SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Lao PDR	Project Title:	Health Sector Governance Program Subprogram 2
Lending/Financing Modality:	Policy-Based Grant	Department/ Division:	Southeast Asia Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Poverty targeting: General intervention

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

The government of the Lao PDR aims to graduate from least-developed country status and lower poverty rates to 10% by 2020, and commits to sustained investment to improve access to, and quality of, basic social services such as health care, with a view to improving health outcomes especially for the poor, women and children under 5.[a] Further, the Lao PDR aims to achieve SDG 3 on health. In line with Lao PDR's development goals, the Asian Development Bank (ADB) country partnership strategy for the Lao PDR for 2017–2020 emphasizes inclusive sustainable growth, reduced inequality and disparities in public service delivery, and improved governance and public financial management.[b] Subprogram 2 of the Health Sector Governance Program strongly supports these objectives.

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

1. Key poverty and social issues. Poverty and ill-health are mutually reinforcing. While poverty can be a major cause of ill-health, ill-health can also drive individuals and families deeper into poverty. On the other hand, a healthier workforce is associated with lower absenteeism, higher labor productivity, higher wages and economic growth.[c] Policy actions under subprogram 2, such as expanding NHI coverage and strengthening human resources, are expected to positively affect population health. The poor, mothers and children under 5 are ensured free health care under the NHI. Policy actions to improve staffing levels in remote and hard-to-reach areas will enhance health service delivery and help address geographic poverty disparities; rural poverty is estimated at 28.6%, compared to 10% in urban areas. An EDGP contains targets for ethnic groups,[d] among whom poverty is generally higher.[e]

2. Beneficiaries. All Lao citizens will potentially benefit from the reforms under subprogram 2, and especially the poor, mothers and children under 5. This is important as access to health services and health outcomes are typically worse among the poor than the rich, despite the greater needs of the poor; there is an 80% percentage point difference in maternal health service coverage between the richest and poorest quintiles.[f] Low coverage of MNCH services (including for immunization, antenatal care, skilled birth attendance, and surgery)[g] manifest in poor health outcomes; declines in newborn and infant mortality rates have been much slower among the poor, less educated and rural populations, and children in the poorest quintile are 3.6 times more likely to die before the age of 5 than those in the wealthiest quintile.[h]

3. Impact channels. The program supports (i) increased resources to deliver free health services for the poor, mothers and children under 5 through NHI; (ii) enhanced skills and qualification of health personnel to improve quality of health care services; (iii) recruitment and retention of female and ethnic health workers in rural areas to support greater use of health services by women and ethnic groups; and (iv) awareness-raising activities on NHI benefits, including development of gender and ethnic group-sensitive materials.

4. **Other social and poverty issues.** Lao PDR ranked 138 out of 188 in 2015 on the Human Development Index. Geographic, ethnic, and rural–urban inequalities persist.[i]

5. **Design features.** The program supports the government's Health Sector Reform Strategy in the areas of governance, health financing, human resources and public financial management.

C. Poverty Impact Analysis for Policy-Based Lending

1. Impact channels of the policy reform(s). The program's main impact channels are via governance reforms, NHI implementation, strengthening of public financial management, and quality improvement of health personnel. Increased health sector budget allocations and financing of free health services for the poor, mothers and children under 5 will enhance use of health care services. An increase in the overall budget allocation for health will be accompanied by improved accounting systems, expenditure monitoring and reporting (to the health facility level), which will increase transparency of health sector funds. Measures to improve certification standards, licensing and accreditation for human resources will help enhance personnel skills and overall service quality. Human resource policies to promote recruitment and retention of female and ethnic health workers in rural areas will support greater use of health services by women and ethnic groups and enhance their employment opportunities. Awareness-raising activities and materials on NHI benefits and entitlements will be gender sensitive and appropriate for ethnic groups. All data in the personnel information systems and program reports will be disaggregated by gender and ethnicity.

2. Impacts of policy reform(s) on vulnerable groups. Positive impacts on vulnerable groups (the poor, women, children under 5, ethnic groups) are woven into the program design. The program encompasses policy actions to

increase quality of and access to health services, that are sensitive to gender and the needs of ethnic groups, and support health sector employment opportunities for women and ethnic group members. The NHI exempts the poor, mothers and children under 5 from co-payments, and policy actions support increasing budget allocations to health.

3. Systemic changes expected from policy reform(s). Policy reforms will result in: (i) better access to and improved quality of basic health care leading to better health outcomes for the entire population; (ii) NHI coverage for 80% of the population by 2020, which will ensure better financial protection from catastrophic expenditures; and (iii) achievement of LDC graduation targets related to MNCH services and universal health coverage (SDG 3 on health).

II. PARTICIPATION AND EMPOWERING THE POOR

1. Participatory approaches and program activities. The GAP and the EGDP contain a range of participatory measures to ensure ethnic groups and women are consulted about health services under NHI, including by ensuring that outreach and information scheduling (time and location) is convenient for women, including ethnic women; and information material and awareness-raising activities on NHI are gender-responsive and suitable for non-Lao speaking audiences. Institutionalized participatory forums such as village health committees can be used for such activities. Community views on NHI have been sought during interviews for the NHI Financial Management Assessment (a policy trigger). Village heads have participated in NHI training workshops and will relay information to their communities. Development partners plan to support the establishment of a hotline for NHI complaints.

2. Civil society organizations. The program does not envisage direct engagement with civil society organizations but many complement MOH reforms, especially in providing primary health care.

3. The following **forms of civil society organization participation** are envisaged during program implementation, rated as high (H), medium (M), low (L), or not applicable (NA):

☒ NA Information gathering and sharing ☒ NA Consultation ☒ NA Collaboration ☒ NA Partnership

4. Participation plan.

☐ Yes. ☒ No. The program's GAP and EGDP under the TA loan recommend several measures to ensure effective community participation for use of health services and NHI by women and ethnic groups. Consultations have been held with central ministries, provincial and district health offices, and facility staff at all levels.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: Gender Equity (GEN)

A. Key issues. Despite good progress on many Millennium Development Goal targets, including those related to MNCH, some targets remain unfulfilled. High maternal mortality rates (206 deaths per 100,000 live births) result from lack of access to emergency obstetric care and skilled birth attendance (only 53.9% of births were attended by skilled birth attendants in 2015), and physical and financial barriers. Access is particularly difficult for women in remote rural areas, especially ethnic group women. In 2016, 65.2% of total staff at health centers and 68.5% in district hospitals were female, but female representation in senior management positions remains low (35%, with only 11% at district and 23% at district and provincial levels). 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.[j]

B. Key actions. Improving access to maternal, sexual and reproductive health remains a priority, especially for women in remote areas and ethnic group women. Policy actions under subprogram 2 support continued provision of free health care for the poor, mothers and children under 5 under the NHI by exempting them from co-payments, and policies to increase the number of women working at health facilities, especially as midwives, are in place.

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

The GAP was revised during the program midterm review to reflect the introduction of NHI, and is being implemented (supported by the corresponding TA loan) during subprogram 2. Achievements include: at least 75.1% (out of 1,017) health centers have at least one midwife (this reached 81.4% in 2017 according to preliminary data); a detailed roadmap guiding preparation of a gender equality strategy in the health sector was developed; a number of workforce development plans were formulated that include action points on gender and equity policies to support women's employment, retention, promotion and capacity development in the health sector; the number of female staff undertaking training in public health and financial management has increased; and health service utilization and personnel data disaggregated by gender and ethnicity is increasingly available.

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

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

1.Key impacts. No land acquisition resulting in involuntary resettlement is planned under subprogram 2.

2. Strategy to address the impacts.

3. Plan or other Actions.

☐ Resettlement plan
☐ Resettlement framework
☐ Environmental and social management system arrangement
☒ No action
☐ Combined resettlement and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Social impact matrix

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

1. Key impacts. Ethnic groups will benefit from improved outreach services, better trained and more skilled health staff at health facilities, and greater representation in the health workforce. Poverty is generally higher among ethnic groups, and therefore potential impacts are greater for this group.

Is broad community support triggered? ☐ Yes ☒ No

2. Strategy to address the impacts. All potential impacts on ethnic groups are positive and no mitigation is required. An EGDP includes measures to ensure ethnic groups will benefit from program reforms to at least the same extent as non- ethnic groups. Targets include increasing: the share of ethnic group health staff; ethnic groups' access to training; and awareness and sensitivity on ethnic group concerns in training activities. Information materials on NHI for ethnic group audiences will be appropriately disseminated. All data will be disaggregated by sex and ethnicity.

3. Plan or other actions.

☐ Indigenous peoples plan
☒ Indigenous peoples planning framework
☐ Environmental and social management system arrangement
☒ Social impact matrix
☐ No action
☐ Combined resettlement plan and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Indigenous peoples plan elements integrated in project with a summary

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. Relevance of the project for the country's or region's or sector's labor market, indicated as high (H), medium (M), and low or not significant (L).

L unemployment L underemployment L retrenchment L core labor standards

2. Labor market impact. There are no risks; only positive impacts. The EGDP and GAP include actions for increasing employment opportunities for women and ethnic groups as health service and management staff.

B. Affordability

The program addresses affordability of health services through support for the NHI scheme.

C. Communicable Diseases and Other Social Risks

1. The impact of the following risks are rated as high (H), medium (M), low (L), or not applicable (NA):

NA Communicable diseases NA Human trafficking
NA Others (please specify) In strengthening general health services and particularly health services for vulnerable populations, the incidence of communicable diseases is likely to fall.

2. Risks to people in project area. No risks identified.

VI. MONITORING AND EVALUATION

1. **Targets and indicators**. The DMF, GAP and EGDP set indicators and targets for the program, with special attention to participation of women and ethnic groups in training, human resource development and recruitment.
2. **Required human resources**. International safeguard expert (3 person-months, int.); international gender expert (3 person-months, int.); national gender and safeguard specialist (6 person-months), are hired under the TA loan.
3. **Information in the project administration manual**. A Project Administration Manual prepared under the TA loan supports implementation of reforms in subprogram 1 and 2.
4. **Monitoring tools**. Monitoring will comprise quarterly progress reports, including updates on the DMF, GAP and EGDP. All data will be disaggregated by gender and ethnicity where relevant.

ADB = Asian Development Bank, DMF = design and monitoring framework; EGDP = ethnic group development plan; GAP = Gender Action Plan; Int. = international; LAO PDR = Lao People's Democratic Republic; MNCH = maternal, newborn and child healthcare; MOH = Ministry of Health; NHI = National Health Insurance; SDG = Sustainable Development Goal; TA = technical assistance

[a] Government of the Lao PDR, Ministry of Planning and Investment. 2016. *8th Five-Year National Socio-Economic Development Plan (2016–2020)*. Vientiane.
[b] ADB. 2017. *Country Partnership Strategy: Lao People's Democratic Republic, 2017–2020—More Inclusive and Sustainable Economic Growth*. Manila.
[c] D. Bloom, D. Canning, and J. Sevilla. 2001. The Effect of Health on Economic Growth: Theory and Evidence. *NBER Working Paper Series*. No. 8587. Cambridge: National Bureau of Economic Research
[d] The plan will be implemented under the TA Loan accompanying subprogram 2.
[e] World Bank. 2014. *Poverty Profile in Lao. Poverty Report for the Lao Consumption and Expenditure Survey 2012–2013.*Vientiane.
[f] United Nations. 2017. *From Millennium Development Goals to Sustainable Development Goals: Laying the base for 2030*. Vientiane.
[g] World Bank. 2011. LAO PDR: Reproductive Health at a Glance.
[h] WHO. 2015. Success Factors for Women's and Children's Health Multisector Pathways to Progress.
[i] UNDP. 2016. Briefing Note on 2016 Human Development Report: Lao People Democratic Republic.
[j] Government of the Lao PDR, Ministry of Health. 2017. Health Personnel Management Information Systems data.