MATRIX OF POTENTIAL ENVIRONMENTAL AND SOCIAL IMPACTS AND MEASURES[1]

Subprogram 1 Policy Actions (August 2013 to July 2015)	Subprogram 2 Policy Actions - Triggers in Bold (August 2015 to March 2018)	Social Impact (Ethnic groups)	Mitigative Action for Ethnic Groups
1.1 The government has established the National Commission on Health Sector Reform (HSR) to steer and to facilitate implementation of the Health Sector Reform Strategy. **1.2 The government has endorsed the HSRF, describing the reform implementation process for 2013–2025.** 1.3 The government has drafted and initiated 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 has approved the 2018 HSR implementation plan, as part of MOH's implementation plan.** **1.2 To enhance monitoring of reforms for 2015–2025, MOH has approved the roadmap for reforms in strengthening health human resources and health system financial management.**	There are no negative impacts on EGs.	Governance improvements and plans to modernize the health sector under Health Sector Reform will benefit the entire population, including EGs. Measures to ensure EGs are included in training activities will be taken. Implementing agencies will receive trainings on EGDP and EG sensitivity, including how to address concerns and needs of EG as well as participatory methods to consult EGs. Data on training, meeting attendance and participation will be disaggregated by sex and ethnicity.

[1] This document focuses on impacts on Ethnic Groups (EG) as there will be no Involuntary Resettlement (IR) or Environmental Impacts.

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2.1 By September 2014, the government has rolled out the free MNCH program in 88 districts for maternal care (out of 146 districts); and has extended the coverage under the HEF safety net program to 46,870 poor families in 110 districts (43% of poor families). 2.2 The MOH has clarified the role of the Health Insurance Bureau (HIB) as administrator of the five existing social health protection schemes. 2.3 MOH has strengthened the capacity of the HIB on financial management, processing and verification of claims, including training of HIB staff on costing; and has established HIB branches in 2 pilot provinces. **2.4 To streamline uniformity of HEF and free MNCH schemes, the MOH has harmonized their implementation guidelines for nationwide application**.	**2.1 The government increased financial resources from 22 billion kip in 2014/5 to 183 billion kip in 2017 to deliver free of charge health services for the poor, mothers and children under 5 in at least 131 districts, in line with the NHI guidelines.** 2.2. MOH continued improving NHI governance arrangements by issuing a NHI decree (outlining benefits, financial management and administrative arrangements) and strengthening capacity of the NHIB and its provincial branches, through training on NHI for staff. **2.3 To ensure sufficient and timely reimbursement to health facilities, MOH assessed financial management, monitoring and health provider payment mechanisms and approved recommendations to improve relevant implementation guidelines.**	There is no negative impact on EGs. However, there is a risk that EGs will not equally benefit from program reforms. EGs' utilization of health facilities might not increase despite NHI due to language barriers, traditions, customs and cultural sensitivities. There is a risk that EGs may not benefit from information material disseminated on benefits and entitlements under NHI if they are only prepared in Lao and written text, or are not prepared and disseminated in a culturally appropriate way.	Information material on NHI will be prepared and disseminated in EG languages and with appropriate non-text media. Ideally this material should be pre-tested before large scale roll out. Where necessary, information should be disseminated orally. Guidelines will be developed on how to disseminate information material in EG community-level meetings separated by men and women. In addition, guidelines will be prepared (i) on how to collect feedback from EG on access to and quality of health services and how to seek suggestions for improvements; and (ii) on how health facilities can ensure outreach activities and information meetings are conducted at times and places convenient for EG women. All guidelines should be disseminated and discussed during trainings. Measures such as increasing EG health staff in facilities are ongoing, to ensure EG needs and sensitivities are addressed and communication is improved.

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3.1 The MOH has rolled out 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 has increased 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 has defined quality standards for medical education institutions and approved competency standards for medical professions (including dentistry) to be included in the training curricula.	3.1 MOH improved the HPMIS to incorporate data on skills, training, sex and ethnicity, and trained provincial health officers to utilize the HPMIS and its 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, at least 12 provincial health offices have approved their workforce plan (including action points on gender and equity policies and appropriate staff incentives).** **3.3. To enhance safe delivery, the MOH gradually increased the deployment of midwives to ensure that 75% of health centers are staffed with at least one community midwife, up from 52% in 2015.** 3.4 MOH has issued a decree which states objectives, rights and responsibilities, the organizational structure and assigned personnel for the Health Professional Council, which is functional.	There is no negative impact on EGs. However, there is a risk that EGs will not equally benefit from program reforms. EG may not have the same opportunities to be hired as health staff due to lower levels of education and qualification. Considering that ethnic minorities make up roughly 46% of the Lao population, numbers of EG health staff, especially EG women, remains low. There is a lack of good quality staff in isolated and remote areas, where many EGs reside.	Personnel management information systems collect and report all data disaggregated by sex and ethnicity. Workforce development plans will support improving staffing levels of health facilities with emphasis on deployment of staff in remote and hard to reach areas, where many EGs reside. Measures will ensure that criteria for hiring health staff and registering as licensed health practitioners will not discriminate against EGs. More EG women in health centers will improve EG women to EG women services particularly in MNCH and will ensure services are culturally sensitive.

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	3.5 To further enhance skills and qualification of health care professionals, MOH approved certification standards, accreditation, licensing, and registration system for health professionals.		
4.1 In 2014, MOH has strengthened staff capacity to adopt multi-year budgeting and budget framework. **4.2 To improve transparency and accountability of public finances, the government has approved rules and regulations for the collection, accounting and utilization of the money collected from service charges by publicly owned health facilities.** **4.3 MOH has issued Implementation Guidelines for the collection, accounting and utilization of the money collected from health service charges.**	**4.1 In FY2017, the Government increased health budget allocation by 20% compared to the FY2014/15 budget allocation.** **4.2 To enhance monitoring of public finances for health, MOH applied the Accounting Handbook for State Agencies and implemented MOF's 'double entry' system to account for sources and uses of funds in health facilities.** 4.3 MOH started piloting MOF's 'double entry' 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.	There is no negative impact on EGs. However, there is a risk that EGs will not equally benefit from program reforms. There is a need to direct resources in areas of highest need and poorest geographic areas (which, in turn, also tend to have highest concentrations of EGs).	Improvements in financial management will allow tracking of budget allocation and expenditure by province, which will then enable the tracking of resources allocated to areas with many EGs.

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4.4 To improve health expenditure transparency, MOH has prepared and published (NHA) for FY2011, and FY2012 detailing health sector funding, its sources, and utilization at national and sub-national levels.	4.4. MOH continued to publish NHA for FY2013–FY2016.		
4.5 The MOF and MOH has initiated 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.	**4.5 To improve budget planning and execution, MOH published approved disbursement figures in the Central Budget Units Annual Report for 2015–2016, Central Budget Units 6-month report for 2017, Provincial Health Office Annual Reports for 2015–2016 and Provincial Health Office 6-month reports for 2017.**		
	4.6 MOH adopted a financial management system and accompanying guidelines to align development partner financing with government plans and budget, consistent with Government chart of accounts.		

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	4.7 To ensure adequate and timely funding for free health services for the poor, mothers and children under 5 and improve financial sustainability of health sector operations, MOH and MOF agreed on a fund flow mechanism.		

ADB = Asian Development Bank; CDTA = capacity development technical assistance; EG = ethnic group; EGDP = ethnic groups development plan; FY = fiscal year; GDP = gross domestic product; GGE = General Government Expenditure; HEF = health equity fund; HIB = Health Insurance Bureau; HPMIS = health personnel management information system; HSRF = Health Sector Reform Framework; MNCH = maternal, newborn, and child healthcare; MOH = Ministry of Health; MOF = Ministry of Finance; NHA = National Health Accounts; NHI = National Health Insurance; ODA = Official Development Assistance; PATA = policy advisory technical assistance; TA = technical assistance.