Currency unit	–	kip (KN)
KN1.00	=	$0. 0001204021
$1.00	=	KN8,305

ABBREVIATIONS

ADB	–	Asian Development Bank
BCC	–	behavioral change communication
CDC	–	communicable disease control
CDC2	–	second communicable disease control project
CEDAW	–	Convention on the Elimination of All Forms of Discrimination against Women
DHIS2	–	District Health Information System 2
DMF	–	design and monitoring framework
EG	–	ethnic group
EGDP	–	Ethnic Group Development Plan
GMS	–	Greater Mekong Subregion
GoL	–	Government of Lao PDR
HEF	–	health equity funds
HSDP	–	Health Sector Development Project
HSGP	–	Health Sector Governance Program
HSRF	–	Health Sector Reform Framework
IEC	–	Information, education and communication
KAP	–	Knowledge, Attitudes and Practice
LECS	–	Lao Economic and Consumption Survey
LNF	–	Lao National Front
LSIS	–	Lao Social Indicator Survey
LWU	–	Lao Women's Union
M&E	–	monitoring and evaluation
MDG	–	Millennium Development Goals
MNCH	–	maternal, newborn and child healthcare
MOH	–	Ministry of Health
NCAW	–	National Commission for the Advancement of Women
NESDP	–	National Economic and Social Development Plan
NHI	–	National Health Insurance
NHIB	–	National Health Insurance Bureau
PHC	–	primary health care
PMU	–	project management unit
SDG	–	Sustainable Development Goals
subCAW	–	sub committee on the advancement of women
VAC	–	village committee
VE	–	village elder
VHV	–	village health volunteer
VHW	–	village health worker
WB	–	World Bank

NOTES

(i) The fiscal year (FY) of the Government of the Lao People's Democratic Republic ends on 31 December. Prior to FY2016, "FY" before a calendar year denotes the year in which the fiscal year ended, e.g., FY2015 ended on 30 September 2015

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

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Executive Summary

1. The proposed Health Sector Governance Program (HSGP) will be implemented nationally with the overarching goal to increase access, quality, and utilization of essential health services, with a focus on maternal, newborn, and child healthcare (MNCH). This will lead to improved health outcomes in the Lao People's Democratic Republic (PDR), particularly among the poor, women and children, and ethnic groups, in remote rural communities.

2. The Social Impact Assessment conducted under subprogram 1 of HSGP and the indigenous people's plan, updated for subprogram 2, identified the need for an Ethnic Group Development Plan (EGDP). The program has been categorized as category B due to the potential positive impact on ethnic groups (EG).

3. According to the national census, the predominant group in Lao PDR is Lao, comprising over 53% of the population. EGs constitute approximately 46% of the population. Other dis-aggregations are made by language and geographic division. As confirmed by the 2012 Lao Social Indicator Survey, EGs do not use health services as frequently as mainstream Lao due to numerous factors including physical location and distance from services, lack of Lao language skills and illiteracy, lack of cash, customs, and local beliefs. The impact of lower service utilization rates compared to mainstream Lao is poorer health outcomes: higher infant, child, maternal mortality rate and malnutrition and stunting.

4. The purpose of this document is to identify the impact of the HSGP activities on EGs and outline the corresponding EGDP with appropriate measures to ensure that EGs (i) benefit equally from program and receive benefits in a culturally appropriate manner; (ii) do not suffer adverse impacts as a result of the program; and (iii) can participate actively where concerned. The EGDP was revised during the mid-term review mission for the corresponding TA loan (TA 3280) in August 2017 and will continue to be implemented under the TA loan which runs across both subprogram 1 and 2's implementation periods.

5. The EGDP provides mechanisms for more equitable outcomes for EGs. This includes measures to increase the share of EGs and EG women as part of the health staff, increase EG's access to trainings and increase awareness and sensitivity on EG concerns in training activities. Information materials on National Health Insurance (NHI) will be prepared for EGs, and guidelines to ensure information is appropriately disseminated and feedback from EGs about health services is collected, will be written. All data will be disaggregated by sex and ethnicity. All activities attempt to mitigate the risk that EGs may not be able to fully participate and capture the same level of program benefits as mainstream Lao.

I. INTRODUCTION

1. The purpose of this report is to present the due diligence that has taken place in preparation of subprogram 1 and updated for subprogram 2 to assess ethnic group (EG) impacts under HSGP, and to provide an approach to ensure that all program activities equally benefit EGs as per Safeguard Requirements.

A. Program Description

2. The Health Sector Governance Program (HSGP) aims to support the implementation of the Lao Peoples Democratic Republic (PDR) Health Sector Reform Framework (HSRF) which aims to (i) improve access to basic health care and financial protection by 2020, and (ii) achieve universal health coverage by 2025.[1] The proposed program modality comprises a policy-based grant of $30m, under a programmatic approach with two subprograms: subprogram 1 was implemented from August 2013 to July 2015 and subprogram 2 is implemented from August 2015 to May 2018. Both HSGP subprograms are designed to support the 5 pillars under the health sector reform strategy (HSRS): (i) health financing; (ii) human resources for health; (iii) governance, organization and management; (iv) health service delivery; (v) information, monitoring and evaluation. Complementary capacity development[2] support and technical assistance (TA) loan[3] (running since subprogram 1's approval) will strengthen both national and subnational levels to design and implement the government's reforms. Other development partners also support the HSRS.

B. Program Outcomes

3. The program impact of the reforms will be improved delivery of health services particularly for the poor, mothers and children. The reform areas are (i) health sector reform process improved; (ii) implementation of free health care for the poor, mothers and children improved; (iii) human resource management capacity strengthened; (iv) health sector financial management system strengthened.

4. The HSGP will provide significant benefits for the population, especially for the poor, women and children, EGs, and people living in remote areas. The program will result in:

(i) better access to health services particularly for the poor, mothers and children;
(ii) reduction of financial barriers to access health care services and increased financial protection from catastrophic expenditures;
(iii) increased resources to deliver free maternal, newborn and child healthcare (MNCH) services and free health services for the poor, mothers and children under 5 through NHI;
(iv) enhanced skills and qualification of health personnel to improve quality of health care services;
(v) recruitment and retention of female and ethnic health workers in rural areas, to support greater utilization of health services by women and EG; and
(vi) higher awareness on benefits under NHI especially amongst women and EGs.

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[1] Ministry of Health. 2013. *Health Sector Reform Framework, 2013 to 2025.* Vientiane.
[2] ADB. 2016. *Technical Assistance to the Lao People's Democratic Republic for Strengthening Capacity of Health Sector Governance Reform*. Manila. Implemented between October 2016–August 2018, supporting training and capacity building.
[3] ADB. 2015. Lao People's Democratic Republic: Health Sector Governance Program.

C. Program Location

5. The program will be implemented nationally, by the Ministry of Health (MOH) and its line agencies at provincial and district levels. It will involve health and medical education institutions and facilities at central, provincial and district levels. There are 18 provinces and 148 districts in the Lao PDR; each province has at least one provincial level public hospital and most districts have one public hospital. In addition, there are about 1017 health centers nationwide. Policies under strengthening human resources are particularly targeted at improving health worker retention in remote and hard-to-reach areas and increase employment of women and EGs in these areas.

II. BACKGROUND INFORMATION

A. Ethnic Groups in the Lao PDR

6. The term 'ethnic minority' or 'ethnic group' is defined in ADB's Safeguard Policy Statement (2009) Safeguard Requirement 3 to describe in a generic sense a distinct, vulnerable, social and cultural group possessing the following characteristics in varying degrees: (i) self-identification as members of a distinct cultural group and recognition of this identity by others; (ii) collective attachment to geographically distinct habitats or ancestral territories in the program area and to the natural resources in these habitats and territories; (iii) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and (iv) a distinct language, often different from the official language of the country or region.

7. In Lao PDR, there are 49 EGs that are officially recognized by the government. They are categorized according to four ethno-linguistic families.[4] The Tai-Kadai family includes Lao, Lue, Phoutay, and other lowland groups. The Mon- Khmer family includes groups such as the Khmou, Khuan, and Samtao. The other groups are the Hmong, Yao, and other Hmong-Tien groups, and the Sino-Tibetan groups. More than half of the nation's population (53.2%) belong to the Lao ethnic group. Khmou and Hmong are the second and third largest groups, respectively. Table 1 depicts the population of Lao PDR by ethnic group[5] and table 2 gives figures on EG populations by province.

Table 1: Population by Ethnic Group

	Population	% to total Population
Lao	3,427,665	53.2
Khmou	708,412	11.0
Hmong	595,028	9.2
Phouthay	218,108	3.4
Tai	201,576	3.1
Makong	163,285	2.5
Katang	144,255	2.2
Lue	126,229	2.0
Akha	112,979	1.8
Others	749,153	11.6

Source: 4th Population and Housing Census (PHC) 2015.

[4] The actual number of ethnic groups may be as high as 236 depending on the level of classification used to groups and subgroups within the main ethno-linguistic families (Chamberlain et. al.1996)

[5] 4th Population and Housing Census (PHC) 2015.

Table 2: Estimated National and EG Population

Province	Total Pop	% EMG	2014 EMG Popn	% and No. of Lao-Tai		% and No. of Mon-Khmer		% and No. of Sino Tibeto-Burma		% and No.of Hmong-Lewmien		% and No. Other	
Oudomxai	329,110	78.5%	253,177	20.6%	54,281	60.5%	150,584	5.7%	10,466	12.3%	35,340	0.0%	156
Phongsali	180,996	80.4%	145,203	18.9%	25,198	20.7%	31,240	53.6%	78,921	6.1%	8,811	0.0%	0
Luang Namtha	181,000	72.2%	123,975	26.9%	34,632	34.3%	35,892	31.2%	43,209	6.8%	9,175	0.0%	0
Bokeo	182,198	62.4%	111,294	37.1%	39,137	28.4%	43,266	18.2%	11,202	15.1%	16,074	0.1%	268
Xiengkhouang	263,465	51.3%	129,540	48.0%	55,326	10.0%	15,037	0.1%	120	41.2%	58,115	0.0%	0
Luangpabang	472,618	70.7%	302,364	30.0%	79,866	51.4%	151,169	0.2%	419	17.6%	52,343	0.1%	313
Houaphan	340,828	44.4%	150,345	55.7%	66,283	20.3%	28,812	0.0%	38	23.1%	34,628	0.0%	13
Sayabouly	403,504	27.2%	106,955	73.6%	58,727	15.8%	27,685	0.1%	206	9.9%	13,397	0.0%	115
Saisomboun	81,801	67.1%	54,824	32.0%	13,876	19.3%	8,198	0.1%	67	47.7%	32,202	0.3%	158
Vientiane Prov	446,270	30.8%	143,469	70.7%	69,680	16.6%	31,956	0.1%	91	11.5%	19,657	0.0%	22
Bolikhamxai	294,707	29.7%	76,420	74.6%	42,182	8.8%	9,067	0.1%	68	14.5%	16,252	0.7%	1,007
Khammouane	434,199	19.5%	64,896	76.4%	41,230	21.5%	21,600	0.1%	176	0.0%	12	0.7%	870
Savannakhet	1,004,646	29.2%	222,757	69.9%	114,959	29.2%	105,742	0.0%	0	0.0%	0	0.2%	348
Champassak	727,821	13.4%	100,654	85.1%	57,208	13.4%	41,925	0.0%	0	0.0%	0	0.2%	401
Saravan	403,575	48.9%	151,431	49.8%	47,751	48.9%	101,195	0.0%	0	0.0%	0	0.6%	1,529
Sekong	115,165	89.3%	98,765	10.0%	11,958	89.3%	86,082	0.0%	0	0.0%	0	0.1%	80
Attapeu	143,934	69.3%	87,857	29.2%	25,180	69.6%	61,550	0.0%	0	0.0%	0	0.1%	77
Vte Capital	903,747	3.7%	40,090	95.0%	36,731	1.4%	601	0.2%	72	2.3%	2,320	0.1%	38
Total	**6,909,583**	**34.2%**	**2,364,017**	**59.3%**	**874,208**	**26.8%**	**951,603**	**4.6%**	**145,055**	**8.2%**	**298,326**	**0.2%**	**5,395**

Sources of data: Population and EMG estimated for 2014 by DPIC, MOH,

8. The four main ethno-linguistic families are often re-categorized according to three topographic locations reflecting the traditional and preferred environments in which they live, and these three terms are commonly used by both government and civil society when describing the classification of the non-Lao EGs (although use of these three categories is now officially discouraged, they remain the most widely used in practice):

(i) Lao Loum - Lowland Lao (mainly Lao Tai), groups traditionally living in the lowland, valley floor regions of the country that historically have cultivated paddy, practiced Buddhism, and are integrated into the national economy. These correspond to the Lao-Tai group.

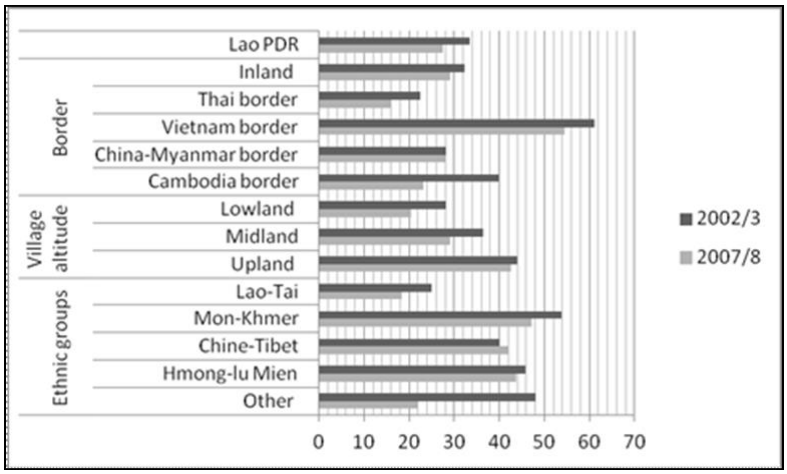
(ii) Lao Teung – Upland (slope) Dwellers (mainly Mon-Khmer), groups traditionally dominating the middle hills and for the most part practice swidden agriculture (rain fed upland hill rice, maize). Many raise cattle, most are reliant on forest products, and to some extent are isolated from the dominant lowland culture. Many groups exhibit varying degrees of assimilation and adaptation to Tai-Lao culture. These groups are the original inhabitants of Southeast Asia and consist of the Austro-Asiatic or Mone-Khmer ethnic groups.

(iii) Lao Soung - Highland Lao (Sino-Tibetan Burma and Hmong-Iewmien), groups dwelling in the highland areas practicing swidden agriculture growing mainly hill rice, maize, and traditionally, many grew opium. Many are historically relatively recent arrivals from Southern China and Vietnam.

B. Poverty and Ethnic Groups

9. The poverty rate is still highest among the Mon-Khmer (42.3%) and Hmong-lewMien (39.8%) groups. The large Lao-Tai group have substantially lower poverty incidence than the other ethnic groups (15.4%). The poverty incidence amongst Mon Khmer is more than two and a half times the rate of the Lao-Tai and have seen a relatively slow decline in poverty incidence compared to the Lao-Tai (lowland dwellers) (Figure 1 and table 2).

Figure 1: Ethnicity, Location and Poverty



Source: Lao Bureau of Statistics: Poverty in Laos 2008

III. LEGAL AND INSTITUTIONAL FRAMEWORK FOR ETHNIC GROUPS IN LAOS

10. The lead government agency in relation to EGs is the Lao Front for National Construction (LFNC), Department of Ethnic Affairs.

A. Constitution of the Lao PDR

11. The Lao PDR 1991 Constitution refers to the "multi-ethnic Lao people" and the official terminology for describing the diverse population is "ethnic" groups. Article 8 of the Constitution proclaims that: *"The State pursues the policy of promoting unity and equality among all ethnic groups. All ethnic groups have the rights to protect, preserve, and promote the fine customs and cultures of their own tribes and of the nation. All acts of creating division and discrimination among ethnic groups are forbidden. The State implements every measure to gradually develop and upgrade the economic and social level of all ethnic groups".* Article 75 of the Constitution specifically indicates that the Lao language and script are the official national language and script.

12. Party policy relating to ethnic minorities remains relatively unchanged from that announced by Party Central in 1992, which identified three essential tasks for EG development:[6]

(i) strengthening political foundations, strengthening national (Lao) identity and equality between EGs;
(ii) increasing production and opening of channels of distribution to convert subsistence-based economics towards market-based economics, and;
(iii) expanding coverage of education, health, and other social benefits for EGs.

[6] Contained within the Resolution of the Party Central Organization Concerning Ethnic Minority Affairs in the New Era (GoL, 1992)

B. National Economic and Social Development Plan

13. The 8th National Socio Economic Development Plan (NSEDP) runs from 2016 to 2020. Outcome 2 of the 8th NSEDP aims to reduce poverty amongst all EGs and ensure all EGs have access to quality education and health services. Output 4 of this outcome calls for action to achieve universal access to quality health care services including (i) improving and expanding infrastructure that will enable the extension of public health services to remote rural areas; (ii) employing and training health care professionals, including nurses, with the skills and ethics required to provide better services; and (iii) ensuring sustainable finance for the health sector by increasing the public budget and funding.[7]

C. Lao Women's Union

14. The Lao Women's Union (LWU) was originally established in 1955 to mobilize women for the Lao People's Revolutionary Party. In 1991 the LWU was recognized under the Constitution of the Lao PDR. Although not established specifically for EGs, the LWU is mandated to represent women of all EGs and to "protect women's rights and interests", mobilize, and increase women's involvement in national development.

15. The LWU is under the Party's Central Committee and plays a key role in the development of Lao government policies with regards women and in national development. The LWU structure is represented in all ministries and reaches down to village level (including EG villages) and has the responsibility for responding to women's development needs; promoting the status and role of women; and promoting unity amongst women of different EGs and social strata throughout the country. The LWU at provincial and district levels is very active in livelihood development and health activities in villages. The LWU is often included as an implementation partner in many projects due to its extensive network in rural communities.

D. National Committee for the Advancement of Women

16. The National Committee for the Advancement of Women (NCAW) was established under the Prime Minister's Decree No. 37/PMO, dated 1 April 2003. NCAW's mandate is to support Sub-committee for the Advancement of Women (SubCAW) networks in line ministries for the promotion of women's issues and to integrate gender into the planning, budgeting, and monitoring and evaluation (M&E) cycle of line ministries. NCAW plays a lead role in coordination of gender development both internally and with international partners. The NCAW, through its SubCAW network, also has the responsibility as the main focal point for the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and work related to the Convention on the Rights of the Child within the Government of Lao PDR.[8] NCAW is tasked with implementing the 3rd National Strategy for the Advancement of Women (NSAW) 2016–2025 which outlines gender related goals for each sector, and has established a basic structure in each ministry. Section 2.3 'Strategy for men and women's equality over 10 years (2016–2025) contains targets to increase the percentage of women in leadership positions, reducing maternal, infant and child mortality rates and facilitating equal pay and conditions for women doing the same work as men.

[7] Ministry of Planning and Investment. 2016. 8th National Economic and Social Development Plan, 2016–2020. Vientiane.

[8] United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly; United Nations Convention on the Rights of the Child, 1990.

IV. SOCIAL ASSESSMENT FINDINGS

17. EGs have benefited less than non-EGs in the countries' economic development. One key reason is the significantly higher costs of developing infrastructure in isolated and upland areas, resulting in less investment even where needs may be higher. Poverty incidence and ethnic minority demographic data confirm that ethnic minorities make up the poorest communities.

A. Relocation

18. EGs have been relocated to lowland areas under government policies. Although officially, the relocation is done in order for the government to provide basic services such as education and health care, there is also relocation of communities to eliminate poppy growing, and granting of land concessions for agribusiness, mining, and hydropower leases. In some cases, EG communities have lost traditional livelihood areas, which has limited their access to crops and timber.[9]

19. Highland and upland communities who are relocated to flat lowland areas encounter higher temperatures and stagnant water which pose health hazards. EGs may have less knowledge about preventing certain diseases such as malaria and dengue, resulting in frequent infection.[10] A survey of 67 displaced villages in six provinces of Lao PDR found there have been epidemics particularly from malaria.

B. Education and Literacy

20. The Lao Social Indicator Survey 2012 (LSIS) found that EGs are disadvantaged with regards to access to education and health care due to isolation and financial constraints. Women from minority communities are even more disadvantaged, being held back by tradition and social practices in many cases.

21. The 2012 LSIS reports that children from non-Lao-Tai EGs living in rural and remote areas have the lowest achievement in primary education. While 89% of students in the capital Vientiane who enroll in grade 1 advance to grade 5, fewer than half do in the most disadvantaged provinces (e.g. Sekong, Saravan). These differences in enrollment and survival are reflected in youth literacy rates; for example, 90% of 15–24 year olds in urban areas are literate, compared with only 41% in rural villages (usually with many EGs) without road access. Literacy rates among the major group, Lao-Tai, are the highest with 95% and 92%, for males and females, respectively. Mon-Khmer was the second largest group with 71.1% and Hmong-lewMien the third largest group with 69.8%. The lowest literacy rate was found among the China-Tibet ethnic group with 46.8%. Proportions of some EGs that never attended school we7usdre higher than 50%.[11] Educational disparities widen at the intersection of gender and ethnicity. Literacy rates for young males of Lao-Tai ethnicity are 84%, but only 63% for Mon-Khmer. The disparity increases for ethnic females, with 81% of Lao-Tai ethnicity and 45% of Mon-Khmer ethnicity literate in the Lao language.[12] This is explained by lower rates of enrollment and greater dropout rates for rural women in remote areas. According to the 2015 census, 79% females compared to 81% of males aged 6–16 years

[9] Included in the rationale or ADB-IFAD. 2010. *Sustainable Natural Resource and Productivity Improvement Project.* Manila.

[10] Field notes, Ket Nam Hon, Feuang District, Vte Prov, AusAID-WB "Lao Upland Agriculture Development Project", 1991

[11] 4th Population and Housing Census (PHC) 2015.

[12] Department of Planning, Ministry of Education and Sports. 2014. *Ethnic Groups Development Plan for the Second Global Partnership for Education Project*. Vientiane.

attended school, while only 19% females compared to 25% males aged 17 to 25 years attended school. The literacy rate for the male population was 90% (versus 80% of the female population).

22. The 2012–2013 Lao Economic and Consumption Survey V (LECS) surveyed the education level of household heads and found the percentage of those with no formal education amongst Lao-Tai was 7.1%, Mon-Khmer 20.5%, Chine-Tibet 59.7%, and Hmong–lewMien 27.1%. The LSIS also reported that urban literacy amongst men and women aged between 15 to 24 years was 91% for women and 92% for men, compared to rural literacy of women 60% and men, 72%.

C. Health

23. According to the 2015 census the national population is 6,492,228 of whom 3,237,458 are female. The annual population growth rate fell from 2.08% (1995–2005) to 1.45% (2005–2015). The crude birth rate in Lao PDR was estimated at 28 births per 1,000 population with the lowest crude birth rate of 22 births per 1,000 population in Vientiane Capital.

24. Significant inequalities in access to health care persist along rural–urban lines and geographic areas (north, center, and south), and among EGs. The Lao PDR has made good progress on many of the Millennium Development Goals (MDGs) on maternal, newborn and child healthcare (MNCH), but still some targets remain unfulfilled, which in turn makes attainment of Sustainable Development Goals (SDGs) challenging. Between 1995 and 2015, the maternal mortality ratio (MMR) decreased from 905 to 206 deaths per 100,000 live births (target 226); under 5 mortality rate (U5MR) reduced from 162 to 67 deaths per 1,000 live births (target 54) and infant mortality rate (IMR) stood at 50.7/1,000 infants (target 37). By 2011, child malnutrition (underweight below 5 years) had fallen to 27% but this was far from the target of 20%. Malaria, dengue fever, water borne illnesses (such as diarrhea, intestinal parasites), and respiratory illnesses are the main health issues affecting EGs and the burden of nursing the sick often falls on females. Isolated upland and highland minority communities lack clean water supply for drinking and sanitation.

25. Poor health outcomes are closely linked to the limited utilization of health services. Simultaneously, emphasis is still on curative, rather than preventive care, and coverage for MNCH services including for immunization, antenatal care, skilled birth attendance, and surgery remain particularly low. Health service quality and access vary widely, particularly between rural and urban areas, with service quality being inversely related to degree of isolation; according to the 2012 LSIS, rural members of Lao-Tai EGs are 10% more likely to seek care than non-Lao-Tai ethnicities.

26. A household survey in 2011 on MNCH[13] in six central and southern provinces demonstrates that financial factors were the most-reported constraint on health service utilization by women. 45% of all women reported that obtaining money for treatment was a barrier to receiving medical treatment. Not wanting to go alone, and/or not being allowed to go alone, and physical access and transportation were additional problems reported.

27. The 2012 LSIS found that fertility is highest among rural women at 3.6 compared with urban women at 2.2; highest for those living in areas without roads and formal education; and lowest among urban educated women. The 2015 census confirmed woman's education and urbanity of the area as determinants of fertility. According to a household survey conducted in

[13] World Bank. 2013. *Maternal health, child health, and nutrition in Lao PDR: Evidence from a survey in six central and southern provinces.* Vientiane.

2014 about 35% of pregnant women self-delivered at home. Only 54% of women aged between 15 and 49 years who gave birth in the two years preceding the survey received antenatal care from a health professional, and nearly half (48%) did not take any iron tablets during their pregnancy. In the same group, only 42% of women who gave birth in the previous two years were assisted at the time of delivery by a health professional, with fewer deliveries in the Northern region assisted by a health professional (31%), compared to the South (33%), and Central regions (53%).

28. Home birth is unavoidable for many women due to distance and time to access health services, and most instances of maternal death occur because the woman has not presented at the health center early enough. When problems arise at home the first resort tends to be traditional treatment, and in many cases the child is born in the village or before they arrive at the health center. Case records show that many deaths are caused by post-delivery blood loss. A priority for village health workers is detecting warning signs so women arrive at health centers before the problem becomes fatal.

29. For non-Lao-speaking EGs, language can be a significant barrier to accessing health information. This was demonstrated in the Second Communicable Disease Control (CDC2)[14] project when separate men and women EGs were presented with information, education, and communication, (IEC) and behavioral change communication (BCC) poster materials being used by various projects and programs of MOH, to assess their understanding of the health messages being conveyed. The posters were designed with minimal text, but understanding of the materials was low (averaging 20%), indicating that the materials were badly designed. It was later found that the materials had not been field tested prior to printing and distribution.

30. A further observation from the CDC2 gender consultant is that the literate EG women living in rural areas are younger women who have received some schooling, while the older minority women had not attended school and their incidence of illiteracy is much higher. This has implications on the selection of village health volunteers or workers and village midwives, as older women are seen to have more social capital but are less educated, while younger women lack social capital but are more educated.

31. Cultural divides have proven to be especially challenging when the health worker and the patient population are from different EGs with different languages, cultures, and beliefs. There are issues of comprehension and then adoption as tradition can prevent the utilization of newly acquired knowledge.

D. Ethnic Group Health Workers

32. According to MOH Personnel Department records from 2016, female staff constituted 65.2% of total staff at health centers and 68.5% of total staff at district hospitals. Overall 47% of junior, mid- and senior management positions across all levels (central, province, district, health center) were held by women. However only 35% of senior management positions were held by women, with only 11% at district level and 23% at province level. The share of EGs as part of the health workforce is still low overall; in 2016 the share of EG staff in health centers was only 17%, representing a 2% decrease from the previous year. The share of ethnic women (of total female staff) at health centers is even lower and has decreased from 11.9% in 2015 to 10.1% in 2016[15].

[14] CDC2 Gender and IP Specialist Field Report, Sept 2012.
[15] Health Personnel Management Information Systems (HPMIS)

Considering that ethnic minorities make up roughly 46% of the Lao population, there is the need to draw many more EG personnel into the health service sector.

33. The MOH has launched the Model Healthy Village initiative (which includes the training of village health volunteers and midwives) to introduce basic primary health care at village level and particularly in ethnic minority communities. The exact number of village health volunteers (VHV) established nationally is not known but runs into several thousands, with many in remote areas. The eight Northern provinces in which the Health Sector Development Project (HSDP) was implemented reported a total of 5,704 VHV in a total of 3,167 villages, of which there are 1,233 women VHVs (21.6%). There are 3,027 EGs included in the total number of VHVs. Of the 3,167 villages, 953 villages (30%) have at least 1 female VHV.

E. Ethnic Group Health Service Needs

34. The Social Analysis prepared under the policy and advisory technical assistance[16] identified several areas that must be addressed to optimize the participation of EGs in the proposed program and improve access to, and utilization of, health care services. These needs include improved physical access, language and communication, increased sensitivity to EG members by health care workers, more ethnic women as healthcare workers, and improved capacity and service quality from village health workers.

35. Physical access remains the primary logistical constraint in providing health care to EGs in remote communities. Mitigating measures implemented by the MOH under both government and development partner programs in the past have included:

(i) establishing health care centers in remote locations
(ii) establishing and training village health workers, village midwives and village health volunteers
(iii) increasing the number of women as health care providers.

V. CONSULTATION AND PARTICIPATION

36. Consultative meetings were held in preparation of subprogram 1 in March 2015 with key departments at the central level including Cabinet and the MOH SubCAW, Planning and International Cooperation, Personnel, and Training and Research. All confirmed the need to improve primary health care and MNCH service delivery, particularly in remote areas, and the need to employ more EG members as healthcare workers. Development partners have provided tuition scholarships for EG medical students, and 2014–2015 was the first year in which MOH used government budget to waive tuition fees for EG medical students to attract more into medical professions. The department also reported that EG sensitivity was addressed in the ethics section of their curricula. All meetings confirmed the government's support for increasing the number of EG members in the health service and the importance of being able to provide EG to EG, and women to women, services. Consultations with several MOH departments and agencies including health facilities in two provinces (Luang Namtha and Bolikhamxay) during the mid-term review of the TA loan in August 2017 and the factfinding mission for subprogram 2 in November 2017, confirmed the need to continue activities targeting EGs to ensure they equally benefit from program reforms. Community views on NHI have also been sought during the NHI Financial Management Assessment (one policy trigger) as well as during a field visit undertaken by the international gender consultant under the TA loan. Consultations revealed that more needs to be

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

done to disseminate information on benefits and entitlements under NHI among poor and EGs, especially in remote areas.

37. Consultations with health agencies and EG communities regarding health and health service needs, access and communication difficulties, was also conducted in Saravan province from March 23 to 25 2015, visiting Samouy and Lao Ngarm districts during preparation of subprogram 1. Interviews with the acting Director of the Provincial Health Office and key staff confirmed the findings of discussed above, and further added:

(i) EGs were benefitting from health service improvements and the use of health care facilities was increasing, especially MNCH services;
(ii) constraints to greater utilization include: insufficient staff, inadequate facilities and equipment, language literacy and communication, and lack of trained EG health workers;
(iii) the province has already initiated a scheme in which partial scholarships are provided to students including EGs from the Champassak Medical School. In exchange for scholarships, recipients agree to work at health center level for 3 years (a group of 8 such students were observed working at the Nong Kae health center in Lao Ngarm district);
(iv) the health agency had made special effort to get support from traditional healers to align with MOH interventions and not to act to prevent or discourage people from seeking health care;
(v) availability of emergency cash was still a constraint to access as transportation allowances paid by government is only about 1/3 of the amount needed.

38. According to members of the Kado community consulted in Ban Meo of Samouy District, Saravan Province, their community:

(i) has previously relied on traditional healers, using herbal remedies and spirit worship (the degree of reliance in Lao PDR varies considerably with remoteness, there are however still elements to be found in all EG communities);
(ii) village traditional healers and spirit men do not interfere with people going to seek health care from facilities, however people still consult with the spirit man before leaving the village to get health care. This is for safety whilst traveling, and to appease the spirits;
(iii) Kado men accompany their wife and children on any visit to facilities, however they would let the doctor examine their wife without their presence in the treatment room;
(iv) both men and women agreed that priority should be given to MNCH services particularly to ensure safe delivery;
(v) sickness had severe implications on the household labor force, and impacted ability to grow crops and livestock;
(vi) it is important that health staff are able to engage people with social capital in the village and obtain their support in promoting modern health care;
(vii) traditional medicines are a valuable resource and their use has an important place in indigenous health care systems.

39. A field trip undertaken by the international gender consultant in late 2017 in Bolikhamxay province included discussions with EGs on the newly implemented NHI scheme. It revealed that communities were overall happy with the NHI service and understand the payment conditions. However, a few issues were identified, including:

(i) The National Health Insurance Bureau (NHIB) has not been disaggregating utilization reports by sex and ethnicity so far.
(ii) Information dissemination:
    - EG women indicated difficulties in understanding information presented in Lao at NHI dissemination meetings by health staff, and sought clarifications from the village health volunteer (VHV) as needed (VHV speak Lao).
    - it is necessary to use local translators when presenting information, and it would be useful to provide a separate forum for EG women to ask questions and seek explanations, as they are uncomfortable doing it in a large meeting.
    - Some pamphlets in basic Lao should be made available, and distributed to VHVs and patients at health facilities.

40. Discussions were also held in a village of mixed ethnicity in Lao Ngarm district close to the Nong Kae health center, where a group of pregnant women and young mothers were interviewed. Previously babies were delivered at home with women assuming it was a natural process and not expecting difficulties. However, due to a high rate of infant death and following outreach visits from health staff, most younger women now prefer to give birth in health centers as a preventative measure. One young mother had lost two children after birthing at home but was planning to use the health center for her third child. All village consultations confirmed strong support for program interventions for improved delivery, MNCH, and packages for children under 5 especially under NHI.

41. Secondary consultative data from previous ADB supported projects[17] was also obtained from provinces with majority EG populations. One project conducted a Knowledge, Attitudes and Practice (KAP) household survey in households with children under 5 years of age and in project villages not yet established as model healthy villages. A total of 1,497 households were interviewed and mothers were target respondents. Results from the survey indicated that 66.3% of respondents had received some antenatal care during pregnancy, 67.6% received iron pills and 82.4% received anti tetanus shots. 96.7% breastfed and 65.3% of children under 5 received vitamin A capsules. Only 18% received post-natal care. The survey demonstrated that EG women are increasingly using health services.

42. Results from another survey indicated that more people are seeking treatment at government facilities and that an increasing number of women are having deliveries attended to by qualified medical staff. Overall use of public health services is reported to have increased 5-fold between 2000 and 2013 to about 0.6 visits per person per year.[18] The project noted that whilst improved health facilities and better skilled staff are available, physical access remains problematic in remote areas, particularly in the rainy season. The percentage of health staff from EGs is increasing but still low, which may prevent EGs from using services. Behavioral change demonstrated by increased health facility use indicates the communities' demand and support for improved health services, and good health.

43. As with ADB, WB also held consultations through the Health Governance and Nutrition Development Project (HGNDP). HGNDP works closely with central and provincial health officers, provincial health coordinators, district health officers, and health officers at the village health centers to organize a series of free, prior and informed consultations with stakeholders, especially

[17] ADB. Second Greater Mekong Subregion Regional Communicable Diseases Control Project. (approved in October 2015) and Lao PDR: Health Sector Development Program.
[18] World Development Indicators http://siteresources.worldbank.org/INTPRH/Resources/376374-1303736328719/LAOhealth41811web.pdf.

the poor and vulnerable groups including those from various ethnic groups, in all project target areas (14 provinces). In March 2015, consultations in three provinces (Saravan, Oudomxay and Bolikhamxay) documented a wide variety of cultural practices, especially with regard to method of delivery, nutrition and post-natal practices. Findings emphasized the need for flexibility in nutrition messaging to ensure local relevancy. Health centers where the staff spoke ethnic languages were much more accessible to EGs because they were able to communicate effectively with staff. Further, at consultations, representatives of NPCO and designated health officers at the local level provided information on overall project objectives, project components with key activities, budget allocations, duration, potential impacts and risks (both positive and negative) and feedback and resolution mechanisms. Consultations show that there is limited awareness among concerned health staff at all levels of the importance of making services available to vulnerable populations, including ethnic groups. There is also weak coordination among relevant sectors/agencies at the provincial level leading to low efficiency and effectiveness of project financial management at the district level.

44. According to the World Bank draft EGDP (March 2015) there were a number of barriers to increased MNCH service access and nutritional improvement across all three provinces:

(i) Many villagers believe that giving birth is a normal process which does not require medical intervention. They would only go to the health center if problems were identified during home birth such as the baby being slow to deliver or excess bleeding.
(ii) Post-natal care was seen by many participants as unnecessary. They stated that they would only attend post-natal care if their baby was sick.
(iii) Some villagers reported the practice of eating less while pregnant to reduce the chance of having a big baby and a difficult delivery.
(iv) Home birth entailed poor cord care, with most participants reporting that the cord was cut with unsterilized instruments, which risks infection.
(v) Many participants requested more flexible birthing practices at health facilities, including incorporating traditional birth positions and allowing family members in the birth room for support.
(vi) Many participants requested health education material to be tailored to EGs, with local language material and pictorial material.

VI. BENEFITS, IMPACTS AND MITIGATIVE MEASURES

45. Preparation of the EGDP is guided by the ADB Safeguard Policy Statement (2009) and the ADB Operations Manual Safeguard Policy statement (Sec F1/OM-2013). In accordance with the requirements, anticipated impacts and mitigative measures have been reviewed for both subprograms. There are no negative impacts under either; however, measures are needed to ensure that EG members benefit to the same extent as mainstream Lao, as indicated in the policy matrix contained in Appendix 1 and also under the EGDP under the TA loan in Appendix 2.

46. The program benefits to EGs will be improved health of men, women, and children, with reductions in infant, child, and maternal mortality through increased use of health services and assisted birthing; reduced expenditure on health care through NHI coverage; and overall improvements in health personnel availability and quality.

47. There are risks that EGs will not benefit as equally as mainstream Lao from program interventions. Table 3 details possible risks with regard to the intended outcomes which have been addressed in the policy matrix and in formulating the EGDP. At a strategic level, the policy

matrix and EGDP provide actions to increase the number of EG men and women employed in the health care sector and improve human resource development and training. Increasing the number of EG women in health centers will improve EG women to EG women health care particularly for MNCH and will ensure services are culturally sensitive. Further, trainings on how to address EG concerns and needs in a participatory manner will also be conducted for implementing agencies. NHI, which will absorb the HEF and FMNCH schemes, is expected to reduce financial barriers and increase access to health services. Actions to make sure EGs will be able to benefit from NHI include producing and disseminating information material on NHI in EG languages and with appropriate non-text media guidelines will also be prepared to ensure information material is appropriately disseminated and feedback on EGs access to health services is collected. All data will be disaggregated by sex and ethnicity.

Table 3: Benefits and Risks

Intended Outcome	Benefit to EGs	Risk
i) increased use of health services and health care facilities by the poor, mothers and children;	Yes	Lower utilization rates of health services despite NHI due to language and literacy issues, traditions, customs and cultural sensitivities. Lack of understanding of information disseminated on benefits and entitlements under NHI if only prepared in Lao and written text, or are not disseminated in a culturally appropriate way. Low number of EG health service staff and especially EG women staff.
ii) health sector reform process improved;	Yes	Implementing agencies insufficiently sensitized to EG issues and do not address EG concerns in health sector reforms. Data not disaggregated by sex and ethnicity to track progress in access to health care and health outcomes among EGs.
iii) Reduction in out-of-pocket payments and financial barriers to access health care services;	Yes	Lower utilization rates of health services despite of NHI due to language and literacy issues, traditions, customs and cultural sensitivities. Lack of understanding of information disseminated regarding benefits and entitlements under NHI if only prepared in Lao and written text, or are not disseminated in a culturally appropriate way.
iv) Improved human resources;	Yes	Few EG staff working at district and health center levels. Lack of good quality staff in isolated and remote areas, where many EGs reside. Low numbers of EG women working in health sector.
v) Strengthened health sector budgeting and financial management	Yes	Political will required to divert resources to areas of need; poorest geographic areas also have highest concentrations of EGs who have lowest levels of socio-political capital.

VII. GRIEVANCE REDRESS MECHANISMS

48. Although no grievances are envisaged under the proposed HSGP, the ADB Safeguard Policy Statement (2009) requires a grievance redress mechanism. In the Lao PDR, the judicial system starts at the local level with the Village Committee (VAC), which is normally used for grievances against local government agencies, civil actions, and minor criminal matters. In the case of most EG communities there is a more informal but very influential Village Elders' group

which includes individuals with high social capital and influence in the community. Village Elders also participate in grievance hearings and suggest resolutions.

49. EG members may make verbal complaints at the village level. If the issue needs to be referred to district authorities, formal complaints must be put in writing and bear the village stamp to indicate that the complaint has been referred correctly through local grassroots authorities. If the village has difficulty in submitting a formal written complaint, the Lao National Front (LNF) office at district level will provide the necessary assistance. Complaints received must be documented and acted upon immediately. The VACs must keep records of grievance hearings.

50. If issues are not resolved at the village level, an appeals process at district and provincial levels will be made available through the respective health office who will act on behalf of the project or program owner. The respective district or provincial health office must request the participation of the provincial or district LNF representatives at all grievance hearings. Any grievance not resolved at the local level can be referred to the Department of Planning and International Cooperation, MOH, again with the participation of LNF representatives. If the matter is still not resolved, the issue can be referred to the Provincial Peoples' Court.

51. Grievance resolution will be aligned with the other safeguard processes where possible. The procedures for filing and resolution of grievance and complaints are described in Table 4.

Table 4: Grievance Procedures

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to VAC/VE at village level. If unwritten the VAC/VE will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance is received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint to the district level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the district level, he/she can seek redress at provincial GRC, which makes a decision within 10 days.
Stage 4	The AP may elevate the complaint to the PMO if still unsatisfied with the decision of GRC at the provincial level. The PMO will ensure to resolve each complaint within 10 days after receipt.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, PMO = Project Management Office, VAC = Village Committee, VE = Village Elder

VIII. CAPACITY BUILDING

52. The EGDP activities are mainstreamed into program implementation activities of the TA loan which will be implemented by the implementing agencies. To ensure the EGDP is disseminated, implementing agencies will receive an EGDP and EG sensitivity training and will be responsible to cascade trainings to provincial and district level. Further capacity building for to achieve EGDP activities will be undertaken as on-the-job training and supported by international and national social safeguards consultants.

IX. INSTITUTIONAL ARRANGEMENTS

53. The program is implemented through the Department of Planning and International Cooperation, MOH. The MOH has responsibility to ensure that EG staffing targets are pursued and that field teams are adopting recommendations and special measures contained in the EGDP with respect to working with EGs. Provincial and district level teams should assign one person at each level to act as the focal point for social safeguards work. Safeguard oversight will be provided through the Project Management Office (PMO) with guidance from the Chief Technical Advisor (CTA) and support from the international safeguard specialist who will provide 3 months of intermittent input and a national gender and safeguard specialist (6 months of input). The CTA and safeguards specialist will cover all three safeguard areas of resettlement, EGs, and environment.

X. MONITORING AND REPORTING

54. The EGDP contains suggested activities with indicators and targets. The CTA and Safeguards Specialist will assist the PMO M&E officer to ensure that all EGDP indicators are properly defined and included in the program M&E system. The PMO M&E officer will prepare quarterly reports on the design and monitoring framework and submit it to ADB.

XI. DISCLOSURE ARRANGEMENTS

55. The EA will endorse the EGDP and ADB will disclose the endorsed EGDP on the web upon receipt.

ETHNIC GROUPS DEVELOPMENT PLAN

Program reform areas	Activities and targets
Reform area 1: Health sector reform process improved	1. Training, meeting attendance, and participation data is disaggregated by ethnicity and gender. Activity 1
Reform area 2: Implementation of free health care for the poor, mothers and children improved	2. Facility attendance and treatment data are disaggregated by ethnicity and sex. Activity 2 3. Information materials on NHI are prepared for non-Lao reading and EG audiences and information is disseminated. Activity 3 4. Guidelines on how to disseminate information on NHI through EG community level group meetings separated by men and women, drafted. Activity 4 5. Guidelines on how to collect feedback from EG men and women on access to and quality of health service provision, including how to seek suggestions for improvements, and an assessment form on proposed feedback to be collected, written. Activity 5 6. Guidelines on how health facilities can ensure outreach activities and information, education and communication meetings are conducted at times and places convenient for EG women, drafted and disseminated. Activity 6 7. Village Health Committees (VHC) established in EG villages include at least one woman as committee member. Target 1
Reform area 3: **Health human Resources management capacity strengthened**	8. Personnel management information systems collect and report all data disaggregated by sex and ethnicity. Activity 7 9. The absolute number of EG health staff increases Activity 8
	10. At least 15% of total training participants are EGs. Target 2 11. Implementing agencies receive EGDP and EG sensitivity training on how to address EG concerns and needs as well as participatory methods to consult EGs. Activity 9 12. Percentage of EG women health center staff (out of total female health center staff) increases to 13% by June 2018 Activity 10
	13. Health training institutions include EG awareness and sensitivity modules in the curriculum. Activity 11 14. Scholarships for 6 EG to study health supported. Target 3 15. Criteria for registration as licensed health practitioners do not discriminate EGs. Activity 12
Reform area 4: Health sector Financial management System strengthened	16. Trainings on planning and budgeting include a component to enhance awareness on EG needs and concerns and participatory methods to consult EGs. Activity 13