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Report No: PAD1371

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 9.4 MILLION
(US$13.2 MILLION EQUIVALENT)

AND

A PROPOSED GRANT

IN THE AMOUNT OF SDR 9.4 MILLION
(US$13.2 MILLION EQUIVALENT)

TO THE

LAO PEOPLE'S DEMOCRATIC REPUBLIC

FOR A

HEALTH GOVERNANCE AND NUTRITION DEVELOPMENT PROJECT

June 2, 2015

Health, Nutrition, and Population Global Practice
East Asia and Pacific Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective April 30, 2015)

Currency Unit	=	Lao Kip (LAK)
1 LAK	=	US$0.000123
US$ 1	=	LAK 8,077
SDR 1	=	US$1.40642

FISCAL YEAR
October 1 – September 30

ABBREVIATIONS AND ACRONYMS

ADALY	Averted Disability Adjusted Life Years
ADB	Asian Development Bank
ANC	Ante Natal Care
CIEH	Center for Information and Education in Health
CLTS	Community-led Total Sanitation
CNP	Community Nutrition Project
CRVS	Civil Registration and Vital Statistics
DA	Designated Account
DG	Director General
DHHP	Department of Hygiene and Health Promotion
DHIS2	District Health Information System
DHO	District Health Office
DLI	Disbursement Linked Indicators
DPD	Deputy Project Director
DPIC	Department of Planning and International Cooperation
DPT	Diphtheria, Pertussis, Tetanus
ECE	Early Childhood Education Project
ECOP	Environment Code of Practice
EEP	Eligible Expenditures Program
ERM	Emergency Response Manual
FM	Financial management
FP	Family Planning
FY	Fiscal Year
GDP	Gross Domestic Product
GOL	Government of Lao PDR
HAP	Household Air Pollution
HEFs	Health Equity Funds
HMIS	Health Management Information System
HSIP	Health Services Improvement Project
HSRF	Health Sector Reform Framework
IDA	International Development Association
IUFR	Interim Unaudited Financial Reports

IYCF	Infant and Young Child Feeding
Lao PDR	Lao People's Democratic Republic
LSIS	Lao Social Indicator Survey
MCH	Maternal and Child Health
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MFNSAP	Multisectoral Food and Nutrition Security Action Plan
MNCH	Maternal, neonatal and child health
MOF	Ministry of Finance
MOH	Ministry of Health
Nam Saat	Center for Environmental Health and Rural Water Supply
NPCO	National Program Coordination Office
NREDS	National Renewable Energy Development Strategy
ODF	Open Defecation Free
OOP	Out of Pocket
PER	Public Expenditure Review
PHO	Provincial Health Office
PNC	Post Natal Care
PRF	Poverty Reduction Fund
SA	Social Assessment
SAO	State Audit Organization
SARA	Service Availability Readiness Assessment
SBA	Skilled Birth Attendant
SBCC	Social and Behavior Change Communication
SDS	Service Delivery Survey
SOE	Statement of Expenditures
TA	Technical Assistance
TOR	Terms of reference
WASH	Water, Sanitation and Hygiene

Regional Vice President:	Axel van Trotsenburg
Country Director:	Ulrich Zachau
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Toomas Palu
Task Team Leaders:	Laura L. Rose, Phetdara Chanthala

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

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PAD DATA SHEET

Lao People's Democratic Republic

Lao PDR Health Governance and Nutrition Development Project (P151425)

PROJECT APPRAISAL DOCUMENT

EAST ASIA AND PACIFIC

Report No.: PAD1371

Basic Information			
Project ID P151425	EA Category B - Partial Assessment		Team Leader(s) Laura L. Rose, Phetdara Chanthala
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date 24 June 2015	Project Implementation End Date 30-Sept-2020		
Expected Effectiveness Date 1 October 2015	Expected Closing Date 31-Dec-2020		
Joint IFC No			
Practice Manager/Manager Toomas Palu	Senior Global Practice Director Timothy Grant Evans	Country Director Ulrich Zachau	Regional Vice President Axel van Trotsenburg

Borrower: Lao People's Democratic Republic			
Responsible Agency: Ministry of Health			
Contact:	Dr. Prasongsidh Boupha	Title:	Director General
Telephone No.:	85621252853	Email:	adb2laos@loxinfo.co.th

Project Financing Data(in USD Million)							
[ ]	Loan	[X]	IDA Grant	[ ]	Guarantee		
[X]	Credit	[ ]	Grant	[ ]	Other		
Total Project Cost:			26.40	Total Bank Financing:			26.40
Financing Gap:			0.00				

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	26.40
Total	26.40

Expected Disbursements (in USD Million)

Fiscal Year	2016	2017	2018	2019	2020	2021	0000	0000	0000	0000
Annual	6.00	6.50	6. 50	3.0	3.0	1.4				
Cumulative	6.00	12.5	19.0	22.0	25.0	26.4				

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

GGODR, GWASE, GEEDR

Cross Cutting Areas

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	75		
Water, sanitation and flood protection	General water, sanitation and flood protection sector	10		
Public Administration, Law, and Justice	Public administration- Health	10		
Energy	General energy	5		
Total				

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes		
Theme (Maximum 5 and total % must equal 100)		
Major theme	Theme	%
Human development	Child health	10
Human development	Nutrition and food security	40
Human development	Health system performance	10
Human development	Population and reproductive health	40
Total		100

Proposed Development Objective(s)

To help increase coverage of reproductive, maternal and child health, and nutrition services in target areas in Lao PDR.

Components

Component Name	Cost (USD Millions)
1. Health Sector Governance Reform	0.50
2. Service Delivery	19.40
3. Nutrition Social and Behavior Change Communication	4.00
4. Project Management, Monitoring and Evaluation	2.50
5. Contingent Emergency Response	0.00

Systematic Operations Risk- Rating Tool (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Substantial
4. Technical Design of Project or Program	High
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
OVERALL	Substantial

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [x]
Does the project require any waivers of Bank policies?	Yes [ ] No [x]
Have these been approved by Bank management?	Yes [ ] No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [x]
Does the project meet the Regional criteria for readiness for implementation?	Yes [x] No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	x	
Natural Habitats OP/BP 4.04		x
Forests OP/BP 4.36		x
Pest Management OP 4.09		x
Physical Cultural Resources OP/BP 4.11		x
Indigenous Peoples OP/BP 4.10	x	
Involuntary Resettlement OP/BP 4.12		x
Safety of Dams OP/BP 4.37		x
Projects on International Waterways OP/BP 7.50		x
Projects in Disputed Areas OP/BP 7.60		x

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Independent Academic Institution		August 1, 2015	

Description of Covenant
The Recipient shall appoint, not later than August 1, 2015, and thereafter maintain throughout the Project implementation period, an independent academic institution, with terms of reference and qualification satisfactory to the Association, for the purposes of carrying out independent verification of DLI targets.

Name	**Recurrent**	**Due Date**	**Frequency**
Institutional Arrangements	X		

Description of Covenant
The Recipient shall maintain, throughout the Project implementation period, the National Program Coordination Office in the Ministry of Health, and project implementation staff at the PHO and DHO in each Target Province, all with a mandate, terms of reference, staffing and resources satisfactory to the Association.

Name	**Recurrent**	**Due Date**	**Frequency**
Memoranda of Understanding	X		

Description of Covenant
The Recipient shall make the proceeds of the Financing allocated to provincial DLIs available to the Target Provinces under an MOU with each Target Province, on terms and conditions satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
Project Operations Manual	X		

Description of Covenant
The Recipient shall carry out the Project in accordance with the Project Operations Manual, and not amend, waive or abrogate any provisions of the manual unless the Association agrees otherwise in writing.

Name	Recurrent	Due Date	Frequency
Annual Work Plans and Budgets			Annual

Description of Covenant
The Recipient shall furnish to the Association, not later than February 15 of each year, an annual work plan and budget for the Project for the following Fiscal Year, in a manner and substance satisfactory to the Association, and thereafter implement the activities under the Project during the relevant Fiscal Year in accordance with such plan and budget.

Name	Recurrent	Due Date	Frequency
Environmental and Social Safeguards	X		

Description of Covenant
The Recipient shall ensure that the Project is carried out in accordance with the ECOPs and EGDP, that the activities under the Project do not involve, or result in, any land acquisition or displacement of persons, and that any studies and TA activities to be supported by the Project are carried out under TOR satisfactory to the Association and are consistent with the Association's safeguard policies.

Name	Recurrent	Due Date	Frequency
Submission of Disbursement Linked Indicators Reports	X		Annual

Description of Covenant
The Recipient shall (i) not later than September 1 of each year during the implementation of this Project furnish reports to the Association on the status of achievement of the relevant DLI targets; and (ii) not later than September 1 of each year furnish to the Association the DLI verification reports of the independent academic institution.

Name	Recurrent	Due Date	Frequency
Contingent Emergency Response	X		Continuous

Description of Covenant
The Recipient shall adopt a satisfactory Emergency Response Manual for Component 5 of the Project and, in the event of an eligible crisis or emergency, ensure that the activities under said Component are carried out in accordance with such Manual and all relevant safeguard requirements.

Conditions

Source Of Fund	Name	Type
IDA	Withdrawal condition	Disbursement

Description of Condition

The Recipient may not withdraw the proceeds of the Financing allocated to Component 2 unless it has adopted the chapter of the POM related to Component 2, furnished evidence that it has achieved the respective DLI targets, including that the MOUs with the relevant target provinces have been executed, and furnished IUFRs documenting the incurrence of EEPs.

Source Of Fund	Name	Type
IDA	Withdrawal condition	Disbursement

Description of Condition

The Recipient may not withdraw the proceeds of the Financing as may be allocated to Component 5 unless an Eligible Crisis or Emergency has occurred, all related safeguards instruments and requirements have been completed, the emergency response implementing entities have adequate staff and resources, and the Recipient has adopted the Emergency Response Manual, acceptable to the Association.

Team Composition

Name	Title	Specialization	Unit
Johanne Angers	Senior Operations Officer	Operations	GHNDR
Leah April	Sr Public Sector Mgmt. Spec.	Public Sector Management	GGODR
Carmenchu D. Austriaco	Finance Officer	Project Finance	WFALN
Phetdara Chanthala	Health Specialist	Co-Team Lead	GHNDR
Khamphet Chanvongnaraz	Procurement Specialist	Procurement	GGODR
Manush Hristov	Senior Counsel	Legal	LEGES
Satoshi Ishihara	Senior Social Development Specialist	Social Development and Safeguards	GSURR
Ashi Kohli Kathuria	Sr Nutrition Spec.	Nutrition	GHNDR
Pema Lhazom	Senior Operations Officer	Operations	GHNDR
Magnus Lindelow	Program Leader	Peer Reviewer - Health	LCC5C
Zhentu Liu	Senior Procurement Specialist	Procurement	GGODR
Nkosinathi Vusizihlobo Mbuya	Senior Nutrition Specialist	Nutrition	GHNDR
Sutayut Osornprasop	Human Development Specialist	Social and Behavior Change Communication	GHNDR
Boualamphan Phouthavisouk	Team Assistant	Team Assistant	EACLF
Aleksandra Posarac	Program Leader	Peer Reviewer - Social Protection/ Community Development	EACPF

Laura L. Rose	Senior Economist	Co-Team Lead	GHNDR
Susanna Smets	Sr. Water & Sanitation Spec.	Water and Sanitation	GWASE
Lars M. Sondergaard	Program Leader	Program Leader	EACTF
Bounthavong Sourisak	Community Dev. Spec.	Community Dev. Spec.	GWASE
Natsuko Toba	Senior Economist	Energy/Cook-Stove pilot	GEEDR
Fred Yankey	Sr. Financial Management Specialist	Financial Management	GGODR
Siriphone Vanitsaveth	Financial Management Specialist	Project Financing	GGODR
Ruxandra Floroiu	Senior Environment Engineer	Environmental safeguards	GENDR
Viengsamay Vongkhamsao	Sr. Water & Sanitation Spec.	Water & Sanitation	GWASE
Saysanith Vongviengkham	Public Sector Specialist	Public Sector Reform	GGODR
Almud Weitz	Principal Regional Team Leader	Peer Reviewer - Water and Sanitation	GWASE
Dinesh Nair	Sr. Health Specialist	Service Delivery, DLIs	GHNDR
Maya Port	Counsel	Legal	LEGES
Sabrina Terry	Program Assistant	Program Assistant	GHNDR
Peter Crawford	Environmental Specialist	Environmental safeguards	GENDR
Claudia Rokx	Lead Health Specialist	Peer reviewer-Nutrition	GHNDR

Extended Team

Name	Title	Office Phone	Location
Gerard Servais	Sr. Health Specialist ADB	+ 632 632 5282	Manila, Philippines
Ken Newcombe	Lead Consultant (CEO, C-Quest Capital)	+1 240 491 2650	Washington, DC
Hope Phillips	Consultant, Operations	+1 703 569 8551	Springfield, VA
Birte Holm Sørensen	Consultant, Service Delivery, DLI approach	+4561606147	Copenhagen
Wei Aun Yap	Consultant, Economic Analysis		Kuala Lumpur, Malaysia

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Lao People's Democratic Republic	Xiangkhoang	Xiangkhouang	X		

Lao People's Democratic Republic	Xiagnabouli	Xaignabouli	**X**		
Lao People's Democratic Republic	Savannahkhet	Khoueng Savannakhet	**X**		
Lao People's Democratic Republic	Salavan	Salavan	**X**		
Lao People's Democratic Republic	Phongsali	Khoueng Phongsali	**X**		
Lao People's Democratic Republic	Oudomxai	Khoueng Oudomxai	**X**		
Lao People's Democratic Republic	Louangphabang	Luang Prabang Province	**X**		
Lao People's Democratic Republic	Loungnamtha	Louangnamtha	**X**		
Lao People's Democratic Republic	Houaphan	Houaphan	**X**		
Lao People's Democratic Republic	Champasak	Champasak	**X**		
Lao People's Democratic Republic	Attapu	Attapu	**X**		
Lao People's Democratic Republic	Xekong	Khoueng Xekong	**X**		
Lao People's Democratic Republic	Bokeo	Khoueng Bokeo	**X**		

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required?
Consultants will be required

I. STRATEGIC CONTEXT

A. Country Context

1. With a current Gross National Income per capita of US$1,600 in 2014 and a population of 6.7 million, Lao People's Democratic Republic (PDR), though still one of the poorest countries in Southeast Asia, is currently undergoing a rapid economic expansion. The country is endowed with natural resources and is part of a fast growing region. This combination of comparative advantages, along with policy steps to exploit them, has yielded an average real GDP growth rate estimated at close to 7.5 percent per year for the past 15 years.

2. The poverty rate halved in two decades from 46 percent in 1992/1993 to 23 percent in 2012/2013. Despite such decline, the poverty rate in rural areas, where nearly three-fourths of the country's 6.7 million people live, is still high (28.6 percent); this is almost three times the rate in urban areas (10 percent). Substantial disparities remain across ethno-linguistic groups, with the Lao-Tai group having much lower poverty rates (15 percent) than the other three groups (an average of close to 40 percent).

B. Sectoral and Institutional Context

3. Lao PDR has made steady and significant progress on key population health outcomes over the past few decades. Life expectancy has increased to almost 68 years in 2012, up from 49 years in 1980. The mortality rate for children under the age of five has also declined significantly over the same period: from 201 per 1,000 live births in 1980 to 71 in 2013. Notable progress has been made in improving maternal health, with maternal mortality decreasing from 1,600 per 100,000 live births in 1990 to 220 in 2013. The total fertility rate has also declined steadily from an estimated 6.0 births per woman in 1990 to 3.2 in 2013.[1]

4. The gains in nutrition have been smaller. In Lao PDR, 44 percent of children under five years of age (around 417,000) are stunted (low height for age), 27 percent are underweight and 6 percent are wasted (low weight for height). Since the early 1990s, stunting has declined at an average annual rate of 0.8 percent. Prevalence of stunting among children from the poorest households is three times higher than that in the richest households. Even amongst the richest households, 20 percent of children suffer from stunting.

5. Low coverage and income disparities in the use of high impact interventions such as family planning and post-natal care for newborns have a negative impact on reproductive, maternal, neonatal and child health (MNCH) outcomes. Skilled birth attendance, a key determinant of maternal mortality, is 42 percent and utilization ranges from 11 percent in the poorest quintile to 91 percent by the richest.

6. Public financing for health care has increased substantially since fiscal year 2011/12, from US$63 million to US$197 million in 2012/13, equaling approximately 1.9 percent of GDP or 7.5 percent of total government expenditures. A large proportion of this increase is due to increases in wages following government reforms of civil service compensation, however, non-

[1] World Development Indicators, 2013.

wage recurrent expenditure has also increased substantially. Nonetheless, spending per capita was low compared to other lower middle income countries and out of pocket (OOP) spending remains high at 38 percent of total health spending.

7. In recent years, the Government of Lao PDR (GOL) has introduced free care for maternal and child health (MCH), and financial protection mechanisms for the poor, such as health equity funds. While these programs have helped to reduce financial barriers, problems with the availability of quality health services remain. Vitamin A distribution, for example, does not reach 41 percent of children age 6-59 months. Primary health centers are typically understaffed, compromising the conduct of regular outreach activities. On the demand side, barriers such as ethno-linguistic barriers, cultural barriers, and physical access should be addressed.

8. The Asian Development Bank (ADB) is simultaneously preparing a Health Sector Governance Program, which, along with the World Bank and other donors, will support the GOL's Health Sector Reform Strategy (HSRS). The ADB Program, which totals US$20 million, includes a program loan of US$13 million, which is based on achievement of a set of policy triggers, and a project loan of US$7 million to support implementation of the program loan and capacity development.

C. Higher Level Objectives to which the Project Contributes

9. The Project supports two GOL programs to improve health and nutrition outcomes. The first is the HSRS (approved in 2013), which, was built around five priority areas: (a) human resources for health; (b) health financing; (c) governance, organization, and management; (d) health service delivery; and (e) health information systems. The HSRS will contribute to GOL's efforts to achieve the Millennium Development Goals (MDGs) for health, and poverty reduction goals and make services available to the disadvantaged. The second is the Multi-sectoral Food and Nutrition Security Action Plan (MFNSAP), which has been drafted to accelerate actions to address the crisis in under-nutrition.

10. The proposed Project contributes to the "Inclusive Development" Theme of the World Bank Group's FY12-16 Country Partnership Strategy for Lao PDR,[2] which in turn is closely aligned with the Seventh National Socio Economic Development Plan, as well as the draft of the Eighth. The proposed Project is well aligned with the World Bank Group's Twin Goals to reduce poverty and promote shared prosperity by focusing Project interventions at the sub-national level and frontline health facilities and by incentivizing integrated outreach services in reproductive, MCH, and nutrition services, especially in the more remote areas.

[2] The World Bank Group's Country Partnership Strategy FY12-16 (Report no. 66692-LA) discussed by the Executive Directors on March 8, 2012 and the Country Partnership Strategy Progress Report (Report no. 90281-LA)

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

11. The Project development objective is to help increase coverage of reproductive, maternal and child health, and nutrition services in target areas in Lao PDR.[3]

B. Project Beneficiaries

12. The Project focuses on reproductive, maternal, and child health and nutrition services. Over the five-year implementation period, the Project is expected to benefit approximately 1 million pregnant women, family planning users, and children age 0 to 23 months across 14 provinces.[4] In addition, children in high priority nutrition districts will benefit from changed behaviors and practices of their caregivers, resulting from intensive social and behavior change communication (SBCC).[5] Indirect benefits will accrue to other members of the communities, as well as the health staff. Project beneficiaries are overwhelmingly women.

C. PDO Level Results Indicators

13. The PDO indicators are:
(a) Number of women who deliver with a skilled birth attendant (SBA)
(b) Number of pregnant women having received 4 antenatal care visits
(c) Number of women 15-49 years who have adopted long-term methods of family planning
(d) Percentage of children age 0-6 months exclusively breastfed.

III. PROJECT DESCRIPTION

A. Project Components

Component 1: Health Sector Governance Reform (US$0.5 million equivalent)

14. This Component will support: (a) development, implementation and maintenance of an improved health management information system (HMIS) of the MOH; and (b) technical support, capacity building and training for MOH staff at the central, provincial and district levels in the use of such system. The Component will also support development and implementation of improved business processes for notification of births, and training for MOH staff in the use of the system.

15. This HMIS is utilized by the MOH to report on their health indicators and provides key management information to inform policy direction and resource allocation. Data generated by

[3] The use of the word, *coverage*, in the PDO is aligned with Monitoring Progress towards UHC: Framework, Measures, and Targets, WHO and World Bank, 2014.

[4] Oudomxai, Phongsaly, Luang Namtha, Bokeo, Xienkhouang, Luang Prabang, Houaphan, Sayaboury, Savannakhet, Champasak, Saravan, Sekong, Attapue, and Xaysomboun.

[5] Component 3 will target approximately 800 villages in three priority nutrition Provinces: Luang Namtha, Oudomxai, and Saravan.

this system will be utilized to inform on targets to be attained in order to ascertain achievement against the disbursement-linked indicators (DLIs) supported under Component 2, Service Delivery.

Component 2: Service Delivery (US$19.4 million equivalent)

16. This Component will support the carrying out of a program of activities designed to strengthen the HMIS at the central level to support and oversee the implementation of decentralized health and nutrition service delivery. It will also support the carrying out of a program of activities designed to strengthen: (a) the health system administration, management, financial management, and monitoring and evaluation at the provincial level; and (b) the delivery of reproductive, maternal and child health, and nutrition services at the provincial, district, village and health facility level in target provinces.

17. Financing for this Component will be provided based on results tracked by DLIs, which are a set of tracer indicators aimed at measuring performance against service delivery outputs and health system strengthening actions. Two sets of DLIs have been adopted. One set of four DLIs at the Central level focuses on management and health system actions that support decentralized service delivery. The second set of DLIs focuses on service delivery in the 14 target provinces.[6]

18. While the DLIs will measure performance against the same seven indicators in each province, there will be 14 province-specific DLI tables which indicate the province-specific baseline, the target and the amount the individual province can receive for each DLI. The total amount available for Component 2 for each province will be allocated based on provincial level population, poverty, and health facility data. The World Bank will disburse funds to the Ministry of Finance (MOF) upon achievement of the central-level DLI targets, which are monitored annually and subject to verification by an independent academic institution. Funds will be disbursed to each of the provinces based on their annual achievement against province-specific DLI targets. The provincial DLIs will be monitored through the HMIS and provincial registers. In addition, a supervisory checklist will be introduced to periodically review performance of the health centers and district hospitals. Support for the independent verification is provided under Component 4. Table 2 below presents the relationship between the DLIs and the PDO.

19. At the request of GOL, financing for Component 2 has been frontloaded in the first three years of the Project. This aligns the Project with the ADB's program loan, which has a three-year implementation period, with the expectation of a follow-on program loan if the policy triggers are met. It also ensures target provinces receive sufficient funds to achieve the DLIs. The end of project targets are realistic given the likely increases in public financing for health over the next five years and likelihood of additional funding from the World Bank and other donors.

[6] The other four provinces were not selected because three are supported by Lux-Development and Vientiane's coverage rates are already high and it would be difficult to reach DLI targets.

Table 2: Disbursement-Linked Indicators Relationship to the PDO

Indicator	How the DLI contributes to the PDO
Central Level Indicators to support provincial services	
Central Level DLI 1: Percentage of HMIS data reports from the Target Provinces provided on time and fully completed in accordance with the the National Guidelines for DHIS2 implementation	The DHIS2 is the key tool to monitor outputs in the provinces; by regularly monitoring the performance on completing the required HMIS forms, the MOH is in a position to provide assistance to provinces, which underperform, thereby contributing to improving overall performance. This will also contribute to the introduction of a culture of data review and use.
Central Level DLI 2: Number of Target Provinces which have two quarters' stock of Essential Family Planning and Nutrition Commodities	Adequate supply of family planning and nutrition commodities are essential for increased use, including long term methods and for provision of adequate nutrition counselling and services to pregnant women and children <5 years.
Central Level DLI 3: Number of Target Provinces in which the number of health centers without a community midwife has been reduced	Increasing number of Community Midwives posted to provinces will increase access to MCH and nutrition services thereby contributing to an increase in skilled attendance at birth as well as regular monitoring of the growth of children < 5 years.
Central Level DLI 4: Number of women in Target Provinces who receive free maternity health care services	Cost of maternity services is one of the barriers to utilization. Removal of fees will increase coverage of women who receive adequate maternity care, particularly of those unable to pay, thereby contributing to reduction of maternal and neonatal mortality
Provincial Service Delivery Indicators	
Provincial Level DLI 1: Number of women who deliver with a skilled birth attendant at home or at a health facility	While maternal mortality is dependent on the full Continuum of Care (family planning (FP), ante natal care, care at delivery, and post natal care-PNC), the globally accepted proxy to track progress of maternal mortality is 'skilled attendance at birth'.
Provincial Level DLI 2: Number of pregnant women who receive 4 Antenatal Care Contacts	Increasing the number of pregnant women registering for ANC before 3 months and complete at least 4 ANC visits (giving iron and folic acid supplements, monitoring blood pressure and urine (for sugar and protein), provide malaria prophylaxis and deworming tablets, weight monitoring and nutrition counseling, sensitization for assisted delivery and PNC within a week of delivery) will contribute to reducing maternal and neonatal mortality and stunting.
Provincial Level DLI 3: Number of new women aged 15-49 years adopting long term methods of family planning	The unmet need for family planning is 27.6 percent, and even higher among women in rural areas (28 percent). More than 60 percent of women in rural areas say they do not want more children. Increasing use of these methods for women in remote areas will contribute to a fertility reduction, an increase in birth spacing and a reduction of maternal and neonatal mortality.
Provincial Level DLI 4: Number of children under 5 years who receive nutrition counselling and an updated growth chart in accordance with MOH guidelines	44% of the children <5 years are stunted. Ensuring that children are regularly weighed, and nutrition counselling provided will contribute to a reduction in child malnutrition and thereby reduce child morbidity and mortality and increase school performance.

Table 2: Disbursement-Linked Indicators Relationship to the PDO

Indicator	How the DLI contributes to the PDO
Provincial Level DLI 5: Number of villages in Zones 2 and 3 with health centers in which Integrated Outreach Sessions are conducted at least four times during the year	Most of the population, especially the poorer sections and the marginalized, live > 2 hours from the nearest health facility; integrated outreach services are essential for increasing service coverage for these women and children. Integrated outreach services are especially important to address malnutrition of pregnant women and children in districts identified as having a high rate of malnutrition.
Provincial Level DLI 6: Percentage of health centers and district hospitals in the Target Pronvices which score more than 50% on the Standard Supervisory Checklist for every quarter of the Year	Standardized supportive supervision is a strong tool to ensure that all the elements required to provide quality services are in place. Regular supervision will contribute to improvement of the quality of the MNCH services provided.
Provincial Level DLI 7: Percentage increase in Target Pronvice non-salary health recurrent expenditure allocated to the districts	An increase in the non-salary health recurrent budget at the primary health care level will increase the operational budget at facility level and allow staff to undertake facility and equipment maintenance, conduct outreach, and purchase minor supplies, thereby improving both the quantity and quality of services provided.

Component 3: Nutrition Social and Behavior Change Communication (US$4 million equivalent)

20. This Component will support the development of an integrated national strategy and implementation plan for social and behavioral change communication to improve nutrition. It will also support implementation of the strategy at the national level and at the village level in selected priority districts, including development and production of marketing and communication tools and materials, and facilitation of training and communication sessions at the village level with a focus on sanitation, personal and environmental hygiene, maternal and child health, and/or other determinants of health and nutrition.

21. This Component will complement the health facility and community-based nutrition-related services supported under Component 2 by financing the implementation of nutrition- and health-related SBCC. SBCC content will cover both nutrition-specific as well as nutrition-sensitive interventions.

Sub-Component 3.1: Preparing an SBCC Strategy (US$0.5 million equivalent)

22. This sub-component will help the National Nutrition Committee prepare a high impact, integrated SBCC strategy, which is a key priority identified in the MFNSAP. The sub-component will finance technical assistance (TA) for: (a) stocktaking of existing SBCC materials and delivery approaches, as well as additional formative research (mostly qualitative) to help fill priority gaps (e.g., maternal nutrition); (b) development of an integrated SBCC Strategy and Implementation plan, including stakeholder consultation; and (c) development of an SBCC campaign concept and umbrella slogan, and a set of integrated campaign tools, such as mass media tools (television spots, videos, radio programs, posters, banners, social media applications,

and collaterals), and also tools/scripts to organize community edutainment events interpersonal communications toolkits for village facilitators, as well as job-aids for health center (outreach) staff.

Sub-Component 3.2: Implementation of SBCC Strategy (US$3.5 million equivalent)

23. At the national level, the sub-component will supplement the existing government budget to finance the following items: (a) delivery costs of the mass-media campaign, including air-time/radio time, social-media costs, staging of community edutainment events focused on selected districts; (b) printing/production costs for SBCC materials, including job-aids for health center (outreach) staff, village facilitator toolkits, posters and production of other collaterals; and (c) equipment needs for villages to support SBCC activities, such as height boards and weighing scales, as well as equipment for SBCC-activities supported by the District Health Office (DHO).

24. At the village level, the sub-component complements national activities through community-based SBCC activities aimed at contributing to improvements in: (a) maternal nutrition and related caring practices; (b) infant and young child feeding and caring practices; (c) appropriate sanitation and personal as well as environment-related hygiene behaviors; (d) Household Air Pollution (HAP) through use of near smokeless cookstoves; (e) dietary diversification; and (f) other determinants of nutrition at the village level. Village-based facilitators, who will comprise mostly female village health volunteers and/or members of Lao Women's Union, will support the SBCC implementation at the village level under the guidance of district health staff. The geographical area of the village-level activities will be identified by the government, and would include priority target "convergence" districts in three provinces from the MFNSAP following a phased approach and with the aim to cover entire districts.[7] The delivery mechanism and implementation are expected to be replicated and scaled up in other areas, contributing to sustainability.

25. Two innovative multi-sectoral programs are highlighted:

(a) Open Defecation Free (ODF) villages[8]. While SBCC activities will deliver messages on sanitation and hygiene to target audiences, complementary community mobilization is needed to empower villagers to collectively stop the practice of open defecation. In line with the priority actions under MFNSAP, the project will support district-wide implementation of Community-Led Total Sanitation (CLTS) for the targeted districts. The project will not pay for construction of latrines, as households are expected to self-finance.

(b) Clean cookstoves. The GOL has created a Lao Clean Stove Initiative Inter-Ministerial Taskforce and initiated an assessment of the practicability and cost-effectiveness of introducing near smokeless "super-clean" cookstoves into households in the poorest rural communities of Lao PDR. Cleaner and more convenient cookstoves contribute to the

[7] The priority districts are: Sing, Long, Viengphouka, Nalae, Nga, Beng, Hoon, Pakbeng, Ta Oi, Lao Ngarm, Samuoi

[8] The definition of ODF in Lao PDR includes that 100 percent of families (including shared households) own and use an improved sanitation facility and all households have installed hand washing facilities.

Project's objectives by improving food safety and treatment of household water by boiling. Addressing HAP and promotion of clean cookstoves will be included in the behavioral change activities under the Project. Annex 7 has more details on the initiative.

Component 4: Project Management, Monitoring and Evaluation (US$2.5 million equivalent)

26. This Component will support provision of technical and operational assistance for the day-to-day coordination, administration, procurement, financial management, environmental and social safeguards management, and monitoring and evaluation of the Project, including the development of checklists for supervision of health facilities, the conduct of third-party verifications by an independent academic institution of the achievement of DLIs, and the carrying out of financial audits of the Project.

27. This Component will also support provision of TA for capacity building of MOH staff at the provincial and district levels for the monitoring and reporting of DLIs, capacity building of MOH staff at the national, provincial and district levels for health program planning and implementation, and carrying out of studies and surveys necessary to inform the implementation of Project activities.

Component 5: Contingent Emergency Response (US$0 million)

28. The objective of the contingent emergency response component, with a provisional zero allocation, is to allow for the reallocation of financing in accordance with the IDA Immediate Response Mechanism in order to provide an immediate response to an eligible crisis or emergency, as needed. An Emergency Response Manual (ERM) will be developed for activities under this component, detailing streamlined financial management (FM), procurement, safeguard and any other necessary implementation arrangements.

B. Project Financing

29. The proposed Project will use Investment Project Financing. Component 1 will use traditional input-based financing. Component 2 will disburse against an eligible expenditures program (EEP) linked to the achievement of targeted results for DLIs. Components 3 and 4 will also use traditional input-based financing. Component 5 provide an immediate response to an eligible crisis or emergency, as needed. An Emergency Response Manual (ERM) will be developed for activities under this component. Annex 2 provides more details.

Table 3: Project Cost and Financing by Component (in US$ Million)

Project Components	Project cost	IDA Financing	% Financing
1. Health Sector Governance Reform	0.50	0.50	100
2. Service Delivery	19.40	19.40	100
3. Nutrition Social and Behavior Change Communication	4.00	4.00	100
4. Project Management, Monitoring and Evaluation	2.50	2.50	100
5. Contingent Emergency Response	0.00	0.00	100
Total Financing Required	**26.40**	**26.40**	**100**

C. Lessons Learned and Reflected in the Project Design

30. The Project is informed by various analytical and advisory work on updates to public expenditures, MNCH OOP, and a policy note on nutrition. The Project incorporates lessons from the on-going World Bank Health Sector Improvement Project (HSIP) (*IDA Grants H1830, H6950, and TF10518*) and ADB supported health projects, [9]the recently closed Community Nutrition Project (CNP) (*IDA Grant TF095274 and TF97071*), and World Bank experience in multi-sectoral nutrition and DLI-based operations.

(a) ***Keep it simple***. The Project comprises mutually supportive activities (systems and service) focused on a limited set of achievements.
(b) ***Focus on results***. Utilizing the DLI approach, supporting Government's stated targets and priorities, it is expected to place the focus on achieving results and encourage an integrated approach to increase efficiency.
(c) ***Avoid fragmentation of development partner inputs and parallel systems***. The proposed Project forms one part of program support being provided by ADB and Lux-Development in support of MOH. It also complements existing partner support and will utilize already established existing report-back structures to keep both MOH and the partners apprised of progress.
(d) ***Utilization of Government indicators***. Indicators to measure progress have been carefully selected and defined and targets proposed are realistic.

[9] World Bank (2012), *Government Spending on Health in Lao PDR: Evidence and Issues*, Policy Report, Vientiane: World Bank. World Bank Report No. 76229-LA
World Bank (2013), *Maternal Health, Child Health, and Nutrition in Lao PDR: Evidence from a Household Survey in Six Central and Southern Provinces*, World Bank Policy Report No. AUS 1920, Vientiane: World Bank.
World Bank (2014), *Evaluating Demand-Side Interventions and Community Mobilization to Expand the Uptake of Essential Maternal and Child Health in Lao PDR: Impact Evaluation of the Community Nutrition Project in Lao PDR*, Independent Evaluation Group Draft Policy Report, Washington, DC: World Bank.
World Bank (2015), *Nutrition in Lao PDR: Trends, Patterns, Response, And Implications For Policy*, Draft Policy Note, Washington, DC: World Bank.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

31. The Project will be implemented by the MOH through the Department of Planning and International Cooperation (DPIC), MOH technical departments and 14 provincial Health Offices (PHOs) and DHOs. Responsible MOH departments include: (a) DPIC; (b) Hygiene and Health Promotion; (c) Health Care; and (d) Finance.

32. The MOH intends to establish a National Program Coordination Office (NPCO) in the DPIC that would be responsible for the execution of the ADB and IDA financed Projects. The Director General of the DPIC will be the Program Director. The NPCO will be responsible for *inter alia*: (a) the overall administration of the Project, including the preparation of annual work plans and budgets and approval of the Project Operations Manual; (b) the overall implementation of Project activities and achievement of DLIs at the national level with the support of MOH technical departments and those PHOs and DHOs participating in the Project; (c) the overall administration of financial management, procurement, environmental and social safeguards management, and communication of all Project activities; (d) the overall monitoring, evaluation and reporting of Project activities and DLIs; and (e) reporting to Technical Working Groups on the implementation of Project activities and the achievement of DLIs.

33. The NPCO will also be responsible for preparing the terms of reference (TORs) and providing input to various procurement related committees which will be established, while the Procurement Unit will handle the procurement aspects and contract management. For matters pertaining to FM, the NPCO will be responsible for ensuring that the activities undertaken are in line with the Financing Agreement, as well as for preparation of documents pertaining to FM. This includes, but is not limited to, ensuring appropriate documentation is maintained, quarterly reports are prepared, and documents necessary for annual audits are prepared.

34. The PHOs will be responsible for: (a) the implementation of Project activities and achievement of DLIs at the provincial level; (b) the monitoring and reporting to the MOH of Project activities and achievement of DLIs at the provincial level; and (c) the provision of technical support to DHOs in the implementation of Project activities at the district level and village level.

35. The DHOs will be responsible for: (a) the implementation of Project activities at the district and village level and reporting to the PHO on said activities; and (b) the supervision and provision of technical support to health facilities in their delivery of reproductive, maternal and child health, and nutrition services.

36. Although the World Bank's fiduciary and safeguard policies do not apply to the ADB-financed project, the World Bank and ADB have agreed to rely on common government implementation arrangements and to align as much as possible their fiduciary and safeguard requirements in support of the government's program. To this end, the World Bank and ADB will rely on common safeguard instruments and operational manual which have been prepared by the Government to satisfy the fiduciary and safeguard requirements of both institutions, and

will undertake joint implementation reviews. More details on implementation arrangements are in Annex 5.

B. Results Monitoring and Evaluation

37. The Results Framework is provided in Annex 1. The DLIs will be a subset of the fuller list of indicators, which will be monitored regularly through various information sources, including the existing health management information system, whose data quality will be strengthened as part of the support to health governance reforms in Component 1. The DLIs need more intensive monitoring and ***independent verification***, to determine the amount of IDA disbursements. MOH will contract a qualified independent academic institution to carry out independent verification of the DLI report. The project will have a strong system of monitoring and evaluation (M&E) based on the existing MOH system for the disbursement of IDA funds (see Annex 3 for a more detailed description of the M&E arrangements). Mechanisms to monitor the SBCC activities at the village level will be finalized as part of the larger program of donor support to the MFNSAP.

C. Sustainability

38. ***Financial sustainability.*** Although current levels of domestic and total health spending are low considering the economic status of Lao PDR, in keeping with the government's target to increase health spending to 9 percent of government spending, planned government health expenditure has already increased substantially in the current fiscal year. With such real increases in domestic health spending expected, the financing of essential health services is fiscally sustainable, especially since providing financial risk protection contributes economically through protecting households from impoverishing health expenditure and liberating precautionary savings.

39. ***Institutional sustainability*.** The proposed Project, as described earlier, is aligned with the Government's priorities for health, builds on experiences gained through the HSIP and CNP where fee reimbursements and payments were made for health outputs provided, known as 'results-based financing.' Proposed activities include specific governance interventions and service-delivery activities (Component 2) using DLIs which will use and strengthen existing central MOH and provincial government structures, human resources, and mechanisms for fund-flows, reporting (using DHIS2, under Component 1), planning, and other implementation aspects. Component 3 will use and strengthen existing government structures, system, and human resources, including existing village-based structures such as village health volunteers and Lao Women's Union. The responsibility of any external consultants contracted will include knowledge transfer as part of their TORs, as well as be one of the aspects on which their performance will be evaluated.

40. ***Technical sustainability***. Most of the project financing will be used for on-going programs in MCH. The project includes resources to continue to build capacity at both the central and sub-national levels. The design of the DLIs takes into consideration the importance of intra-sectoral collaboration to achieve efficiencies with a view to contributing to technical sustainability.

V. KEY RISKS

Overall Risk Rating and Explanation of Key Risks

41. The overall Project risk is substantial. There is a risk that the project may not reach the poor and underprivileged such as non-Lao Tai ethnic groups residing in difficult to reach areas. This risk will be mitigated by incentivizing integrated outreach services especially to the more remote areas. Another risk is that women may be encouraged to use long-term family planning methods without sufficient knowledge. This risk will be mitigated by using the existing cadre of family planning volunteers supported by UNFPA to provide counseling. Midwives will also receive training in family planning counseling. The project introduces results-based financing on a large scale through DLIs. There is a risk that the MOH and Provincial Health Officers may take time to understand this new funding mechanism and may not use the additional funding optimally for achieving the agreed objectives. The Project will provide capacity building on the new funding mechanism at the central and provincial levels. Verification of achievement of the DLIs by an independent agent is crucial, and funds have been allocated under Component 4 to contract an independent academic institution to fulfill this requirement.

42. In consideration of the IDA 17 climate change agenda, this operation has been screened to identify, and, if relevant, address any potential short- and long-term climate change and disaster risks. Between 1970 and 2010, there were 33 natural hazard events (mostly floods and droughts) affecting almost 9 million people and caused economic damage of over US$400 million. Based on the activities proposed for support, the Project is not expected to impact the climate.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

43. **Investing in efficiency**. Proposed project interventions include expanding coverage of immunizations, family planning, sanitation and nutritional status (chiefly stunting) which have high benefit-costs ratios[10] and have large positive externalities resulting in larger benefits to society than to just the individual.

44. **Investing in equity**. The project addresses equity by promoting (a) equitable access to health and nutrition services; (b) equitable and effective utilization of health and nutrition services; and (c) equitable protection from financial risk. With regard to equitable access, investments in outreach funded through provincial-level DLIs will allow health workers to reach and provide basic health and nutrition services to rural and remote communities. Nutrition-related social and behavioral change campaigns will further be held at village locations, thus allowing communities access to these activities. With regard to equitable and effective utilization of health and nutrition services, two perspectives are relevant and addressed by project interventions. From the supply-side perspective, funding through DLIs can and should be used by provincial health authorities to ensure the availability of essential medicines. From the demand-side perspective, constraints in optimal utilization due to poor health seeking knowledge

[10] (For stunting, this ratio is estimated at between 3.6 to 48, for rural sanitation the ratio is between 4 and 8.2

and behaviors will be addressed through outreach services to remote locations and the social and behavior change campaign. With regard to equitable protection from financial risks, the free MCH interventions which will receive investments under Component 2 will expand the geographical coverage of user fee waivers (and for certain services, cash transfers to cover transportation and opportunity costs).

45. **Financing and sustainability.** Per capita spending on health was approximately US$ 28 per capita in 2013/14. IDA financing over the five years would be around US$ .80 per person per year, an affordable increase given the country's growth. IDA financing from Component 2.2 which allocates funds directly to the 14 Target Provinces based on an allocation formula which used population, poverty, and number of health facilities would average about US$ 1 per capita per year over the first three years of the Project, a 15% increase from the current US$5 per capita expenditure in the Target Provinces. In a recent study[11], health centers reported average annualized non-wage recurrent expenditures of US$ 1 – 2 per capita population. Therefore, IDA funds could have a substantial impact if used appropriately.

B. Technical

46. The interventions are universally recognized as being among the most cost-effective and are expected to have a significant impact on MNCH and nutrition of children under two years. The empowerment of communities for nutrition activities will lead to their proactive involvement in local planning and implementation of health actions.

C. Financial Management

47. The Project will apply procedures and fiduciary requirements acceptable to the World Bank. An assessment of the FM arrangements has been carried out for this Project in accordance with OP/BP 10.00, and the overall FM risk is assessed as high. The main risks are associated with: (a) capacity of the staff at health centers, district level and provincial levels to manage the larger scale of operational budget; (b) inadequate guidance in planning and budgeting at provincial and district level; (c) delay in the release of funds due to inability to submit expenditure reports or approve budget on time; and (d) inadequate documentation of policies and procedures.

48. Disbursement under Component 2 (Category (1)) relating to the EEP will be based on the MOH fulfilling the following requirements: (i) adopting the Project Operations Manual, in form and substance satisfactory to the World Bank; (ii) furnishing evidence satisfactory to IDA that it has achieved the respective DLIs targets; including that a memorandum of understanding, in form and substance satisfactory to the World Bank, has been duly executed between the MOH and the target provinces; and (iii) furnishing to the World Bank the interim unaudited reports documenting the incurrence of EEPs against which withdrawal is requested. If the EEP is lower than the DLI values, the disbursement of IDA will be adjusted accordingly—a situation which is not expected to occur. The proposed EEP, which will be set forth in the Project Operations Manual, would consist of the GOL's expenditure line Chapter 10 (wages, salaries for

[11] World Bank, 2015. *Government Expenditure on Health in Lao PDR (under finalization).*

government health staff). The budget figure for Chapter 10 is adequate for the purpose of the EEPs. The interim unaudited report will also include evidence of the additionality that IDA funds bring to the central and the provincial level allocation of GOL and provincial budget (not applicable in the first year). Retroactive financing of up to SDR 3,760,000 may be provided under the IDA credit and grant to finance payments made for eligible expenditures during the period between October 1, 2014 and the signing of the Financing Agreement.

49. Funds disbursed for the central level will be transferred from the MOF to the MOH at the central level and for the provincial level DLIs from the MOF directly to the PHO following the GOL funds flow procedures. For the purpose of reimbursing against achievement of DLIs, a Memorandum of Understanding, including a province-specific DLI matrix, will be prepared and signed between the MOH and the provincial governor for each target province. To ensure sufficiency and timely release of funds, a bank account at the provincial level is required to be opened specifically to receive transfer of funds from MOF for the project. Once the funds are received into the provincial account, PHO will make transfers to levels below them according to their approved budget. For transfer to MOH at the Central level, the amount will be based on the value of the Central Level DLIs achieved. Based on verification reports,[12] MOH will make a request to MOF for the transfer. For district level activities under Component 3, funds will flow to the provincial and district accounts and will be allocated to relevant units under the DHO following GOL fund flow procedures.

D. Procurement

50. Procurement under the Project will be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 and revised in July 2014; and the "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 and revised in July 2014, and provisions stipulated in the Financing Agreement. The DPIC will be responsible for the procurement activities of this proposed project through its NPCO. NPCO will maintain the staffing required to carry out procurement. For each contract to be procured and financed under the project, the different procurement methods, estimated costs, prior review requirements, and timeframe will be defined in a Procurement Plan. The Plan will be updated at least annually, or as required, to reflect actual project implementation needs and improvements in the institutional capacity. Based on a procurement capacity assessment undertaken in preparation of the Project, the overall project risk for procurement is high. More detailed information is presented in Annex 3.

E. Social (including Safeguards)

51. The population of Lao PDR consists of the Lao-Tai group (67 percent), along with three major non-Lao-Tai ethno-linguistic groups, namely the Mon-Khmer (21 percent), the Hmong-Lu Mien (8 percent) and the Chine-Tibetan (3 percent). These groups further splinter into 49 distinct ethnicities and 200 ethnic subgroups. Components 2 and 3 will be implemented in districts where

[12] The verification reports will include the internal verification report, the external verification report from the independent academic institution and the un-audited expenditure statements for the EEP.

poor ethnic groups reside, thereby triggering World Bank Operational Policy 4.10 on Indigenous Peoples.

52. The DPIC, together with the DHHP, has undertaken a social assessment (SA) which included participatory assessments and free, prior and informed consultations with ethnic groups, in order to assess the Project's potential positive and adverse effects on local communities, including but not limited to ethnic groups, and examine alternatives where adverse effects may be significant. In particular, the SA has reviewed existing barriers for ethnic women and children to receive proper health services, including those related to language, traditions, customs, values, etc. Focus group discussions were conducted as part of the SA in three Provinces, one in each region of north, central and south, covering a total of 17 villages, through which perspectives of ethnic groups were collected and reflected in the Project design. The SA found a broad community support among ethnic groups who joined the participatory assessment to the Project.

53. The existing Ethnic Group Development Plan of the HSIP and CNP was updated based on the finding of the SA which provides measures to ensure free, prior and informed consultations with ethnic minorities during implementation leading to their broad community support, and steps to be taken to address barriers to their receiving project benefit and address negative impact that may occur, if any. It was disclosed in country on March 24, 2015 and on the World Bank website on April 16, 2015. A more detailed description of these documents is provided in Annex 3. Provisions to follow IDA safeguard policies, including OP4.01 will be included in the relevant TORs of TA.

F. Environment (including Safeguards)

54. The Project is considered category "B" in accordance with the World Bank policy OP/BP 4.01 on Environmental Assessment with potential environmental impact expected to be minimal as activities will not finance any civil works. There will be no new construction of buildings; rehabilitation or refurbishment of existing health centers or administrative offices or minor repairs (window rehabilitation, wall painting, internal wall demolition, etc.). The Project will support only TA-related activities to achieve open defecation free (ODF) villages such as operational costs for SBCC and CLTS, and training for village facilitators, health staff and sanitation businesses. The project is not expected to finance activities that may increase health care waste such as provision of medicine or medical equipment that may generate environmental impacts. The Project has been screened in accordance with IDA 17 climate change requirements.

55. No major impacts are anticipated on physical cultural resources, natural habitats or forests. Possible minor site specific environmental impacts could appear during installation and/or operation of latrines, which will be solely done by villagers. In this cases, an Environmental Code of Practice (ECOP) adopted by MOH and acceptable to the World Bank will be followed to address mitigation measures. The ECOP was disclosed in country for the purpose of the project public consultation held between March 25-29, 2015, in Bolikhamxay, Saravan, and Oudomxai. It was disclosed on the World Bank website on April 16, 2015.

56. For Clean cookstoves related activities that involve equipment replacement, installation, and/or operation, the MOH will adopt an ECOP acceptable to the World Bank prior to the

commencement of any such activities. The TORs for any TA activity that has environmental implication will follow World Bank policies and include considerations to ensure that measures are mainstreamed into these advisory services.

G. World Bank Grievance Redress

57. Communities and individuals who believe that they are adversely affected by specific country policies supported as prior actions or tranche release conditions under World Bank Investment Project Financing may submit complaints to the responsible country authorities, appropriate local/national grievance redress mechanisms, or the World Bank's Grievance Redress Service. The Grievance Redress Service ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of the World Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and World Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

Project Development Objectives

PDO Statement

The Project development objective is to help increase coverage of reproductive, maternal and child health, and nutrition services in target areas in Lao PDR.

These results are at | **Project Level**

Indicator Name	Unit of Measure	Core/Custom Indicator	Baseline [13]	Cumulative Target Values					
				YR1	YR2	YR3	YR4	YR5	End Target
Women who deliver with a skilled birth attendant at home or at a health facility (DLI P1)	Number		62,505	10% over baseline	20% over baseline	30% over baseline	40% over baseline	50% over baseline	50% over baseline
Pregnant women who receive 4 Antenatal Care Contacts (DLI P2)	Number		45,985	10% over baseline	20% over baseline	30% over baseline	40% over baseline	50% over baseline	50% over baseline
Number of new women aged 15-49 years adopting long	Number		235,145	10% over baseline	20% over baseline	30% over baseline	40% over baseline	50% over baseline	50% over baseline

[13] Baselines for DLI P1, P2, P3, and C4 are from DHMIS 2013/2014 and will be verified by independent academic institution prior to project effectiveness.

term methods of family planning (DLI P3)									
Children age 0-6 months in target high priority nutrition districts exclusively breastfed	Percent		Pending selection of districts						
Direct Project Beneficiaries	Number	Core							1.4 million
o/w female	Percent	Core							80

Intermediate Results Indicators

Indicator Name	Unit of Measure		Baseline	Cumulative Target Values					
				YR1	YR2	YR3	YR4	YR5	End Target
Component 1: New born children provided with birth Notification in target provinces	Percentage		TBD	Action plan approved by MOH	10% over baseline	20% over baseline	30% over baseline	40% over baseline	40% over baseline
Component 2: Villages in Zones 2 and 3 in the areas of the health centers where integrated outreach sessions are conducted at least four times during the year (DLI P5)	Number		0	10% over baseline	20% over baseline	30% over baseline	40% over baseline	50% over baseline	50% over baseline

Component 2: Women in Target Provinces who receive free maternity health care services (DLI C4)	Number		47,066	10% over baseline	20% over baseline	30% over baseline	40% over baseline	40% over baseline	40% over baseline
Component 2: Health centers and district hospitals which score more than 50% on the Standard Supervisory Checklist for every quarter of the Year (DLI P6)	Percentage		TBD	All district health teams trained and scores reported for two quarters	30% over baseline	50% over baseline	70% over baseline	80% over baseline	80% or more
Component 3: Female village facilitators trained in SBCC in target districts	Number		0	200	600	1200	1600	1600	1,600
Component 3: Children under 5 years who receive nutrition counselling and an updated growth chart in accordance with MOH guidelines (DLI P4)	Percentage		Pending selection of districts	10% over baseline	20% over baseline	30% over baseline	40% over baseline	% over basel	50% over baseline
Component 3: Villages declared open defecation free in target districts	Number		0	30	105	240	360	400	400
Component 3	Percentage			Baseline		10%		25% incr	25% increase

Beneficiaries reporting satisfaction with social and behavior change communications activities taking place in their communities				to be determined		increase over baseline			over baseline

Indicator Description

Project Development Objective Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Number of women who deliver with a skilled birth attendant at home or at a health facility (DLI P1)	Skilled Birth Attendance refers to workers/attendants which are accredited health professionals - such as a midwife, doctor or nurse - who have been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Both trained and untrained traditional birth attendants (TBA) are excluded.	quarterly	DHIS2, independently verified annually	MOH/Third Party Verifiers
Number of pregnant women who receive 4 Antenatal Care Contacts (DLI P2)	This indicator measure the number of pregnant women in target provinces receiving four antenatal care services during pregnancy at home or outreach as described in the Integrated Package of Maternal Neonatal and Child Health Services.	quarterly	DHIS2, independently verified Annually	MOH/Third Party Verifiers
Number of new women aged 15-49 years adopting long term methods of family planning (DLI P3)	This refers to the number of women aged 15-49 years who are using a long-term method of family planning for the first time, including intra-uterine device (IUD), injectable, or the implant (including Norplant). Excluding pills and condoms.	Semi-annual	UNFPA, independently verified annually	MOH/Third Party Verifiers
Children age 0-6 months in target high priority nutrition districts exclusively	This indicator measures the percentage of children 0–6 months of age in the target high priority nutrition districts who are fed	Baseline, mid-project, and end of	survey	MOH/NNC

breastfed	exclusively with breast milk.	project		

Intermediate Results Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Health Sector Governance Reform - New born children provided with birth Notification in target provinces	This indicator refers to the number of new born children in target province who received birth notification provided by health facilities staff. Baseline will be established prior to project effectiveness	Monthly	DHIS2, independently verified	MOH/Third Party Verifiers
Number of villages in Zones 2 and 3 in in the areas of the health centers which Integrated Outreach Sessions are conducted at least four times during the year (DLI P5)	This indicator refers to the number of villages located 5-10 km (zone2) and more for zone 3 which received integrated outreach packages of services including EPI, FP, ANC, Weighing and nutrition counselling for children under 5.	Semi-annual	DHIS2, independently verified	MOH/Third Party Verifiers
Number of women in Target Provinces who receive free maternity health care services (DLI C4)	This indicator is calculated as number of women aging 15-49 years old who received free full maternal services such as ANC, delivery and PNC at different provinces where free maternal service is available (not only at the project provinces and districts).	Semi-annual	DHIS2	MOH/NHIB
Percentage of health centers and district hospitals which score more than 50% on the Standard Supervisory Checklist for every quarter of the Year (DLI P6)	This indicator refer to number of health center and district hospital has gone through quality assessment by applying standard supervision checklist with score > 50%. Determination of baseline is required to disburse Year 0 of this DLI	Annual	Provincial reports	Provincial Health Office
Social and Behavior Change Communication-Female village facilitators	This refers to the female villages who will be trained in transferring key sanitation and hygienic messages to the villagers	Annual	Consolidated training report	PHO/MOH/ DPIC

trained in SBCC in target districts	under their catchment areas.			
Social and Behavior Change Communication Number of children under 5 years who receive nutrition counselling and an updated growth chart in accordance with MOH guidelines (DLI P4)	This indicator refers to number of children aged < 5 receiving bi-monthly weighing and update growth chart which has been recorded at the health facilities registration book as well as follow up maternal and child health book (pink book).	Semi-annual	DHIS2, independently verified	MOH/Third Party Verifiers
Social and Behavior Change Communication - Number of villages declared open defecation free in target districts	This refers to the number of villages in target districts that all village members have adopted sanitation and hygienic practices after being trained by village facilitator and received the behavioral change messages.	Annual	Consolidated progress report	MOH/PHO
Percent of beneficiaries reporting satisfaction with social and behavior change communications activities taking place in their communities	This is a measure of community engagement to assess project activities.	3 times during project	Survey	MOH/DHHP

Annex 2: Detailed Project Description

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

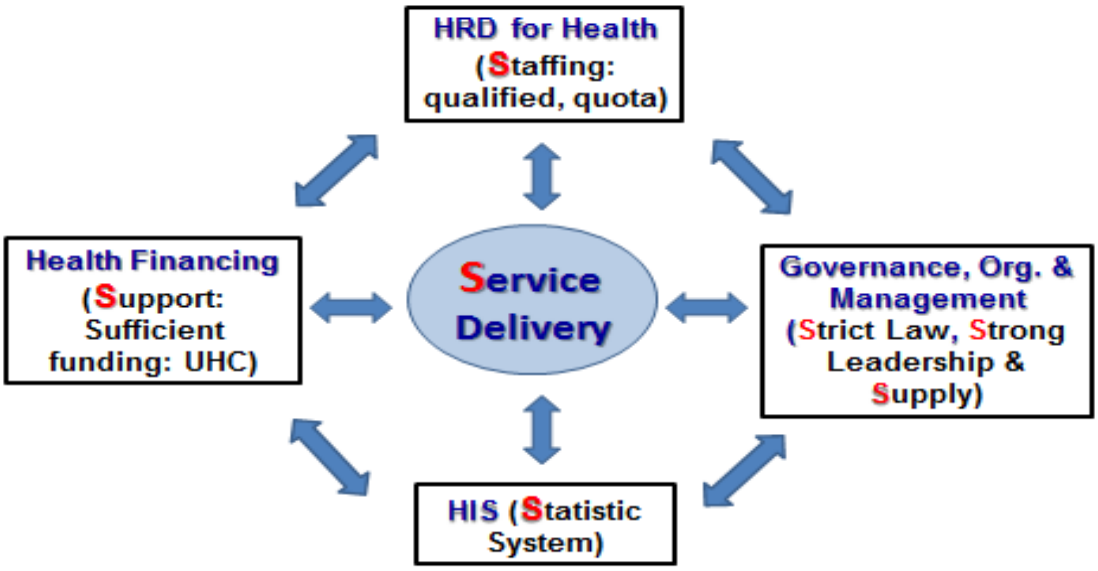
THE GOVERNMENT'S PROGRAM

58. The Project aims to support two GOL programs: the HSRF and the MNFSAP which are under the overall Government Policy Agenda and the eighth National Social and Economic Development Plan (2015-2020) which is under development. Over the past two years, development partners have provided their project and technical support around these two Programs. The Project would be one of several donors, along with GOL, which contribute to these Programs. The two Programs are complementary. In particular, the HSRF does include health actions to reduce nutrition. The MNFSAP is multi-sectoral focused on a single high priority issue, nutrition.

Health Sector Reform Framework

59. The HSRF aims to (i) improve access to basic health care and financial protection by 2020, and (ii) achieve universal health coverage by 2025. It has five priority areas (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 as depicted below.

Figure 2.1: The Health Sector Reform Framework



60. The ADB and IDA are preparing new projects to support the HSRF to complement support already provided by Lux-Development, UNICEF, UNFPA, and WHO. The ADB has a long and on-going engagement in the health sector with the Health Service Delivery Project, which focuses on Northern provinces while the World Bank-financed Project, the HSIP, covered the south and Lux-Development covered the middle. It has been agreed that ADB and IDA support to the HSRF will no longer be geographically based. Instead, each will support a piece of the Government's Program.

61. The UN agencies are expected to play an important role in implementing the HSRF, particularly in continuing technical assistance in HMIS (WHO), Health Financing (WHO), HRH (WHO, UNICEF, UNFPA), Governance (WHO) and Service Delivery (WHO, UNICEF, and UNFPA).

62. The ADB, IDA, and MOH and have agreed on the use of common implementation arrangements to the greatest extent possible. In addition, agreement in principle has been reached to carry out joint implementation reviews. The DPIC of the MOH will be the executing agency of the both Projects, and the ADB and World Bank intend to subscribe to common planning and reporting requirements, which will have (a) a common administrative structure; and (b) similar funds flow mechanisms. a shared operational manual, and to utilize similar coordination mechanisms by making use of appropriate existing MOH structures (such as Technical Working Group or Steering Committee), and undertaking joint implementation reviews.

A large portion of the IDA and ADB funds will go to provinces to support service delivery. The table below provides indicative cost estimates prepared by the DOF of the MOH of the demand and supply side requirements to achieve the Government targets: (a) all MCH services are provided free of charge, except in provincial capitals and Vientiane City and (b) 80 percent of the estimated number of poor families are enrolled in HEFs. Financing from IDA, the ADB, and GOL will provide US$52 million over three years and the estimated financing gap of US$13.7 million will be covered mostly by Lux-Development.

Table 2.1: Indicative Provincial Program Expenditure Plan, FY16-18 (US$ million)

	Cost	Source			GAP
		IDA	ADB	GOL	
Demand Side Program	**32.7**	**0**	**4**	**15**	**13.7**
HEF	*9.7*				
Free Maternity	*12.8*				
Free Child Under Five	*6.9*				
Administrative Costs	*3.3*				
Supply Side Program	**33**	**14**	**4**	**15**	**0**
TOTAL PROGRAM	**65.7**	**14**	**8**	**30**	**13.7**

The Multi-sectoral Nutrition and Food Security Action Plan (MNFSAP) 2014-2020

63. The Action Plan has two distinct features, designed to increase the impact of interventions and reduce coordination costs: (a) a proposal to focus interventions on 46 high risk districts (out of 72), sequenced in two phases (2014-15, and 2016-2020); and (b) a substantial reduction in the number of interventions to be targeted at these districts (from 44 in the previous plan to 28). Four sectors (agriculture, education, and health and WASH) are responsible for intervention selection, and the interventions are consistent with those advocated in the Scaling-Up Nutrition movement, to which the Government is a participant. The MFNSAP combines so-called "nutrition-specific" interventions (those which address under-nutrition directly and which operate primarily out of the health sector), with "nutrition-sensitive" interventions (that address the causes or determinants of under-nutrition, which are located primarily in the agriculture, education and WASH sectors). An important element of the MFNSAP is to converge development partner activities to reduce under-nutrition in 26 districts in 7 provinces[14] over the next 2 years.

64. UNICEF and the EU are key partners in support to implementation of the MFNSAP along with IFAD and the FAO. The Project will work closely with UNICEF in the design and implementation of SBCC, building their on-going interventions and expertise. Interventions at the village level with be closely coordinated with other agencies, particularly IFAD who will support agriculture interventions in the Project supported Districts.

Component 1: Health Sector Governance Reform (US$0.5 million)

65. This Component will support (a) development, implementation and maintenance of an improved health management information system of the MOH; and (b) technical support, capacity building and training for MOH staff at the central, provincial and district levels in the use of such system. The Component will also support development and implementation of improved business processes for notification of births, and training for MOH staff in the use of such system.

66. This system is utilized by the MOH to report on their health indicators and provides key management information to inform policy direction and resource allocation. Data generated by this system will be utilized to inform on targets to be attained in order to ascertain achievement against the disbursement linked indicators (DLIs) supported under Component 2, Service Delivery.

67. A roadmap has been developed for strengthening and expanding the Lao health management information system covering 2014-2020, in collaboration with WHO and agreed to by participating development partners. A DHIS2 site http://hmis.gov.la has been set up in all Provinces, the last ones trained in February 2015, and the server has been installed in Lao PDR,

[14] Luang Namtha Province (Sing, Long, Viengphouka and Nalae); Oudomxai Province (Nga, Beng, Hoon, Pakbeng); Saravan Province (Ta Oi, Lao Ngarm, Samuoi); Phongsaly Province (May, Samphanh, Nhot Ou); Houaphan Province (Xiengkhor, Viengthong, Huameuang, Xamtay, Sopbao); Xienkhouang Province (Kham, Nonghed, Khoune, Phookood); and Sekong Province (Lamarm, Kaleum, and Dakcheung).

in collaboration with the eGovernment Centre, Ministry of Post and Telecommunication. Consequently legacy data for the period 2008–2013 are now available on line. Monthly data, from the 15 Provinces trained in October 2013, is now available in the DHIS2/health management information system. Coordinated support from development partners for the deployment of DHIS2 in the country has resulted in a national plan for rolling out DHIS2, with joint funding and support from MOH, Lux-Development, IDA, WHO, UNFPA, UNICEF, and the University of Oslo. The Project will contribute to support needed over the next five years for the DHIS2 including: (a) technical support for the Central level core team, as well as the provision of coaching and capacity building for central and decentralized levels, and conducting quarterly in-country reviews which will contribute to the annual review of the system (comprising TA and operating costs); (b) on-site supportive supervision for Districts and Provinces, as well as central level hospitals (operating costs); and (c) costs for the system (internet connectivity and electricity costs, as well as maintenance, and possibly replacement of some units (goods and operating costs).

68. Lao PDR is among 75 countries that have been characterized as lacking well-functioning Civil Registration and Vital Statistic (CRVS).[15] According to the 2011–12 Lao Social Indicator Survey, 75 percent of children under age 5 have had their births registered but only 16.6 percent had birth certificates at the time of the survey. The GOL is intending to take urgent measures to improve the CRVS system. As a first step, a comprehensive assessment of the CRVS has been undertaken to identify underlying bottlenecks and a draft strategic plan has been developed under the leadership of the Ministry of Home Affairs – the agency responsible for CRVS -- and the MOH and other relevant stakeholders. The Project will support the standardization of business processes for birth -notification. This will include developing of the processes for onsite birth certificates with registration numbers/national ID number and training health center staff.

Component 2: Service Delivery (US$19.4 million)

69. This Component will support carrying out a program of activities designed to strengthen Lao PDR's health system management at the central level to support and oversee the implementation of decentralized health and nutrition service delivery.

70. This Component will also support the carrying out of a program of activities designed to strengthen: (a) Lao PDR's health system administration, management, financial management, and monitoring and evaluation at the provincial level; and (b) the delivery of reproductive, maternal and child health, and nutrition services at the provincial, district, village and health facility level in Target Provinces.

71. Financing for this Component will be provided based on results tracked by DLIs, which are a set of tracer indicators aimed at measuring performance against service delivery outputs and health system strengthening actions. Two sets of DLIs have been adopted. One set of four DLIs at the Central level focuses on management and health system actions that support decentralized service delivery and thereby support achievement of the Project objectives. The

[15] World Bank and World Health Organization. Global Civil Registration and Vital Statistics Scaling Up Investment Plan: 2015-2024. http://www.worldbank.org/en/topic/health/publication/global-civil-registration-vital-statistics-scaling-up-investment

second set of DLIs focuses on service delivery in 14 of the 18 provinces.[16] The seven Provincial DLIs are linked the performance of agreed targets in each of the 14 provinces will be individually measured. Funds will be disbursed to the Provinces based on their individual annual achievement against Province specific DLI targets.

72. Four of the eleven DLIs directly address interventions to improve nutrition outcomes. At the Provincial level, this includes: (i) ensuring women who attend ante-natal care receive iron and folic acid (IFA) supplementation; (ii) growth monitoring and nutrition counselling; and integrated outreach to remote areas to provide vitamin A and IFA supplements and counselling. Several of the Provincial level DLIs also indirectly support nutrition such as contraceptive use among women which reduces low birth weight and improves maternal nutrition and the use of a supervisory check list at health centers and district hospitals which will measure the availability of nutrition supplies such as scales and nutrition commodities. Two of the Central Level DLIs also support nutrition: to reduce stock-outs of nutrition commodities, and to increase the number of midwives who provide nutrition counseling as well as other types of nutrition sensitive promotion activities such as hygiene and food diversification.

73. **Component 2.1: Financing for Results at the Central Level (US$5.4 million):** In this sub- Component IDA will release funds to the Central MOH based on achievement of a set of DLIs. These Central Level DLIs target critical management and health system bottlenecks that support service delivery at the Province and below and support delivery of project objectives. The Central level DLIs focus on actions such as ensuring essential family planning and nutrition commodities are distributed, that adequate human resources are made available, and that project management functions are met.

74. **Component 2.2**: **Financing for Results at the Provinces (US$14 million)**. This sub-Component of the Project will cover 14 of the 18 Provinces, excluding the three Provinces currently receiving similar support from Lux-Development, and excluding the Capital, Vientiane. An estimated 4.9 million people (of the 6.9 million population in the country) will benefit from this sub component. In this sub-Component IDA will release funds based on participating Provinces' achievement of a set of DLIs. While the DLIs for the 14 provinces will measure performance against the same seven indicators in each province, there will be 14 province specific DLI tables which indicate the province specific baseline, the target and the amount the individual province can achieve for each DLI. The amount available for each province will be allocated based on provincial level population, poverty, and health facility data. Provincial Governors will each sign a Memorandum of Understanding with the Central MOH agreeing to the DLIs, targets and the part of the financing proceeds available on achievement of the DLIs.

75. Achievement of targets will be monitored through the national health information system and provincial registers and external verification will be carried out annually by an independent academic institution. A supervisory checklist will be introduced to periodically review performance of the health centers and district hospitals and will, in addition to the national health

[16] The other four provinces were not selected because three are supported by Lux-Development and Vientiane's coverage rates are already high and it would be difficult to reach DLI targets.

information system, form the backbone of the service monitoring efforts (see Table 2.3 for the details of the Provincial and Central level DLIs).

Table 2.2: Total Allocation by Province per Year (US$)

Province	Provincial budget allocation weights (%)[17]	3 Year Total
Phongsaly	5.5	748,162
Luang Namtha	4.4	622,900
Oudomxai	9.1	1,267,473
Bokeo	4.3	596,408
Luang Prabang	9.4	1,294,137
Houaphhan	9.8	1,366,547
Sayaboury	7.6	1,059,232
Xiengkhouang	4.9	695,972
Savannakhet	18.2	2,601,496
Saravan	7.6	1,072,273
Sekong	2.9	411,614
Champasak	10.4	1,451,122
Attapue	3.6	502,174
Xayxomboun	2.3	310,490
Total	**100**	**14,000,000**

76. When deciding on the amount to be disbursed based on DLI achievement, a discrepancy of up to 5 percent between the internal and the external verification will be accepted as having achieved the target. In the case of partial achievement of a DLI target, a minimum value of 60 percent of the DLI target must be achieved to qualify for payment; in cases of achieving less than 100 percent but more than 59 percent, the province will receive 50 percent of the DLI value (rounded to the nearest whole number); the amount not disbursed will be added to the following year, in case the target for that year is achieved. If targets are not fully achieved the following year, the amount not disbursed will be added to the total amount to be disbursed to all provinces through DLI achievement. If, at the end of the project, all funds for Component 2 have not been disbursed due to non-achievement of DLIs, the remaining amount may be cancelled or the GOL may request for a project extension and restructuring to utilize the unspent amount.

[17] This allocation formula is based on poverty (20 percent), population (50 percent) and health facilities (30 percent)

Table 2.3: DISBURSEMENT LINKED INDICATORS (SDR)

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Central Level DLIs					
Central Level DLI 1: Percentage of HMIS data reports from the Target Provinces provided on time and fully completed in accordance with the National Guidelines for DHIS2 Implementation	**DLI Target**: (1) National Guidelines on DHIS2 Implementation approved by MOH Steering Committee; and (2) Baseline established for April 1, 2015 – June 30, 2015 on the completeness and timeliness of data entry reports **DLI Value:** SDR 90,000	**DLI Target**: Average percentage of HMIS data reports from all Target Provinces provided on time and fully completed in accordance with the National Guidelines for DHIS Implementation increased by 10% over baseline **DLI Value:** SDR 90,000	**DLI Target**: Average percentage of HMIS data reports from all Target Provinces provided on time and fully completed in accordance with the National Guidelines for DHIS Implementation increased by 20% over baseline **DLI Value:** SDR 90,000	**DLI Target**: Average percentage of HMIS data reports from all Target Provinces provided on time and fully completed in accordance with the National Guidelines for DHIS Implementation increased by 30% over baseline **DLI Value:** SDR 0	**DLI Target**: Average percentage of HMIS data reports from all Target Provinces provided on time and fully completed in accordance with the National Guidelines for DHIS Implementation increased by 40% over baseline **DLI Value:** SDR 0
Central Level DLI 2: Number of Target Provinces which have two quarters' stock of	**DLI Target**: (1) MOH committee established to	**DLI Target**: Details of stock availability of Essential Family	**DLI Target**: 4 Target Provinces have 2 quarters' stock of Essential	**DLI Target**: 8 Target Provinces have 2 quarters' stock of Essential	**DLI Target**: 12 Target Provinces have 2 quarters' stock of

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Essential Family Planning and Nutrition Commodities	forecast and monitor the supply of Essential Family Planning and Nutrition Commodities; and (2) List of Essential Family Planning and Nutrition Commodities approved by MOH committee **DLI Value:** SDR 30,000	Planning and Nutrition Commodities in all Target Provinces recorded by MOH **DLI Value:** SDR 1,060,000	Family Planning and Nutrition Commodities available every quarter of the Year **DLI Value:** SDR 1,040,000	Family Planning and Nutrition Commodities available every quarter of the Year **DLI Value:** SDR 0	Essential Family Planning and Nutrition Commodities available every quarter of the Year **DLI Value:** SDR 0
Central Level DLI 3: Number of Target Provinces in which the number of health centers without a community midwife has been reduced	**DLI Target**: Baseline for number of health centers with no community midwife in each Target Province established **DLI Value:**	**DLI Target**: 4 Target Provinces report 20% reduction from baseline **DLI Value:** SDR 140,000	**DLI Target**: 6 Target Provinces report 40% reduction from baseline **DLI Value:** SDR 140,000	**DLI Target**: 8 Target Provinces report 60% reduction from baseline **DLI Value:** SDR 0	**DLI Target**: 12 Target Provinces report 80% reduction from baseline **DLI Value:** SDR 0

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	SDR 140,000				
Central Level DLI 4: Number of women in Target Provinces who receive free maternity health care services	**DLI Target**: Government decree issued for the implementation of guidelines for the nationwide provision of free maternity health care services **DLI Value:** SDR 720,000	**DLI Target**: Baseline for number of women receiving free maternal health care services in Target Provinces established **DLI Value:** SDR 280,000	**DLI Target**: 10% increase over baseline **DLI Value:** SDR 0	**DLI Target**: 20% increase over baseline **DLI Value:** SDR 0	**DLI Target**: 30% increase over baseline **DLI Value:** SDR 0
Provincial Level DLIs					
Provincial Level DLI 1: Number of women who deliver with a skilled birth attendant at home or at a health facility	**DLI Target per Target Province**: Target Province Baseline established **DLI Value per Target Province:** As set out in the Project Operations	**DLI Target per Target Province**: 10% increase over Target Province Baseline **DLI Value per Target Province:**	**DLI Target per Target Province**: 20% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the	**DLI Target per Target Province**: 30% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the	**DLI Target per Target Province**: 40% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0	Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0
Provincial Level DLI 2: Number of pregnant women who receive 4 Antenatal Care Contacts	**DLI Target per Target Province**: Target Province Baseline established **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	**DLI Target per Target Province**: 10% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	**DLI Target per Target Province**: 20% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	**DLI Target per Target Province**: 30% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0	**DLI Target per Target Province**: 40% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0
Provincial Level DLI 3: Number of new women aged 15-	**DLI Target per Target Province**: Target Province	**DLI Target per Target Province**: 10% increase	**DLI Target per Target Province**: 20% increase over	**DLI Target per Target Province**: 30% increase over	**DLI Target per Target Province**: 40% increase over

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
49 years adopting long term methods of family planning	Baseline established **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0	Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0
Provincial Level DLI 4: Number of children under 5 years who receive nutrition counselling and an updated growth chart in accordance with MOH guidelines	**DLI Target per Target Province**: Health facility staff in selected priority districts trained in nutrition counselling in accordance with MOH guidelines **DLI Value per Target Province:** As set out in the Project Operations Manual up to a	**DLI Target per Target Province**: Target Province Baseline established **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all	**DLI Target per Target Province**: 10% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	**DLI Target per Target Province**: 20% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces	**DLI Target per Target Province**: 30% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	maximum total DLI Value for all Target Provinces of SDR 500,000	Target Provinces of SDR 500,000		of SDR 0	of SDR 0
Provincial Level DLI 5: Number of villages in Zones 2 and 3 with health centers in which Integrated Outreach Sessions are conducted at least four times during the Year	**DLI Target per Target Province**: Target Province Baseline established **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	**DLI Target per Target Province**: 10% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	**DLI Target per Target Province**: 20% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 500,000	**DLI Target per Target Province**: 30% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0	**DLI Target per Target Province**: 40% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0
Provincial Level DLI 6: Percentage of health centers and district hospitals in the Target Provinces which score more than 50% on the	**DLI Target per Target Province**: Training of at least 1 PHO staff of each Target Province in the use of Standard	**DLI Target per Target Province**: Training of at least 2 health facility staff in each district of each Target	**DLI Target per Target Province**: 30% of health centers and district hospitals in Target Province score more than 50% on	**DLI Target per Target Province**: 50% of health centers and district hospitals in Target Province score more than 50% on	**DLI Target per Target Province**: 70% of health centers and district hospitals in Target Province score more than 50% on

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Standard Supervisory Checklist for every quarter of the Year	Supervisory Checklists completed **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 140,000	Province in the use of Standard Supervisory Checklists completed; and (2) Standard Supervisory Checklist scores for all health centers and district hospitals in each Target Province for 2 quarters of the Year completed and recorded by PHO **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces	the Standard Supervisory Checklist for every quarter of the Year **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 670,000	the Standard Supervisory Checklist for every quarter of the Year **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0	the Standard Supervisory Checklist for every quarter of the Year **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0

Disbursement Linked Indicators with DLI Targets and DLI Values					
DLIs	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
		of SDR 670,000			
Provincial Level **DLI 7:** Percentage increase in Target Province non-salary health recurrent expenditure allocated to the districts	**DLI Target per Target Province**: Target Province Baseline established **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 140,000	**DLI Target per Target Province**: 5% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 430,000	**DLI Target per Target Province**: 10% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 430,000	**DLI Target per Target Province**: 15% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0	**DLI Target per Target Province**: 20% increase over Target Province Baseline **DLI Value per Target Province:** As set out in the Project Operations Manual up to a maximum total DLI Value for all Target Provinces of SDR 0

Table 2.4: Verification Protocols for DLIs

DLI C 1	Indicator Identification Data and Compliance Information
Indicator	Percentage of HMIS data reports from the Target Provinces provided on time and fully completed in accordance with the National Guidelines for DHIS2 Implementation
Compliance Condition	National guideline on DHIS2 implementation will be approved by the MOH Steering Committee to include rules and regulation of reporting system e.g. timely data entry and completeness of HMIS data
Compliance Specification	The guidelines will specify specific dates by which information must be entered into the DHIS2 system and specify that all formats must be filled
Means of verification	Quarterly review of the data entered by the MOH/DPIC
Compliance Verification procedure	The DHIS2 will provide information every quarter on the timeliness and completeness of data for each province; at the end of the year there will an average collected for each quarter. The average of the four quarters for the 14 provinces will be measured.
Expected cumulative target increase over baseline	Baseline is (i) approval of the national guidelines for DHIS2 implementation by MOH Steering Committee by July 1, 2015 (ii) registration of the baseline indicator value for April to June Quarter 2015; Average for four quarters for 14 provinces increased by 10% over baseline on July 1, 2016; Average for four quarters for 14 provinces increased by 10% over baseline plus 20% on July 1, 2017; Average for four quarters for 14 provinces increased by 10% over baseline plus 30% on July 1, 2018; Average for four quarters for 14 provinces increased by 10% over baseline plus 40% on July 1, 2019
Responsible Department	MOH, DPIC

DLI C 2	Indicator Identification Data and Compliance Information
Indicator	Number of target provinces having 2 quarters' stock of essential family planning and nutrition commodities
Compliance Condition	The MOH will set up committees to monitor availability of and forecast need for Family Planning and Nutrition Commodities. Based on available information from UNFPA and UNICEF the MOH will prepare standard list of items and quantities of Family Planning and Nutrition Commodities to be available in each province to cover two quarters' consumption
Compliance Specification	The committee will specify the requirements to be available at provincial level for two quarters. UNICEF and UNFPA will be members of the committee and have the required baseline information as well as experience in forecasting needs. The provinces will report every quarter on the Family Planning and Nutrition Commodities available (in stores and at facilities)
Means of verification	Quarterly reports from the provinces to the MOH on stocks available
Compliance Verification procedure	The Independent Academic Institution will, on a sample basis, verify that stock availability is in accordance with the stock registered at provincial level
Expected cumulative target over baseline	By July 1, 2015 Committees established; list of commodities approved; Stock availability in all 14 provinces recorded by July 1 2016; by July 1 2017, 4 provinces have reported every quarter that they have 2 quarters' stock of essential FP and Nutrition commodities available; by July 1 2018, 8 provinces have reported every quarter that they have 2 quarters' stock of essential FP and Nutrition commodities available; by July 1 2019, 12 provinces have reported every quarter that they have 2 quarters' stock of essential FP and Nutrition Commodities

Responsible Department	MOH, DHHP

DLI C3	Indicator Identification Data and Compliance Information
Indicator	Number of target provinces in which the number of health centers without a community midwife has been reduced.
Compliance Condition	While the MOH norm is to have 1-2 community midwives in each health center, this indicator will measure annual reduction in the number of health centers with no community midwife posted
Compliance Specification	The MOH norm is that 1-2 midwives must be posted in every health center. In this context we will limit the specification to 1 midwife posted in every health center. Midwives are employed directly by the MOH; records on level, seniority, posting etc. are maintained at the MOH. The MOH reviews all staff employed every month to register any staff who is retired, terminated or transferred
Means of verification	The province will on an annual basis report to the MOH on the number of health centers that do not have a community midwife posted; this will be compared to the Department of Personnel records of staff posted in the province
Compliance Verification procedure	The Independent Academic Institution will compare lists of community midwives posted with the people present in a sample of health centers
Expected cumulative target	Baseline for number of health centers with no community midwife for each province will be established by July 1, 2015; 4 Provinces report 20 % reduction from baseline in the number of health centers with no community midwives by July 1, 2016; 6 Provinces report 40 % reduction from baseline in the number of health centers with no community midwives by July 1, 2017; 8 Provinces report 60 % reduction from baseline in the number of health centers with no community midwife by July 1, 2018; 12 provinces report 80 % reduction from baseline in the number of health centers with no community midwife by July 1, 2019
Responsible Department	MOH, Department of Personnel, Provincial Health Department

DLI C4	Indicator Identification Data and Compliance Information
Indicator	Number of women in target provinces who receive free maternity health care services
Compliance Condition	While only women in specified districts and provinces are currently entitled to free maternity care a pending government decree will state that all women in the country will receive free maternity care this indicator will measure the total number of women who receive free Maternity care.
Compliance Specification	As per Government Decree No 273, all women in the country are entitled to free Maternal Care. The maternity services to be provided are specified in the Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services The GOL will reimburse health facilities the expenditure following set guidelines.
Means of verification	Compensation to health facilities for provision of free maternity care is provided through the Health Insurance Bureau. The Bureau will therefore report to the MOH on an annual basis the number of women for which they have compensated health facilities for the delivery of maternity care.
Compliance Verification procedure	The independent academic institution will compare the list of free maternity care cases received from the Health Insurance Bureau with the records provided by the individual facilities. In addition, a sample of women who

	delivered in the previous year will be interviewed to ensure they received free maternity care.
Expected cumulative target	Baseline for Year 0 by August 1, 2015; Government Decree on implementation guidelines for HEF and Free maternity Care to be applied nationwide issued; the baseline for number women receiving free maternity care services in target provinces established by July 1, 2016; increase by 10% over baseline by July 1, 2017; by 20% over baseline by July 1, 2018; by 30% over baseline by July 1, 2019
Responsible Department	MOH, DPIC, National Health Insurance Bureau

DLI P1	Indicator Identification Data and Compliance Information
Indicator	Number of women who deliver with a skilled birth attendant at home or at health facility
Compliance Condition	Lao PDR has a staff accreditation system. Doctors and nurses as well as Community Midwives who have completed their basic education receive accreditation to conduct deliveries. They are referred to as Skilled Birth Attendants
Compliance Specification	The skilled birth attendant must have conducted the delivery – in a health facility or at the home
Means of verification	Recorded quarterly through the DHIS2
Compliance Verification procedure	The Independent Academic Institution will review records at selected health facilities and visit a sample of women to confirm that their delivery was conducted by a skilled birth attendant
Expected cumulative target; 14 separate DLI tables with province specific baselines and targets will be prepared and included in the Operational Manual	Baseline represents the value recorded in the DHIS2 for June 2014 – May 2015 as recorded on June 1, 2015; by June 1, 2016 the value must have increased by 10%; by June 1, 2017 the value must have increased by 20%; by June 1, 2018 the value must have increased by 30%; by June 1, 2019 the value must have increased by 40%
Responsible Department	MOH, DPIC, Provincial Health Department

DLI P2	Indicator Identification Data and Compliance Information
Indicator	Number of pregnant women who receive 4 ante natal care contacts
Compliance Condition	The MOH Department of Maternal Child Health has a guideline (Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services) for the services to be provided during 1st, 2nd, 3rd and 4th ante natal care visit. By confirming that 4 ante natal care contacts have been conducted it is assumed that these services have been delivered.
Compliance Specification	An 'ANC contact' includes a specified package of services defined by the MOH, and in line with WHO guidelines, to be provided during ante natal care visits. The indicator will therefore measure the number of pregnant women who receive this package of services at least four times. The provincial health office will be responsible for ensuring that guidelines for ANC are available and followed in every health facility.
Means of verification	Quarterly reporting through the DHIS2
Compliance Verification procedure	The Independent Academic Institution will compare DHIS2 reports with records in a sample of health facilities; on a sample basis women who have received ante natal care will be contacted to confirm the actual services they were provided. To confirm this DLI is has to be verified that all services as prescribed in the national guidelines have taken place.

Expected cumulative target; 14 separate DLI tables with province specific baselines and targets will be prepared and included in the Operational Manual	The baseline is the number provided in 2014-2015 as recorded in the DHIS2 by June 1, 2015; by June 1, 2016 this must be increased by 10%; by June 1, 2017 this must be increased by 20%; by June 1, 2018 this must be increased by 30%; by June 1, 2019 this must be increased by 40%;
Responsible Department	MOH/DPIC/MCH Department/Provincial Health Department

DLI P3	Indicator Identification Data and Compliance Information
Indicator	Number of new women aged 15-49 years adopting long term methods of family planning
Compliance Condition	Long term methods of family planning are defined as the use of intrauterine device (IUD), Injectable, or Implant. These methods are selected as they require the assistance of a health care service provider and their use can therefore be recorded and monitored. These are the most effective contraceptive methods available and, therefore, should be considered as first-line choices. These methods work well, mostly because the woman does not have to remember anything on a regular basis
Compliance Specification	The correct use of Family Planning methods is described 'Family Planning handbook'
Means of verification	Provision of contraceptives is recorded in a health facility register and reported in the DHIS2 on a quarterly basis
Compliance Verification procedure	The Independent Academic Institution will compare the reports with a sample of facility registers and also on a sample basis interview contraceptive acceptors to confirm that they have received the service
Expected cumulative target; 14 separate DLI tables with province specific baselines and targets will be prepared and included in the Operational Manual	The baseline is the number of new acceptors of long term family planning methods provided in the year 2014 – 2015 as recorded in DHIS2 by June 1, 2015; by June 1, 2016 this must be increased by 10%; by June 1, 2017 this must be increased by 20%; by June 1, 2018 this must be increased by 30%; by June 1, 2019 this must be increased by 40%
Responsible Department	MOH; DPIC; Department of MCH; Provincial Health Department
DLI P4	Indicator Identification Data and Compliance Information
Indicator	Number of children under 5 years who receive nutrition counselling and an updated growth chart in accordance with MOH guidelines
Compliance Condition	The Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services specifies that monthly weighing of children from age 0 – 59 months includes nutrition counselling to mothers of these children. This DLI will record bi-monthly weighing due to the difficulty of reaching remote communities. By recording that bi-monthly weighing has taken place this includes the services to be provided during weighing i.e. nutrition counselling according to the guideline. This will be confirmed through the Independent –Academic Institution
Compliance Specification	The GOL strategy must be in line with UNICEF recommendations on weighing and nutrition counselling of children < 5 years. UNICEF has guidance and training manuals for providing nutrition counselling to pregnant women as well as mothers of children < 5 years. MOH must ensure that provinces have these guides and recommendations and that they are provided to the health facilities and used in the province.
Means of verification	Weighing and nutrition counselling for children <5 is recorded on a health

	facility register as well as on a child's growth chart. The number of children 'weighed' – understood as a service which also includes nutrition counselling, is recorded quarterly in the DHIS2. This record is assumed to include nutrition counselling as per the guideline
Compliance Verification procedure	The Independent Academic Institution will compare the DHIS2 records with registers in a sample of health facilities. They will further interview a sample of mothers of children <5 to confirm that both weighing and nutrition counselling has taken place as recorded. To confirm this DLI it has to be verified that both weighing and counselling has taken place.
Expected cumulative target; 14 separate DLI tables with province specific baselines and targets will be prepared and included in the Operational Manual	For year 0 health facility staff in high priority districts for nutrition have been trained in counselling skills before October 1, 2015; Baseline established for the number of children who have been weighed bi-monthly and have received nutrition counselling in the year 2015 – 2016 as recorded in the DHIS2 by June 1, 2016; by June 1, 2017 this number must be increased by 10%; by June 1, 2018 this number must be increased by 20%; by June 1, 2019 this number must be increased by 30%;
Responsible Department	MOH; DPIC; Department of MCH; Provincial Health Department

DLI P 5	Indicator Identification Data and Compliance Information
Indicator	Number of villages in zone 2and & 3 areas with health centers in which integrated outreach sessions are conducted at least four times during the year
Compliance Condition	The integrated outreach package of services includes EPI, FP, ANC, PNC, weighing and nutrition counselling for children <5 years. Zone 2 is 5-10 km from the health center; Zone 3 is more than 10 km; the health center team has to stay overnight to reach villages in Zone 3. Districts have records of all villages in these zones.
Compliance Specification	MOH must ensure that the detailed guidelines for conducting integrated outreach is in line with WHO/UNICEF/UNFPA guidelines. Such guidelines must be available in the province for the province to provide to all health facilities and the health facility to follow these guidelines.
Means of verification	Provincial register of outreach to zone 2 and 3 villages conducted
Compliance Verification procedure	The Independent Academic Institution will compare the Provincial register with the health facility registers and verify the information through visits to selected villages to confirm that there has been integrated outreach conducted four times in the past year there.
Expected cumulative target; 14 separate DLI tables with province specific baselines and targets will be prepared and included in the Operational Manual	The baseline is the number of villages in zones 2 & 3 that have received four or more outreach sessions in the year 2014 – 2015 as recorded by June 1, 2015; by June 1, 2016 this number must be increased by 10%; by June 1, 2017 this number must be increased by 20%; by June 1, 2018 this number must be increased by 30%; by June 1, 2019 this number must be increased by 40%
Responsible Department	MOH; DPIC; MCH Department; Provincial Health Department

DLI P 6	Indicator Identification Data and Compliance Information
Indicator	Percentage of Health Centers and District Hospitals in target provinces which score more than 50% on the standard supervision checklist for every quarter of the year
Compliance Condition	A supervisory checklist which monitors the physical state of the facility,

	availability of essential drugs, supplies and equipment, availability of adequate staff and maintenance of records. Supervision must be conducted at least quarterly in every facility and the checklist record any follow up on observations recorded during previous supervisory visits
Compliance Specification	A standard supervision checklist will be prepared by an external consultant based on the one already in use under the Results Based Financing Additional Financing Project. The supervision checklist must including a scoring function which can be used to supervise and monitor MCH activities at the district hospital and health center level. It must be in compliance with the relevant WHO/UNICEF/UNFPA guidelines. A copy of the supervision report with a score should be retained at the facility
Means of verification	The province will keep a record of the facilities supervised and the score obtained during each supervision visit. This will be reported to the MOH on a quarterly basis
Compliance Verification procedure	The Independent Academic Institution will compare the register of supervisions conducted and the scores achieved with information obtained (verbally and though the copy of the checklist) from a sample of facilities
Expected cumulative target; 14 separate DLI tables with province specific baselines and targets will be prepared and included in the Operational Manual	The baseline action will be to train at least 1 PHO staff in each target province in the use of the supervisory checklists and field test their use by July 1 2015. By June 1, 2016, training of at least 2 health facility staff in each district must have been completed and supervisory checklist scores for all health centers and district hospitals for 2 quarters must have been completed and recorded; by June 1, 2017, 30% of district hospitals and health centers report scores above 50% for every quarter of the year; by June 2018, 50% district hospitals and health centers report scores above 50% for every quarter of the year; by June 1, 2019, 70% of health centers and district hospitals report scores above 50% for every quarter of the year.
Responsible Department	MOH, DPIC, Provincial Health Department

DLI P 7	Indicator Identification Data and Compliance Information
Indicator	Percentage increase in Target Provinces non-salary health recurrent expenditure allocated to the districts
Compliance Condition	Annual Budgets to the provinces for Chapter 12 (operations and maintenance) and 13 (subsidies and transfers) will be reallocated to the district by the province. This budget should increase over time
Compliance Specification	The province is in charge of allocating their budget to the districts. The ability of the primary care facilities to provide free MCH services is dependent on the non-salary recurrent budget allocated to the district
Means of verification	Interim un-audited expenditure statement for the year from the province clearly identifying the expenditure by the district level for the preceding year
Compliance Verification procedure	The Independent Academic Institution will compare the un-audited expenditure statement for the year with the budget received by a sample of districts for that year
Expected cumulative target; 14 separate DLI tables with province specific baselines and targets will be prepared and included in the Operational Manual	The baseline is the district level non-salary health recurrent expenditure for 2013 – 2014 as reported by 1st April 2015. By 1st April 2016 this will be reported for the year 2014-2015 to have been increased by 5% over the baseline value. By 1st April 2017 it will be reported for the year 2015-2016 to have been increased by 10% over baseline; by 1st April 2018 it will be reported for the year 2016-2017 to have increased by 15% over baseline; by 1st April 2019 it will reported for the year 2017 – 2018 to have been increased by 20% over baseline
Responsible Department	MOH; DPIC; Department of Finance; Provincial Health Office

Component 3: Nutrition Social and Behavioral Change Communication (SBCC) (US$4 million)

77. This Component will support the development of an integrated national strategy and implementation plan for social and behavioral change communication to improve nutrition.

78. This Component will also support implementation of the strategy at the national level and at the village level in selected priority districts, including development and production of marketing and communication tools and materials, and facilitation of training and communication sessions at the village level with a focus on sanitation, personal and environmental hygiene, maternal and child health, and/or other determinants of health and nutrition.

79. This component will complement the health facility and community-based nutrition-related services supported under Component 2, by financing the implementation of nutrition- and health-related SBCC, including family planning. Activities supported under this Component will cover two broad areas: (a) efforts related to the preparation of national strategy for a SBCC; and (b) implementation of SBCC at the national and village level in a selected number of high priority districts that are identified in the MFNSAP. SBCC content will cover both nutrition-specific as well as nutrition-sensitive interventions.

Sub-Component 3.1: Preparing an SBCC Strategy (US$0.5 million)

80. Supporting the National Nutrition Committee to prepare a high impact, integrated SBCC strategy is a key priority identified in the MFNSAP and it is also one of the four interventions that the UN agencies and the World Bank agreed to prioritize for their support following the high level discussion on nutrition during the Chief Executive Board meeting of the UN in November, 2014 (see details in Annex 5).

81. The preparation and delivery of SBCC interventions is an evidence-based, interactive process. The development of SBCC messages, media, and materials begins with a solid understanding of relevant human behaviors and social norms, and what it takes to change these for positive outcomes. SBCC is informed by formative research to learn more about each target behavior, the target audience, their beliefs, motivations and their barriers to adopt the desired behaviors and develop social norms to support and sustain these behaviors. These insights guide the methodical development of communication objectives, messages, media and a range of activities tailored for the right audience, at the right time, delivered through the most-effective channels. SBCC includes advocacy, behavior change communication, and mobilization of groups, communities and society. This approach has the best impact when it is designed alongside other non-communication interventions as part of an overall strategy to address barriers faced.

82. Global evidence on SBCC shows that different types of communication and social mobilization can be used to promote and influence healthy behaviors and sustain behavior change. At its core is change in normative behavior, which is expected to lead to new or changed habits. SBCC can directly achieve many positive health and nutrition behavior and social changes, but it may not achieve all without complementary interventions. For example, well-designed SBCC campaigns promoting iron folate acid or Vitamin A can successfully increase demand for these supplements; however, without functioning supply chains and sufficient stocks in place in the facilities or communities, the desired levels of use of iron folate acid or Vitamin A cannot be attained no matter how high the demand. Likewise complementary feeding and family planning commodities and staff to administer them must be available to cater to any increase in demand for these. Similarly for sanitation, SBCC can help to influence social norms around open defecation and create demand for toilets usage. However, if affordable and suitable products are not easily accessible in the local market, and if financing options are not available, actual behaviors may proof difficult to change and sustain, especially for cash-constrained households. Thus, SBCC needs to be part of an integrated strategic approach that encompasses advocacy, leadership, services, systems, policies, resources, information and messages, and other necessary investment interventions to facilitate the adoption of desired nutrition behaviors and social change.

83. This sub-component will finance the following related activities:

(a) Stocktaking of existing SBCC materials and delivery approaches, as well as additional formative research (mostly qualitative) to help fill priority gaps (e.g.

maternal nutrition, animal and child feces disposal and clean play areas for infants)[18];

(b) Development of an integrated SBCC Strategy and Implementation plan, including stakeholder consultation; and

(c) Development of an SBCC campaign concept and umbrella slogan, and a set of integrated campaign tools, such as mass media tools (television spots, videos, radio-programs, posters, banners, social media applications, and collaterals), and also tools/scripts to organize community edutainment events interpersonal communications toolkits for village facilitators, as well as job-aids for health center (outreach) staff.

What is Social and Behavior Change Communication?

SBCC activities can be categorized into two primary types – mass media and community-based approaches, which for successful campaigns, are best delivered in a complementary manner. In addition, it also includes advocacy activities for nutrition, targeted at different levels of leaders and decision markers.

Mass media approaches can be in the form of edutainment or social marketing campaigns. Edutainment is characterized by radio and television messages, dramas aired on radio or television, songs containing relevant messages, and may also include social media. Mass media campaigns have been commonly used for family planning are increasingly used for a broader set of interventions, such as for promotion of complementary feeding for young children, or for sanitation and hygiene behaviors. Informed by an understanding of mass media consumption habits of the target audience, mass media approaches can be an effective way to reach large numbers of people to increase awareness, knowledge and change attitudes towards a certain behavior, and help to create repeat exposure to consistent messaging. Inter-personal communications with trusted peers is often needed to support the actual change of a behavior, and hence the need to deliver both mass-media and community-based approaches in tandem.

In contrast, ***community-based approaches*** leverage social networks, outreach activities, and peer influence to promote discussion among communities, within households and among peers. The aim to influence utilization of services and behaviors via norms, information, emotional drivers and social and peer support. These approaches can be delivered in the form of community edutainment events, community discussion groups, peer groups, or one-on-one exchanges and are often targeted at specific sub-populations (such as, pregnant women, women with children under a certain age, men, adolescents, etc.). Community-based approaches include: (a) health/nutrition counselling by health professionals during integrated outreach services at the village level; (b) Community-based, interpersonal communication sessions and follow-up by village facilitators (such as health volunteers and members of Lao Women Union) to help reinforce messages on nutrition (including sanitation and hygiene); (c) community edutainment events related to nutrition; and (d) Community mobilization processes, such as CLTS.

84. The implementation of this sub-component will follow the guidance of the National Nutrition Committee with close collaboration with relevant government units across the relevant ministries (including National Nutrition Committee's Secretariat, Ministry of Information and

[18] In this context it is important to note that IYCF packages have been developed by UNICEF; WSP-WB, UNICEF, Plan, Stichting Nederlandse Vrigwilligers have jointly conducted formative research and are currently developing BCC materials for sanitation. IFAD has developed mass media materials on agriculture-related behaviors. The challenge for the campaign is to integrate all these different materials under a campaign concept, which is mutually reinforcing behaviors.

Communication, Ministry of Education, and Ministry of Agriculture) and development partners (including the EU, UNICEF and civil societies) to ensure complementarity and avoidance of duplication.

Sub-Component 3.2: Implementation of SBCC Strategy (US$3.5 million)

85. This sub-component will support the implementation of the SBCC strategy at national and village levels, and will directly contribute to both health and nutrition service delivery DLIs identified in Component 2. At the national level, the sub-component will supplement the government's budget to finance the following items:

(a) Delivery costs of the mass-media campaign, including air-time/radio time, social-media costs, staging of community edutainment events focused on selected districts;
(b) Printing/production costs for SBCC materials, including job-aids for health center (outreach) staff, village facilitator toolkits, posters and production of other collaterals; and
(c) Equipment needs for villages to support SBCC activities, such as pocket projectors, height boards and weighing scales, as well as equipment for SBCC-activities supported by the DHO.

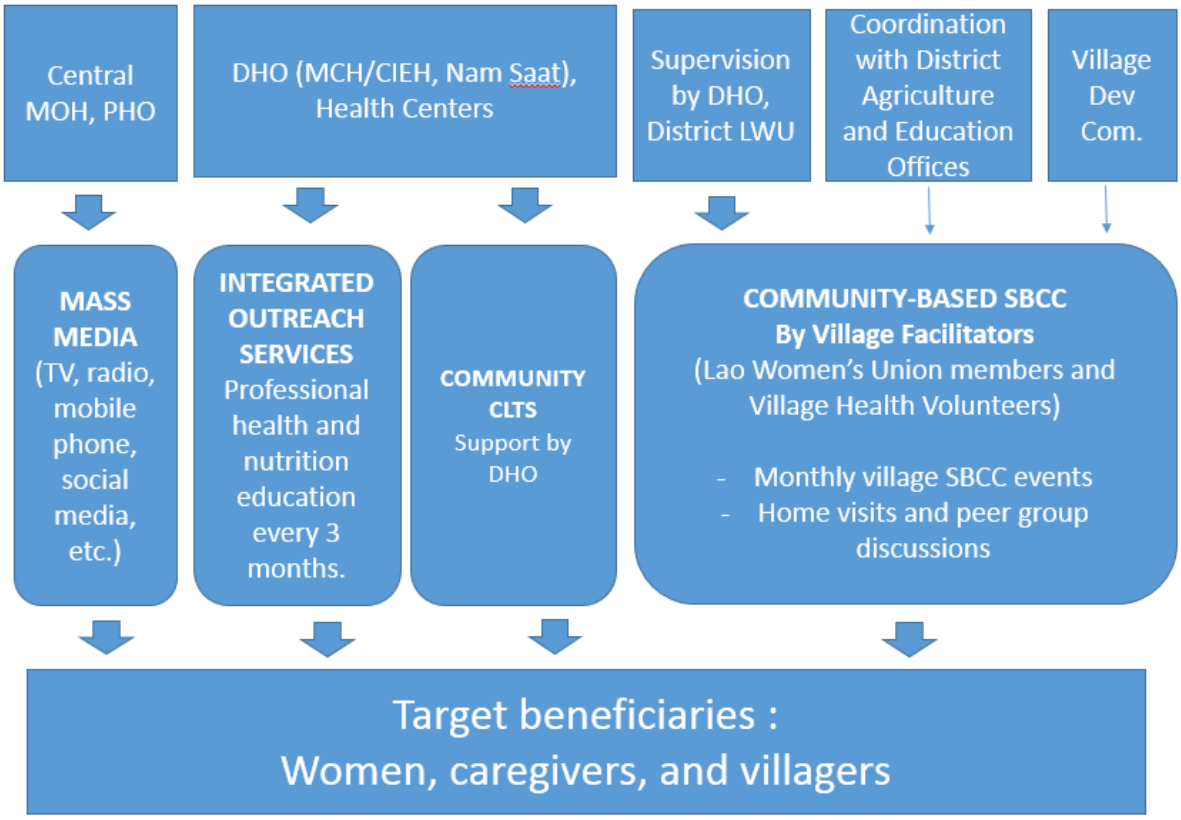
86. At the village level, the sub-component complements national activities through community-based SBCC activities aimed at contributing to improvements in: maternal nutrition and related caring practices; infant and young child feeding and caring practices; appropriate sanitation and personal as well as environment-related hygiene behaviors; HAP through use of near smokeless cookstoves; dietary diversification; and other determinants of nutrition at the village level. Village-based facilitators, who will comprise mostly female village health volunteers and/or members of Lao Women's Union, will support the SBCC implementation a village level, under the guidance of district health staff. Family Planning Volunteers, with technical assistance from UNFPA, will also provide counseling to women on family planning options. The village-based facilitators will organize at least monthly communications sessions, conduct home visits for follow-up on pregnant women and children under two, support in organizing edutainment community events, whilst liaising with relevant district line agencies. The facilitators will focus their efforts on, among other behaviors, the (nutritional) care of pregnant and lactating women, exclusive breastfeeding and complementary feeding to support infant and young child feeding (IYCF), clean household air through full-time use of clean burning stoves when available, dietary diversity, sanitation and hygiene messages and information to support the achievement of ODF villages in close collaboration with district-level CLTS facilitators from the District (Nam Saat and District level CIEH). In those areas where very clean burning cookstoves will be made available, the facilitators will also include product information on such cookstoves.

87. Village-level SBCC sessions promoting the ownership and use of sanitation facilities as well as personal and environmental hygiene are unlikely to be sufficient to achieve ODF villages by themselves, Therefore, this sub-component will also support CLTS interventions. CLTS is essentially a community empowerment process where "triggered" by emotions of shame and

disgust, communities are collectively working towards ending open defecation practices and enforcing social norms to sustain that behavior[19]. This triggering is normally done by external well-trained facilitators, such as from District Nam Saat or other human resources available at kum ban or district level. The community mobilization process of CLTS is reinforced with the delivery of SBCC sessions by village health workers and/or members of the Lao Women's Union on sanitation and hygiene. These sessions will include provision of information for households to make informed choices, including options that can be constructed with local materials, as well as more aspirational once offered by the local private sector sanitation suppliers. Households are expected to self-invest in their sanitation facilities. Once a village announces itself as ODF, a verification team will be dispatched to verify the status, and if successful, an official declaration - often including multiple villages - will be organized to recognize this achievement. The process of CLTS and ODF verification has been detailed in the MOH's Guideline and ODF verification guideline. The definition of ODF in Lao PDR includes that 100 percent of families (including shared households) own and use an improved sanitation facility and all households have installed hand washing facilities.

[19] The concept involves provoking shame and disgust about poor sanitation in order to bring about collective change and the enforcement of social norms for toilet usage. A process called triggering is used to propel people into taking action. This takes place over half a day in a village with a team of facilitators from outside the village, typically including Nam Saat staff. Several participatory tools are used to support villagers the community in the awareness process of their own sanitation situation. This tends to cause disgust in participants, and the facilitators help participants to plan for becoming ODF. A village sanitation committee is formed to monitor and support the change process.

Figure 2.1: Delivery Channels of SBCC for Target Beneficiaries



88. In areas that are overlapping with the Poverty Reduction Fund[20], the Fund's Kum Ban facilitators and Nam Saat officials from DHOs will lead the CLTS triggering and follow-up process, with increasing reliance on Kum ban facilitators for community-support. In areas that are not overlapping with the Poverty Reduction Fund, the sub-component will rely on Nam Saat officials leading the CLTS triggering and follow-up visits, which may need to be augmented with other district level cadre (such as from CIEH or Lao Women's Union).

89. This sub-component will finance the following items:

(a) Training, including training of trainers for master trainers at the provincial and district level;
(b) Training of village-based nutrition/sanitation facilitators on the SBCC toolkits for monthly sessions and follow-up support activities;
(c) Training of local sanitation enterprises/masons;
(d) Operating costs for the provincial department of health and district (Nam Saat, CIEH, MCH) for CLTS, as well as supervision and support of the SBCC implementation;

[20] Overlap between PRF2 and convergence districts is currently limited to x districts out of PRF-2 total districts. It is expected that PRF3 will focus its attention on convergence districts as well so that better synergies can be developed

(e) Operating costs for village health volunteers and members of Lao Women's Union as village facilitators; and
(f) Workshops for advocacy, orientation, and progress review at provincial and/or district level.

90. The geographical area of the village-level activities will be identified by the government, and would include priority target "convergence" districts in three provinces from the MFNSAP following a phased approach and with the aim to cover the entire districts. To support the nutrition convergence strategy and plan, it is desirable for the village-level SBCC activities to take place in the same villages that receive other nutrition-sensitive interventions provided by other partners, e.g. water investments and sanitation and agriculture interventions in the same villages. In areas that are overlapping with the Poverty Reduction Fund II (PRF II) Project, the PRF may also be able to support water supply infrastructure, and there will be division of labor in delivery of SBCC between this sub-component and Improving Livelihood Opportunities and Nutritional Gains (LONG) Pilot under PRF II, whereby SBCC under this sub-component will focus on health/nutrition/hygiene/sanitation messages while that under the LONG pilot will focus on livelihood-linked nutrition messages.[21] In areas that are overlapping with Early Childhood Education Project (ECE), the ECE will provide support for interventions that are related to school meals and school-based gardens.[22] The project will also coordinate with the Community Awareness Campaign under the ECE to ensure complementarity and division of labor in the delivery of health, nutrition, hygiene and sanitation villages at the village level.[23] It is also expected that UNICEF, through the nutrition governance support with EU funding, will help strengthen multi-sectoral nutrition coordination platforms between stakeholders, line agencies and projects supported by different partners at the national, provincial, and for convergence districts.

91. Although the implementation of village-level SBCC strategy under Component 3 will cover a relatively small geographical area, the delivery mechanism and implementation are expected to be replicated and scaled up in other areas, contributing to sustainability.

[21] LONG pilot currently covers selected villages in 4 districts in 2 Provinces: Houaphan (Hiem, Son) and Savannakhet (Sepone and Nong). It is expected that the geographical areas will be expanded under PRF II-AF.

[22] The ECE project's school meals and school-based gardens will be implemented in 9 districts in 5 Provinces, as follows: Oudomxay (La), Houaphan (Houameuang, Xamtay, At, Sobbao, Viengxay), Xayaboury (Xaysathan), Bolikhamxay (Xaychamphone), and Phongsaly (Khoua).

[23] The objective of the community awareness campaign of the ECE project is to increase the knowledge and understanding of the parents of children aged 0-5 years as well as other community members in all target villages about: (a) the importance of ECE and the first 1,000 days of a child's life since conception; (b) appropriate parenting skills for age groups 0 to 5 on early stimulation; (c) nutrition; (d) health; (e) hygiene; and (f) childhood disability awareness. The campaign will be delivered in 23 districts in 11 Provinces.

Table 2.5: Impact of Key Nutrition and Nutrition-related Behaviors

Behavior	Impact on Nutrition
IYCF	IYCF, which includes breastfeeding and complementary feeding, is a key area to improve child survival and promote healthy growth and development. The first 2 years of a child's life are particularly important, as optimal nutrition during this period lowers morbidity and mortality, reduces the risk of chronic disease, and fosters better development overall.
Exclusive breastfeeding	Breastfeeding is widely recognized as one of the most cost-effective investments to improve child survival (UNICEF, 2013). According to The Lancet Series on Maternal and Child Under Nutrition, the adoption of exclusive breastfeeding through six months of age and continued breastfeeding through age two in 36 high burden countries could avert 11.6 percent of all deaths in children under the age of one, and nearly 10 percent of all deaths in children under the age of two (Bhutta et al., 2008a). The benefits of breastfeeding stretch beyond a child's survival. Breastfed children do better on cognitive and motor development tests, and generally achieve better academic outcomes than non-breastfed children (Horta et al., 2013).
Dietary diversity and complementary feeding	Around the age of 6 months, an infant's need for energy and nutrients starts to exceed what is provided by breast milk, and complementary foods are necessary to meet those needs. If complementary foods are not introduced when a child has reached 6 months, or if they are given inappropriately, an infant's growth may falter. (WHO, Infant and Young Child Feeding Fact Sheet, 2014 and Bhutta et al, Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Lancet, 2013).
Open defecation	Open defecation results in community environments that are fecally contaminated, which leads to diarrhea and environmental enteropathy, a sub-clinical condition of small intestine that limits nutrient absorption, and is a major cause of stunting. Open defecation rate in Lao PDR is high – 38 percent nationally, above 50 percent in the 7 priority nutrition provinces, and 82 percent among the poorest wealth quintile. Recent econometric analysis from the Lao Social Indicator Survey (LSIS-2012) data showed that open defecation and/or unimproved sanitation in rural villages of Lao PDR is associated with shorter children living in those villages. It also underscored the externalities of open defecation, even for households that use an improved toilet themselves (Quattri, et. all, 2014), hence the emphasis on ODF villages. At the same time success is also measured through incremental change in access to improved sanitation, as not all villages are expected to achieve ODF status.
Hygiene behaviors	There are several hygiene behaviors known to be essential for child health outcomes, such as hand washing with soap at critical times, such as before cooking/feeding a child/eating and after defecation/cleaning a child. Hand washing has shown to be one of the most cost-effective public health interventions (Curtis, et al, 2003). Limited research is currently available on the impact of other hygienic behaviors such as safe child feces disposal. In Lao PDR, 82 percent of households unsafely dispose child feces. Even among households with improved sanitation, almost two thirds reported unsafe child feces disposal behaviors (UNICEF/WSP, 2014). Child feces may be more harmful due to the higher prevalence of diarrhea and some pathogens in children compared to adults or animals.

Source: Strategy and Planning Framework for the Integrated Package of Maternal Neonatal and Child Health Services 2009-2015.

92. This Component will also provide technical assistance for capacity building of MOH staff at the provincial and district level for the monitoring and reporting of DLIs, capacity building of MOH staff at the national, provincial and district level for health program planning and implementation, and carrying out of studies and surveys necessary to inform the implementation of Project activities.

Component 4: Project Management, Monitoring and Evaluation (US$2.5 million)

93. This Component will support provision of technical and operational assistance for the day-to-day coordination, administration, procurement, financial management, environmental and social safeguards management, and monitoring and evaluation of the Project, including the development of checklists for supervision of health facilities, the conduct of an independent academic institution to verify the achievement of DLIs, and the carrying out of financial audits of the Project.

It will also finance technical assistance for capacity building of MOH staff at the provincial and district level for the monitoring and reporting of DLIs, capacity building of MOH staff at the national, provincial and district level for health program planning and implementation, and carrying out of studies and surveys necessary to inform the implementation of Project activities. Details are in table 2.6.

Table 2.6: Description of Studies and TA to be financed under Component 4

Activity	Description	Estimated Budget US$
Studies		
Rapid Household Surveys	Twice over the project period a rapid household survey will be conducted to provide province -level information on health and nutritional status and related information for children and women. It will provide province level estimates for key indicators and information for DLI matrices used by the provinces to monitor their progress on project objectives.	300,000
Nutrition and Knowledge, Attitude, and Practices Survey	These surveys will be undertaken in the districts covered by village SBCC activities in Component 3, including questions to understand how knowledge, attitudes and practices as a result of the SBCC activities. There will be three surveys during the project.	350,000
Technical Assistance		
Supervisory Checklist	Various Quality Supervisory Checklists exist in the Lao context including in the results based financing project. The Central department of health will review various tools and arrive at a national harmonized QSC which will have a strong focus on availability of essential drugs and commodities, availability of key service professionals, utilization of service protocols, safeguards adherence and follow up on critical health actions. Checklists are revised regularly based on lessons learned and levels of performance achieved.	150,000
Provincial DLI Program Support	Project funds will support the setting up of Regional Teams with capacities in health program planning and implementation as well as finance and administration, who will report to the DPIC.	600,000
Project Implementation Support	This will cover the costs of two deputy project directors, one for Component 2 and one for Nutrition, including Component 3 as well as procurement and financial management staff.	350,000
Independent Verification		
	The project M&E system will also contract an independent academic institution to provide third-party verification assessment on progress on DLIs. This is a core aspect of project design as the disbursements are dependent on the DLI achievement. The DPIC will contract an independent academic institution to carry out an independent sample based survey of filled supervision checklists/health management information system reports and Provincial DLI achievement reports to verify the veracity of the results. Detailed TORs, sampling methodology, and presentation of results will be included in the Operational Manual. Financing for this will come from Component 4. The draft TOR for the Independent Academic Institution was agreed at negotiations, and accordingly the selection of the organization will be carried out in accordance with the IDA guidelines. It is estimated this Independent Academic Institution will be in place by August 1, 2015.	750,000

Component 5: Contingent Emergency Response (US$0 million)

94. A Component with a provisional allocation of zero US dollars is included under this project that will allow for rapid reallocation of Grant/Credit proceeds in the event of an eligible crisis or emergency under streamlined procurement and disbursement procedures. In the event of an emergency, financial support could be mobilized by reallocation of funds from other Components and/or application for additional financing to support expenditures on a positive list of goods and/or specific works and services required for emergency recovery. In the case of such reallocation, the relevant Components' activities would be reviewed and revised as necessary. Requirements for withdrawals under this Component include: (a) preparation and disclosure of all safeguards instruments required for activities under the Components, if any, and the government has implemented any actions which are required to be taken under said instruments; (b) establishment of adequate implementation arrangements, satisfactory to the IDA, including staff and resources for the purposes of said activities; and (c) preparation and adoption of the ERM acceptable to IDA and annexed to the Operational Manual. Disbursements under this Component will be made according to the process described in Annex 3.

SUPPORT TO GENDER

95. This Project's support to Government's policy on free MNCH and nutrition is expected to be highly beneficial to women and children, through reduced costs for services (ante- and post-natal care, care at delivery, and for infants and children up to the age of five), and Government's aim to have midwives at health center level. Reforms supported will also benefit women through better trained staff and better quality service delivery; filling gaps through selection of health workers to be from female and non-Lao Tai ethnic group staff, course content that is sensitive to gender and ethnicity, and includes an emphasis on MNCH, including nutrition, reproductive health and family planning. Outreach activities supported will continue to work with women's groups (i.e., Lao Women's Union) at the village level. Ongoing efforts to ensure that outreach services provide an environment for women to talk about their health in private will continue, with separate (male and female) focus group discussion at village level in order to ensure that women can discuss and articulate their health priorities; peer learning will use separate gender based groups to ensure understanding of messages, and men will be sensitized about the importance of nutrition during pregnancy. Health planning needs will be based on sex-disaggregated data and on monitoring indicators, and data collection methodologies will be reviewed. Project's support for health management information system (DHIS2) will improve gender disaggregated monitoring of services. Performance indicators will be disaggregated to the extent possible, in order to track gender inequalities. The Gender Action Plan prepared will also guide Program implementation.

Annex 3: Implementation Arrangements

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

Project Institutional and Implementation Arrangements

96. The Project will be implemented by the MOH through DPIC, MOH technical departments and 14 PHOs and DHOs. Responsible MOH Departments include: (a) DPIC; (b) Hygiene and Health Promotion; (c) Health Care; and (d) Finance.

97. The MOH intends to establish an NPCO in the DPIC that would be responsible for the execution of the ADB and IDA financed Projects. The Director General of the DPIC will be the Program Director. The NPCO will be responsible for *inter alia*: (a) the overall administration of the Project, including the preparation of Annual Work Plans and Budgets and approval of the Project Operations Manual; (b) the overall implementation of Project activities and achievement of DLIs at the national level with the support of MOH technical departments and those PHOs and DHOs participating in the Project; (c) the overall administration of financial management, procurement, environmental and social safeguards management, and communication of all Project activities; (d) the overall monitoring, evaluation and reporting of Project activities and DLIs; and (e) reporting to Technical Working Groups on the implementation of Project activities and the achievement of DLIs.

98. The NPCO will also be responsible for preparing the terms of reference (TORs) and providing input with respect to various procurement related committees which will need to be established, while the Procurement Unit will handle the procurement aspects and contract management by preparing the appropriate documents to ensure that procurement activities are in line with the World Bank's Consultant Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 and revised in July 2014, and provisions stipulated in the Financing Agreement. For matters pertaining to FM, the NPCO will be responsible for ensuring that the activities undertaken are in line with the Financing Agreement, as well as for preparation of documents pertaining to FM. This includes, but is not limited to, ensuring appropriate documentation is maintained, quarterly reports are prepared, and documents necessary for annual audits are prepared.

99. The PHOs will be responsible for: (a) the implementation of Project activities and achievement of DLIs at the provincial level; (b) the monitoring and reporting to the MOH of Project activities and achievement of DLIs at the provincial level; and (c) the provision of technical support to DHOs in the implementation of Project activities at the district level and village level.

100. The DHOs will be responsible for: (a) the implementation of Project activities at the district and village level and reporting to the PHO on said activities; and (b) the supervision and provision of technical support to health facilities in their delivery of reproductive, maternal and child health, and nutrition services.

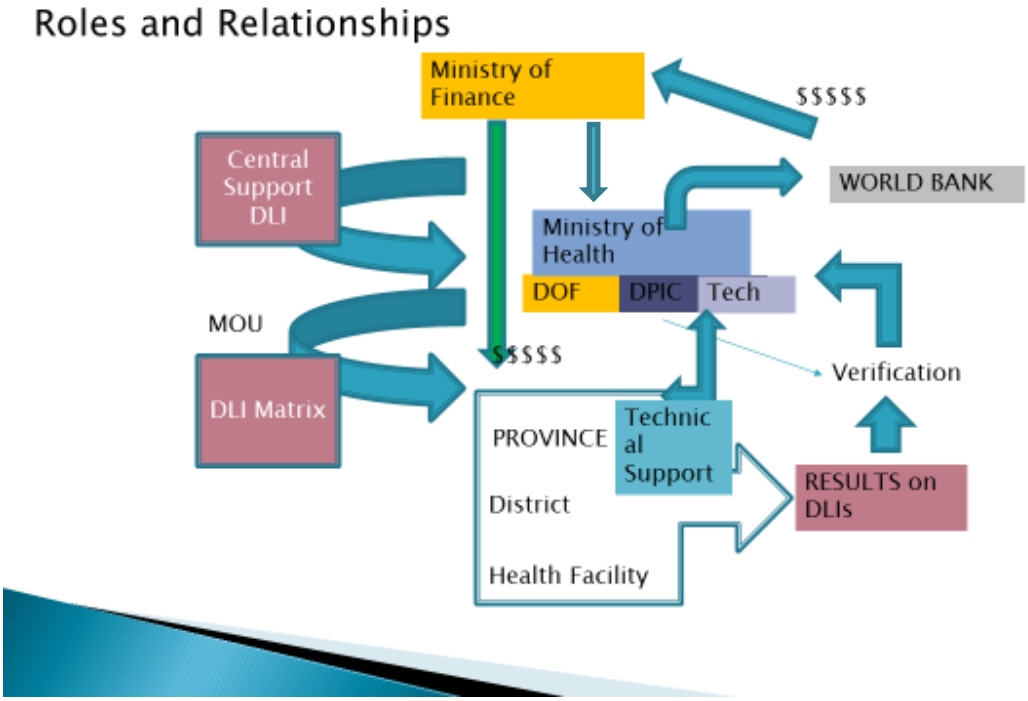
101. Although the World Bank's fiduciary and safeguard policies do not apply to the ADB-financed project, the World Bank and ADB have agreed to rely on common government implementation arrangements and to align as much as possible their fiduciary and safeguard requirements in support of the government's program. To this end, the Bank and ADB will rely on common safeguard instruments and operational manual which have been prepared by the Government to satisfy the fiduciary and safeguard requirements of both institutions, and will undertake joint implementation reviews.

102. The proposed Project will support the implementation of the Government's overall health sector program embedded in the HSRF, in coordination with various projects financed by other development partners in Lao PDR, including the UN agencies (e.g. UNICEF, UNFPA, WHO), the European Union, the ADB, Lux-Development and bilateral partners (Korea, Japan, USA). In particular, the Bank-financed project will be closely aligned and coordinated with a complementary project which will be financed by an ADB policy-based loan, investment loan and TA grant, and which will support improvements in health sector reform processes, social protection of the poor through HEFs, mother and child health care, human resources management capacity, and health sector FM.

DLIs

103. With respect to the DLIs, the Project will use the Government decentralized structure to support implementation of the project. Roles and responsibilities for each level of Government are noted in the figure below and further highlighted in the table below.

Figure 3.1 Organizational Chart of DLIs



104. Technical support for project implementation of the DLIs will derive from different levels of the Lao health system. The Technical Departments at MOH Central level will be responsible for the development and capacity building on protocols for service delivery of MNCH and nutrition services. Similarly, PHOs will be responsible for capacity building of DHOs on the use of supervisory checklists and implementation of service protocols. To ensure that additional capacity is available for provinces to plan and implement services and thereby achieve the DLIs, two key additional TA avenues will be established: (a) Project funds will support TA (financed under Component 4) with capacities in health program planning and implementation, who will report to the DPIC; (b) at the Province level, as a part of the efforts to harmonize TA, all development partners active in the sector in the Province will work together to arrive at a TA Plan to support implementation of the service programs and achievement of the DLIs.

105. ***DLI Component Costing, Funds Flow, Eligible Expenditures***. Project funds will be part of, and additional to, the overall MOH budget and flow through existing government mechanisms. Disbursements for the first year will be made at the time of IDA Project effectiveness, and subsequently at the beginning of each FY based on achievement of DLIs of the preceding year. Disbursement on Project effectiveness, and in subsequent years, will be contingent upon the borrower fulfilling these requirements: (i) adopting the Project Operations Manual, in form and substance satisfactory to IDA; (ii) furnishing evidence satisfactory to IDA that it has achieved the respective DLIs targets; including that a memorandum of understanding, in form and substance satisfactory to IDA, has been duly executed between the MOH and the target provinces; and (iii) furnishing to IDA the interim unaudited reports documenting the incurrence of EEPs against which withdrawal is requested. If the EEP is lower than the DLI values, the subsequent disbursement of IDA will be adjusted accordingly—a situation which is not expected to occur. The proposed EEP, which will be set forth in the Projects Operations Manual, would consist of the GOL's expenditure line Chapter 10 (wages, salaries for government health staff). The budget figure for Chapter 10 is adequate for the purpose of the EEPs. The interim unaudited report will also include evidence of the additionality that IDA funds bring to the central and provincial level allocation of GOL and provincial budget (not applicable in the first year). Efforts will be made to synchronize the disbursement of IDA funds with the GOL's budget cycle. DLI measurement, reporting and fund release will therefore be timed so that resources are available just prior to the start of Lao FY. On project completion, the final DLI achievement for DLI 2018 would be verified by the third party evaluation by September 15, 2019.

106. Retroactive financing of up to SDR 3,760,000 may be provided under the IDA credit and grant to finance payments made for eligible expenditures during the period between October 1, 2014 and the signing of the Financing Agreement.

107. When deciding on the amount to be disbursed based on DLI achievement, a discrepancy of up to 5 percent between the internal and the external verification will be accepted as having achieved the target. In the case of partial achievement of a DLI target, a minimum value of 60 percent of the DLI target must be achieved to qualify for payment; in cases of achieving less than 100 percent but more than 59 percent, the province will receive 50 percent of the DLI value

(rounded to the nearest whole number); the amount not disbursed will be added to the following year, in case the target for that year is achieved. If targets are not fully achieved the following year, the amount not disbursed will be added to the total amount to be disbursed to all provinces through DLI achievement. If, at the end of the project, all funds for Component 2 have not been disbursed due to non-achievement of DLIs, the remaining amount may be cancelled or the GOL may request for a project extension and restructuring to utilize the unspent amount.

Results Monitoring and Reporting

108. Results monitoring is an integral part of a performance management system; the project will invest in strengthening M&E mechanisms. There will be two elements to this strengthened M&E system:

(a) Internal Monitoring System: This will be done through two key tools:

(i) Supervision Checklist for Quality Monitoring, where the Province and District management teams will use a standardized supervision checklist on a quarterly basis to review health center/districts' performance and provide a quality score. This Supervisory Checklist serves two key functions: it has a system strengthening effect and provides supervisory health teams with a rigorous tool to assist health facilities to adhere to national norms and guidelines. The quantitative quality checklist is applied once per quarter to each health center and district hospital, in the target provinces. Data from the supervision checklist will be entered on an online dashboard and disclosed for improved transparency and review so that corrective action can be taken; and

(ii) DHIS2, which can provide up-to-date health information for service output monitoring and will be used to track performance on most of the DLIs.

(b) External Monitoring System: To ensure financing for results through DLIs linked to credible data, the Project will use two interlinked methods for tracking validity of information: (i) an Independent Academic Institution will be hired for the duration of the project, and will use a sample survey methodology to verify data on the DLIs from the participating Provinces and the Central level and report to the DPIC; and (ii) Periodic Surveys will be carried out to measure project performance against the results framework. These surveys will include (i) a community based health indicator survey (mini demographic health survey/multiple indicator cluster survey) to track performance on progress against health outcomes; (ii) a Service Delivery Survey to track performance of health service quality (SDS/SARA); and (iii) a PER. These surveys/studies will be interspersed throughout the project implementation and will be led by the DPIC. These surveys will be financed through the on-going analytical work support by the World Bank and other DPs, particularly WHO.

109. Reporting on progress of the Health Sector Reform Strategy Program will be made to the relevant Technical Working Groups which already exist in the MOH. A single report will be prepared reporting on progress of IDA and ADB supported interventions separately. In addition,

the DPIC will use existing reporting structures for reporting internally, and to the development partners, as appropriate.

110. Government is in the process of formalizing the set-up of a Technical Working Group for Food and Nutrition Security, chaired by the Deputy Minister of Health to support the National Nutrition Committee and its Secretariat; the IDA financed Project will report on matters relating to nutrition in this forum once it is set up. It is proposed that reporting back on the overall progress under this financing be made to the operational level Sector Working Group for Health which meets four times a year and has wide participation from the development partners and relevant sector ministries.

Financial Management, Disbursements and Procurement

111. The assessment was carried out in accordance with OP/BP 10.0. The assessment is based on an assessment carried out for the HISP and field assessment of Accounting and Finance Unit at MOH and of two provinces. The assessment is carried out to assess if the existing FM arrangement is adequate for the project.

112. The overall FM risk for this project is assessed as high. The main risks are associated with: (a) limited and weak capacity of the staff health centers, district level and provincial levels to manage the larger scale of operational budget; (b) inadequate guidance in planning and budgeting at provincial and district level; (c) delay in the release of funds due inability to submit expenditures reports and budgets on time; and (d) inadequate documentation of policies and procedures. Risk mitigation measures to address risks (a) and (b) are included as part of the reforms under financed by the ADB. Key actions to be undertaken include: (a) open provincial account specifically to store/receive funds to ensure availability and timely release of funds; (b) have in place acceptable FM manual/guidelines to be used for both ADB and IDA- this action will mainly be supported by ADB with the World Bank review to ensure compliance with Bank requirements; (c) provide FM training to staff at all levels: this will be supported by both ADB and WB; (d) recruit qualified FM consultants to provide support and training to provincial and district level staff during initial startup of the project: - this will be supported by WB until the ADB support becomes available; and (e) recruit qualified FM consultant to provide FM support to Department of Finance at Central MOH level – to be supported by IDA. Per IDA Access to Information Policy, audit reports will be made public.

113. ***Project/Program financial management***. It has been agreed that the Financial Control Unit, a part of the NPCO, will be responsible for FM. The unit will be located at the DPIC within MOH. The unit will be responsible for maintaining accurate accounting records for the projects, maintaining adequate support documents, preparing timely financial reports, ensuring the timely release of funds to the provinces and Central level MOH from the MOF treasury and putting in place satisfactory auditing arrangements for the projects as required. The Financial Control Unit will be headed by a Director of Finance and a number of staff. They have staff with required experience and qualification capable of maintaining the required accurate accounting records.

114. ***Staffing***. There are limited staff at provincial and district finance unit. On average PHO have between 5-6 staff and 2-3 staff at DHOs. There is also no designated accounting/finance

staff at health center level. The head of health center or one other staff is responsible for finance of the health center. Most of the staff at provincial and district level have extensive experience in their current accounting and finance job. Although staff at some PHO and DHO have extensive experience in their job and have been trained by various development partners, they still lack in depth accounting and FM knowledge and skills to be able to manage and resolve issues on their own. There is also the challenge with periodic loss of capacity through staff transfer and promotion in some provinces. Hence, availability of capable staff at provincial and district level remain a constraint. Therefore, improving the knowledge and skills through training and coaching and increasing number of staff will enable PHO and DHO to manage increase funding from the project. The ADB as part of the support to FM reform under the HSRF, will finance a comprehensive package of support to provincial and district staff development of computerized accounting systems and training to facilitate roll out of reforms. However, as an interim measure, the IDA's TA will support by assigning FM consultants to support the PHO and DHO staff until ADB regional teams are in place.

115. At MOH Central level, there are adequate staff at the Department of Finance. The staff has many years of experience in their current positions. Staff capacity is assessed as adequate to manage and report using government system. In addition IDA will provide some short term FM specialist support to ensure effective delivery of the FM functions at the initial start of project implementation.

116. ***Planning & Budgeting***. At provincial level, the PHO is responsible for coordinating budget plans for PHOs, DHOs and various units within the PHO responsible for vertical programs. The provincial budget is certified by the Administration Section and approved by PHO Director prior to submission to the Provincial Finance Office and MOH. MOH then consolidates and submits to MOF for onward submission and approval by National Assembly. Once approved by the National Assembly, MOH announced the budget allocation to provinces. Budget may need to be adjusted in some cases to fit the overall approved envelop. Although, budgeting follow bottom up approach, there are some challenges, including limited guidance on budget preparation e.g. health sector priorities to be achieved and limited ability to combine or link budget to physical or output information in the budget plan. These challenges will be addressed in short term through detailed procedures and guidance on budgeting for all levels as part of the Operations Manual. In the longer term, the ADB Project will also introduced reforms in the budgeting areas at provincial levels and below i.e. support 'bottom up' provincial planning and budgeting processes. It is envisaged that in determining the annual provincial allocation, the IDA will follow the existing formula, budgeting and approval procedures as proposed by the ADB and in use by the MOH presently. The use of one formula and arriving at figures for each province without identifying sources of financing will avoid duplication. This will normally be financed by ADB program funds, IDA DLI component and normal GOL budget funds.

117. The budget for Component 1 and Component 3 will be prepared specifically for the project by the respective implementing departments. The budget will be consolidated by the Financial Control Unit and will be sent to the IDA for review and no objection prior to implementation. This will be part of the annual work planning process to ensure effective project implementation.

118. ***Fund flows.*** Under the government system, funds are withdrawn from respective treasury or finance offices. At the central level, it is through the National Treasury. Withdrawals are made via GFIS i.e. request is prepared and approve in the system. However, not all spending units have such facilities. At provincial level, a manual system or paper based forms are still largely in use. Challenges identified include delay in disbursement of funds due to inability to submit expenditure report timely and delay in approval of budget and availability of cash at treasuries at each level. To overcome these issues, clear procedures on approval and submission of report will be outlined in the operations manual and opening of account at provincial level specifically to receive and make available funds at provincial level as part of the arrangements under the project.

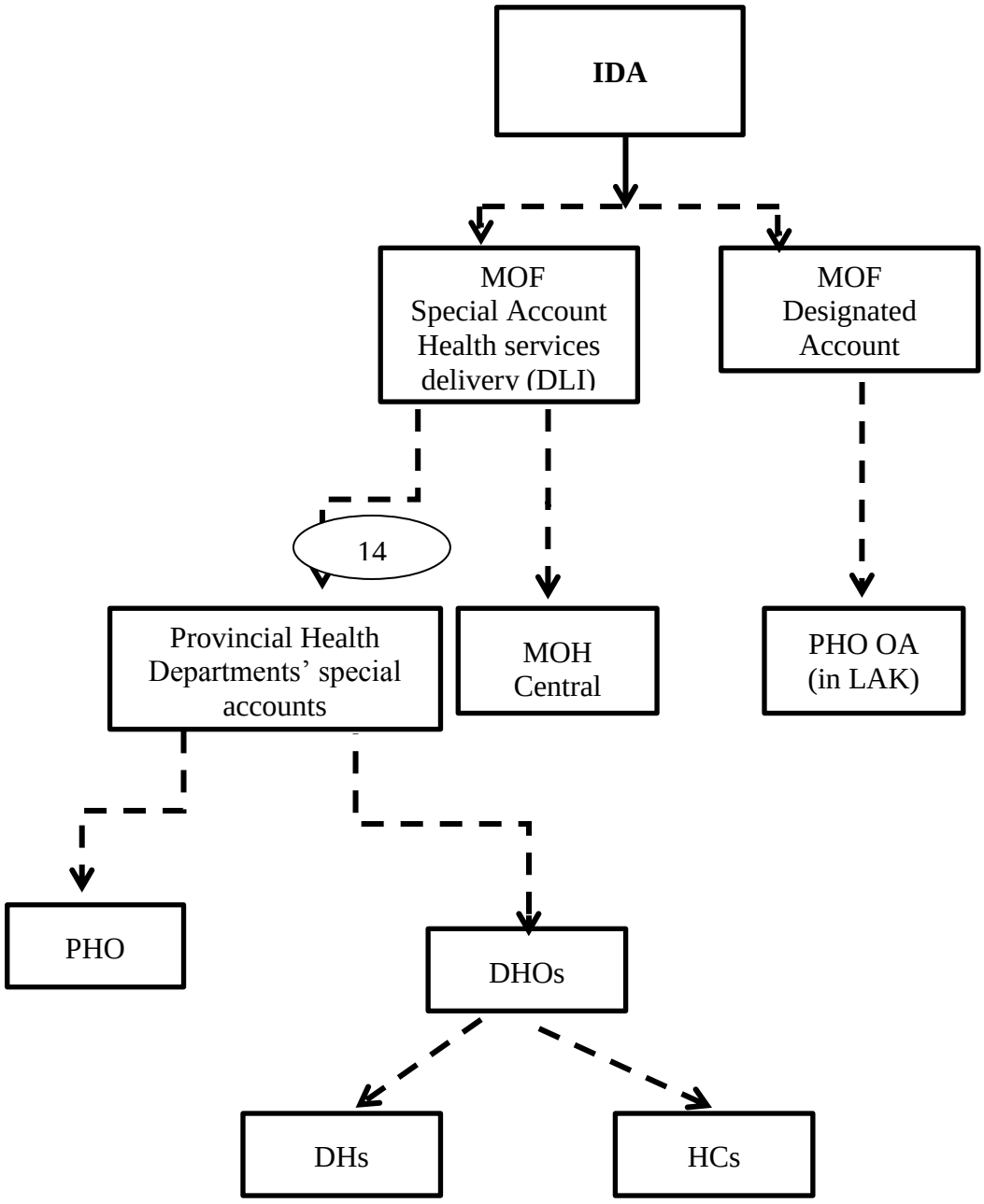
119. ***Flow of IDA funds to Ministry of Finance***. It is envisaged that one designated account (DA) will be opened at the Bank of Lao, managed by Treasury, MOF to be used to support components 1, 3 and 4 of the project. The GOL/MOH will also open a second account at the Bank of Lao and also managed by the Treasury, MOF to be used for Component 2 which will receive funds once DLIs have been achieved and results verified. The total value of DLIs achieved will be transferred 100 percent to this GOL bank account on the basis of certified EEPs as captured in the MOH financial reports (budget execution reports). The disbursement for this component will be on the basis of reimbursement for MOH incurred and financed expenditures relating to the EEPs. It is expected that this bank account, to be advised to World Bank can be pooled with ADB program funds for supporting MOH activities. This will also ensure easy verification that these funds are additional to the MOH's budget funding from GOL. DA for Component 1, 3 and 4 of the project will be based on traditional input based disbursement. DA will support the TA and other activities under the project which will be input based and payments made as advances into the DA, which will require the funds to be accounted for and reconciled on regular basis. The ceiling for this DA will be flexible or variable and will be based on the six month planned expenditure. Figure 3.2 illustrates the Project's flow of funds.

120. For Component 2, funds will be transferred from MOF to MOH Central, provincial and below following the GOL funds flow procedures. However, to ensure sufficiency and timely release of funds, a bank account at the provincial level is required to be opened specifically to receive transfer of funds from MOF. Once the fund is received into the provincial account, PHO will make transfers to levels below them according to the approved budget. For transfer to PHO and MOH Central, the amount will be based on the value of the related DLIs achieved and independently verified. Based on verification report, MOH will make a request to MOF for the transfer to each related level.

121. For components 1, 3 and 4, funds will flow to provincial account and to district account, in line with approved work plans and budgets. Funds will be made available to the provincial and district levels to enable them undertake their respective activities. Each level will be required to report on use of funds in line with agreed format of reporting. These reports will be consolidated by the –DPIC/NPCO at the MOH head office and one report sent to the ADB and WB. They (all levels) will be required to maintain the support documents at their offices and make them available for IDA team review missions and external audits.

122. The provincial accounts shall be operating accounts which will be opened to facilitate day to day operation and small payments. The account will be denominated in LAK with a ceiling of an equivalent of US$25,000.

Figure 3.2: Fund Flow Arrangement



MOF = Ministry Of Finance, MOH: Ministry of Health, PHO = Provincial Health Office, PH = Provincial Hospital, DHO = District Health Office, DH = District Hospital, HC = Health Center, OA = Operating Account

123. ***Internal control procedure***. Payment procedures and internal controls systems are not documented in a single manual at all levels. However, there are instructions issued by MOF departments, in particular, National Treasury in relation to making and requesting payments. There are also internal approval procedures to control expenditures individually developed and may differ from one place to another. Although, there appears to be written job descriptions, however the roles and responsibilities, line of reporting and limits of authority are not well defined. Moreover, there is no clear segregation of duties especially in places where staff numbers are limited. Bank reconciliation and system of safeguarding of assets are also not practiced, especially in provincial and district level.

124. The existing procedures of the government under the applicable financial rules and regulations, including various national manuals and guidelines in relation to MNCH and nutrition, will be used to support the implementation of Component 2 of this project. The National manual or guideline for MNCH activities is closely aligned with manuals currently used in the existing IDA-financed project, HSIP. As an immediate measure, systems of internal controls shall be strengthened/improved and be documented and used to supplement the current government system.

125. For other components, procedures as detailed in the FM manual will be followed.

126. ***Recording and reporting***. The government system uses government financial information system (GFIS) to record expenditure and produce the budget expenditure implementation report. At the provincial level, GFIS or Excel is used. At district level, due to lack of capacity and equipment, an Excel and paper based recording system is used. For provinces supported by overseas development assistance, various accounting software are used to record project expenditure e.g. Manila (used by ADB financed projects) and PAS (used by IDA financed projects). Manila software allows recording of expenditure of government budget in accordance with the government chart of account, whereas the software used by IDA project records expenditure in accordance with project chart of account which differs from the government. Manila software may be used to support accounting and reporting of Component 2 at provincial level where GFIS is not in used. For the purpose of the project, an annual health sector budget expenditure implementation report will be required to be submitted to IDA for disbursement of Component 2. Therefore, this report must be prepared and provided to the IDA timely to avoid disbursement delay.

127. As for Components 1, 3 and 4, software used by the Financial Control Unit will be used to record transactions. Transactions must be recorded by component and disbursement category. Semi-annual IUFR must be prepared to report on these expenditures and submitted to the IDA no later than 45 days after the semester end.

128. The project will follow the government's reporting period of October 1 to September 30.

129. ***Internal Audit***. There are inspection units within the MOH and PHOs. However, their main activity is to review staff behavior and compliance with government rules and regulations. Staff in the unit is often limited in numbers as well as skills and knowledge in audit is still limited.

130. ***External Audit***. The State Audit Organization (SAO) audits MOH. PHOs are also to be audited by SAO as part of audit of the province accounts. However, there is no audit report of the PHOs in the six provinces visited. With limited staff and capacity, audit of ministries are often in arrears. Given that we are using government health sector expenditures as EEPs, the IDA will require MOH to forward a copy of the audit report and management letter of the MOH and the target provinces conducted by SAO to the IDA after these reports are submitted to parliament.

131. The IDA project will be audited by the SAO. This will be done in accordance with TOR acceptable to IDA and the annual audited report together with management letter will be submitted to the IDA no later than six months after the end of each FY. At any point during project implementation, the IDA has the discretion to request the implementing agency (MOH) to recruit private auditors if there is a concern over the quality of the audit or significant governance issues related to the audit are discovered. IDA will assess the performance and quality of the audit report after the first year audit report is submitted.

132. The project audited financial statements will be subject to public disclosure. The mechanism for disclosure is to be agreed.

Implementation Support and Supervision Plan

133. Implementation support for FM functions will be provided more frequently to the task and client teams in the first year of project implementation; IDA will then limit its review to at least bi-annually thereafter depending on the updated project FM risk assessment and progress. The FM missions will include reviews of the continuous adequacy of the FM arrangements, progress with FM capacity building activities, adequacy and timeliness of preparation of IUFRs and progress in implementation of agreed FM actions and recommendations from project audits. The table below identifies the FM actions required.

Table 3.1: FM Actions

Required actions	Timing
Draft financial management manual	July 30, 2015
Agree on audit terms of reference	July 30, 2015

Eligible Expenditures Program for Component 2 -DLI Based Approach

134. As the project seeks to provide flexible and predictable funding for strengthening MNCH, and nutrition services, it will use a set of GOL budget expenditure lines as the basis of expenditures to support the payment of funds from the IDA credit and grant. These expenditures will be the EEP. These EEP will be used as basis of expenditures when the DLIs have been met. After review of GOL expenditure lines, Chapter 10, salaries for health sector workers have been identified as EEPs under this project and will be set forth in the Project Operations Manual. The GOL has to demonstrate that expenditures on Chapter 10 for health sector (Center and Province) exceed the amount being requested from IDA in the particular reporting period. This demonstration will be through submission of the budget execution expenditure implementation

report prepared by the MOH for Central level and Provinces and certified by the Director of Finance of the MOH.

Disbursement Arrangements for Component 2 -DLI Based Approach

135. IDA will disburse funds based on achievement of DLI targets at each level. Different sets of DLIs are being proposed for provinces and Central MOH level.

136. Project funds are expected to be additional to the overall MOH budget and flow through existing government mechanisms. Disbursements is planned to follow the Government budget cycle ensuring that funds are available at the start of the implementation of the each budget year. The first year funds are likely to be available only after Project effectiveness which could be sometimes within the first quarter of the start of the FY, and subsequently at the beginning of each FY based on achievement of DLIs of the preceding year Disbursement under Category (1) relating to the EEP will be based on the MOH fulfilling the following requirements: (i) adopting the Project Operations Manual, in form and substance satisfactory to IDA; (ii) furnishing evidence satisfactory to IDA that it has achieved the respective DLIs targets; including that a memorandum of understanding, in form and substance satisfactory to IDA, has been duly executed between the MOH and the target provinces; and (iii) furnishing to IDA the interim unaudited reports documenting the incurrence of EEPs against which withdrawal is requested. The interim unaudited report will also will also include evidence of the additionality that IDA funds bring to the central and provincial level allocation of GOL and provincial budget (not applicable in the first year). Efforts will be made to synchronize the disbursement of IDA funds with the GOL's budget cycle. DLI measurement and reporting and fund release will therefore be timed so that resources are available at the start of Lao FY. On project completion, the final DLI achievement for DLI 2018 would be verified by the third party evaluation by September 15, 2019. If, at the end of the project, all funds for Component 2 have not been disbursed due to non-achievement of DLIs, the remaining amount may be cancelled or the GOL may request for a project extension and restructuring to utilize the unspent amount.

137. Retroactive financing of up to SDR 3,760,000 may be provided under the IDA credit and grant to finance payments made for eligible expenditures during the period between October 1, 2014 and the signing of the Financing Agreement.

Financing at the Province Level

138. Performance of the Province on DLI achievement will be monitored annually and payment will be as per achievement and the value attached to each DLI. The total amount allocated to each Province using the proposed allocation formula based on population and poverty is in Table 3.3.

Disbursement calendar and GOL budget cycle

139. In an effort to synchronize the disbursement of IDA funds with the GOL's budget cycle, the following calendar of actions has been developed. DLI measurement and reporting will be done annually, as they relate to the GOL's FY (October 1 to September 30), with verification

carried out by August 31, and disbursement of following and subsequent years' payments completed by October.

Table 3.2: Disbursement-Related Steps

Date	IDA disbursement-related steps
	First Year
September	Disbursement of year one amount for provinces (as per the allocation formula) and Central level at project effectiveness based on achieved DLIs for Year 0 and documented unaudited eligible expenditures programs (EEPs) for 12 months prior to signing.
	Subsequent Years
June 1	Province prepares a report on annual DLI performance (June – May for DLIs 1-6 and previous financial year (October – September for DLI 7); Center prepared a DLI performance report (June – May).
June 15	Both Province and Center prepare report on Eligible Expenditures plus document that IDA funding has been additional to regular government funding.
July 1	DPIC contracts the I-Independent Academic Institution verify the DLI reports.
August 31	DPIC prepares report from the DLI report, which includes the Eligible Expenditure Report, the Internal Verification Report and the Verification Agents Report, and forwards to MOF; A summary report and a disbursement request is then forwarded to IDA.
September 1	IDA fields review mission, reviews the DLI report and GOL request; prepares policy dialogue report along with aide memoire which includes a table showing the DLI disbursement.
September 15	IDA sends intimation of funds release to MOF.
	Review and evaluation
Every month	Health Centers & Districts prepare HMIS report and enter into DHIS2
Quarterly	District and provinces report on score from supervisory checklist and villages in Zones 2 & 3 for outreach clinics are held by MOH
Monthly	District meeting with Health Centers to review performance
Monthly	Provincial meeting with districts to review performance
Quarterly	DPIC meeting with provinces to review performance

Disbursement Arrangements-Input Based Approach for Component 1, Component 3 and Component 4

140. The primary disbursement methods will be Advances and Direct Payments. Reimbursements will also be made available. One DA will be opened at the National Treasury, MOF. The DA will be denominated in US Dollars. The ceiling will be variable based on six monthly forecast. Supporting documentation required for eligible expenditures paid from the DAs are Summary Sheets with Records and Statement of Expenditures (SOEs).

Reimbursements will also be documented by SOEs. Direct Payments will be documented by records. The frequency of reporting of expenditures paid from the DAs shall be monthly or a period not exceeding 3 months.

141. The minimum application size for Reimbursements and Direct Payments will be equivalent to US$100,000.[24]

Disbursement for Component 5: Contingent Emergency Response

142. No withdrawal shall be made under Component 5 until the government has: (a) prepared and disclosed all safeguards instruments required for activities under Component 5 of the Project, if any, and the government has implemented any actions which are required to be taken under said instruments; (b) established adequate implementation arrangements, including a positive list of goods and/or specific works and services required for emergency recovery, satisfactory to the IDA, including staff and resources for the purposes of said activities; and (c) has prepared and adopted an ERM, acceptable to IDA and annexed to the Operational Manual, so as to be appropriate for the inclusion and implementation of activities under Component 5. The ERM will be developed during the first year of project implementation, or in any event prior to the release of any funds under Component 5.

143. **Disbursements** would be made either against a positive list of critical goods and/or against the procurement of works, and consultant services required to support the immediate response and recovery needs of GOL.[25] All expenditures under this component, should it be triggered, will be in accordance with OP/BP 10.00 and will be appraised, reviewed and found to be acceptable to the Bank before any disbursement is made. All supporting documents for reimbursement of such expenditures will be verified by the Financial Control Unit and the implementing department, certifying that the expenditures were incurred for the intended purpose and to enable a fast recovery following the crisis or emergency, before the withdrawal application is submitted to the Bank. This verification would be sent to the Bank together with the application.

144. Disbursements from the Grant and Credit shall be made against the following expenditure categories:

[24] Proposed amount in DL; to be determined/confirmed.
[25] To be confirmed.

Table 3.3: IDA Credit Expenditure Categories and Amounts

Category	Amount of the Grant Allocated (expressed in SDR)	Amount of the Credit Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Eligible Expenditure Programs under Part 2 of the Project	6,900,000	6,900,000	100%
(2) Goods, non-consulting services, consultants' services, Training and Workshops, and Operating Costs under Parts 1, 3 and 4 of the Project	2,500,000	2,500,000	100%
(3) Emergency Expenditures under Part 5 of the Project	0	0	100%
TOTAL AMOUNT	9,400,000	9,400,000	

Disbursement Arrangements (All Components)

145. The project will have a Disbursement Deadline Date (final date on which the IDA will accept applications for withdrawal from the Recipient or documentation on the use of Grant and Credit proceeds already advanced by the IDA) of four months after the Closing Date of the project. This "Grace Period" is granted in order to permit the orderly project completion and closure of the Credit and Grant account via the submission of applications and supporting documentation for expenditures incurred on or before the Closing Date. Expenditures incurred between the Closing Date and the Disbursement Deadline Date are not eligible for disbursement. All documentation for expenditure forwarded to IDA for disbursements will be retained and be made available to the external auditors for their annual audit, and to the IDA and its representatives if requested[26]. In the event that auditors or the IDA implementation support missions find that disbursements made were not justified by the supporting documentation (including IUFRs, SOEs, and DLI reports), or are ineligible (either due to non-adherence to EEP or due to under-achievement of DLIs in the case of Component 1), the IDA may, at its discretion,

[26] The General Conditions require the Recipient to retain all records (contracts, orders, invoices, bills, receipts, and other documents) evidencing eligible expenditures and to enable the WB's representative to examine such records. They also require the records to be retained for at least one year following receipt by the WB of the final audited financial statement required in accordance with the legal agreement or two years after the closing date, whichever is later. Recipients are responsible for ensuring that document retention beyond the period required by the legal agreement complies with their government's regulations

require the Recipient to: (a) refund an equivalent amount to the IDA; or (b) exceptionally, provide substitute documentation evidencing other eligible expenditures.

146. In the event that auditors or the IDA implementation support missions find that disbursements made were not justified by the supporting documentation (including IUFRs, SOEs, and DLI reports), or are ineligible (either due to non-adherence to EEP or due to under-achievement of DLIs in the case of Component 1), the IDA may, at its discretion, require the Recipient to: (a) refund an equivalent amount to the IDA; or (b) exceptionally, provide substitute documentation evidencing other eligible expenditures.

Procurement

147. A procurement capacity and risk assessment of NPCO was carried out by IDA. The assessment reviewed the staffing and institutional arrangement of NPCO for procurement. The major risks and mitigations are summarized as follows:

(a) Delays in procurement process: based on the past experience, procurement can be subject to delays at various stages, especially when documents are subject to approval by the minister, which may in turn cause delays in project implementation. This risk would be mitigated by careful procurement planning and scheduling, procurement advancing as much as possible, procurement monitoring by using procurement tracking form, closer coordination between NPCO, Implementing Departments and the Association and more frequent supervisions and follow up by the Association.

(b) Less experience and capacity of staff in the NPCO: Procurement training and capacity development will be provided to the staff of the NPCO to increase their knowledge and capacity to carry out procurement in accordance with government and the IDA procedures. Staff in the NPCO also will be invited to attend the WBG's procurement training workshop. NPCO will retain the required staff to carry out the procurement activities.

(c) Relatively complex procurement (QCBS, QBS etc.): all complex procurement of consulting services shall be carried out with the assistance by the procurement advisor.

(d) All communications between the NPCO and other departments will be done through Director of DPIC. The DG of DPIC is assigned as Project Director. For each of the contracts to be procured, a detailed monitoring schedule will be prepared by the NPCO which will indicate the time to be used by the related departments in each of the steps of procurement process. This schedule will be used for monitoring progress by both MOH and the IDA task team.

148. The overall procurement risk is rated as high.

149. In addition to prior review, field procurement supervision will be conducted as part of the regular implementation support missions, which will be conducted at least twice a year. The IDA

will periodically undertake the ex-post review by a procurement specialist; once a year in case there are sufficient contracts for review.

150. Applicable Guidelines: Procurement for the proposed Project will be carried out in accordance with the World Bank Guidelines: Procurement under IBRD Loans and IDA Credits, dated January 2011 and revised in July 2014; and Guidelines: Selection and Employment of Consultants by World Bank Borrowers, dated January 2011 and revised in July 2014, and the provisions stipulated in the Legal Agreements for the proposed Project.

151. Procurement plan: The MOH has prepared a common detailed Procurement Plan for the first 18 months of Components 1, 3, and 4, which provided the basis for the selected procurement procedures. Component 2 will finance Chapter 10 (wages, salaries for government health staff). Wages and salaries are not procurable and no procurement is involved for this Component. This Plan has been discussed and agreed with the IDA on May 11, 2015 as summarized below. The Plan will be updated with the WBG's prior concurrence, annually or as required, to reflect changes in implementation needs and improvements in institutional capacity. The procurement plan is summarized as follows:

Goods and Works and non-consulting services.

152. **Prior Review Threshold**: Procurement Decisions subject to Prior Review by the WBG as stated in Appendix 1 to the Guidelines for Procurement*:*

Table 3.4: Prior Review Threshold

Ref. No.	Procurement Method	Procurement Method Threshold	Comments (Prior Review Requirement)
1	National Competitive Bidding (NCB) (Goods)	100,000 - <500,000	First contract
2	Shopping (Goods)	<100,000	

Selection of Consultants

153. **Prior Review Threshold**: Selection decisions subject to Prior Review by the World Bank as stated in Appendix 1 to the Guidelines Selection and Employment of Consultants:

Table 3.5: Prior Review Threshold

Ref. No.	Selection Method	Procurement Method Threshold	Prior Review Requirements
1.	Quality and Cost based Selection (QCBS), and Quality Based Selection (QBS)	>= 300,000	All
2	Least Cost Selection (LCS) and Selection based on Consultants' Qualifications (CQS)	<300,000	>= US$100,000 and/or first Contract for each selection method regardless of value
3.	Single Source (Firms)		All
4.	Individual		>10,000 for Single Source Selection (SSS) and contracts for fiduciary or legal assignments

154. **Short list comprising entirely of national consultants**: Short list of consultants for services, estimated to cost less than US$200,000 equivalent per contract, may comprise entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Table 3.6: Procurement Plan with Procurement Methods and Timelines, First Eighteen Months

PP ref	Goods and Works	Estimated Cost (USD)	Method	Review by Bank (Prior / Post)	Expected Bid Opening Date	Implementers	Remarks
1	2	3	4	5	6	7	8
Component 1 : Health Sector Governance Reform							
	Support to MOH Information Management						
C1/G/01	Printing registration Form for Free MCH and Health Management Information System	50,000	shopping	Post	Jan-16	Center Level	
C1/G/02	IT Equipment	50,000	shopping	Post	Jan-16	Center Level	

PP ref	Description of Consultancy Assignment	Estimated Cost (USD)	Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date	Remarks
1	2	3	4	5	6	7
Component 1: Health Sector Governance Reform						
	Support to MOH Health Management Information System					
C1/COF/01	Consulting Firm for Supporting the Operation and Management of HMIS and DHIS2	250,000	SSS	Prior	Jan-16	Continuation. Competitive selection under HSIP.
C1/COF/02	Consulting Firm for Operation & Maintenance the Server for HMIS	9,000	SSS	Prior	Jan-16	Continuation. Competitive selection under HSIP.
C1/LIC/03	IT consultant for HMIS	54,000	SSS	Prior	Oct-15	Continuation. Competitive selection under HSIP.

PP ref	Description of Consultancy Assignment	Estimated Cost (USD)	Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date	Remarks
1	2	3	4	5	6	7
Component3: Social and Behavior Change Communication						
	Development of SBCC Strategy and Campaign					
C3/COF/01	Individual International Short Term Consultant for BCC Strategy Development	125,000	CQS	Prior	Oct-15	Responsible for gap analysis, analysis of Formative research; and strategy development and consultation
C3/COF/02	Local consultant for qualitative formative research	12,500	CQS	Post	Dec-15	Carry out qualitative research
C3/COF/03	Consulting Firm (creative agency) for Social Behavior Change Campaign	300,000	QCBS	Prior	Mar-16	Develops SBCC tools and materials, including mass media (TVC, radio) (could be packaged together with the firm for edutainment events
C3/COF/04	Local Consultant to support SBCC Strategy and development process	40,000	CQS	Post	Feb-16	Develops SBCC tools and materials, including mass media (TVC, radio) (could be packaged together with the firm for edutainment events
	Implementation of SBCC Strategy and Campaign					
C3/COF/05	Production of existing toolkits, posters, manuals and collateral for village facilitators and health staff	100,000	CQS	Prior	Mar-16	Using existing materials developed by UNICEF, WSP, and other partners,

PP ref	Description of Consultancy Assignment	Estimated Cost (USD)	Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date	Remarks
1	2	3	4	5	6	7
						while SBCC strategy is being developed
C3/COF/06	Production of newly designed SBCC toolkits, posters, manuals and collateral for village facilitators and health staff	300,000	QBS	Prior	Mar-17	Includes counseling job aids for health center staff in 14 provinces; and toolkits and manuals for village facilitators in 12 convergence districts of 4 target province
C3/COF/07	Broadcasting time on national/provincial TV and radio	400,000	QCBS	Prior	Mar-17	Contract will include phasing of broadcasting over year 2-
C3/COF/08	Consulting firm for edutainment on nutrition	200,000	CQS	Prior	Mar-17	Edutainment events to be targeted to 12 convergence districts in 4 provinces, including phasing over year 2-4; could be packaged with firm for edutainment event
Component 4: Project management, Monitoring and Evaluation						
C4/LIC/01	Deputy program managers (2) for Components 1,2 & 3	192,000	SSS	Prior	Oct-15	Continuation. Competitive selection under HSIP.
C4/LIC/02	Procurement Officer	72,000	SSS	Prior	Oct-15	Continuation. Competitive selection under HSIP.
C4/LIC/03	Office Administration	57,600	SSS	Prior	Oct-15	Continuation. Competitive selection under HSIP.

PP ref	Description of Consultancy Assignment	Estimated Cost (USD)	Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date	Remarks
1	2	3	4	5	6	7
C4/LIC/04	Assist to Administration	28,800	SSS	Prior	Oct-15	Continuation. Competitive selection under HSIP.
C4/COF/05	Independent Academic Institution for third party verification	750,000	QBS	Prior	Feb-16	Procurement Method to be verified
C4/COF/06	Development and Implementation of Supervision Check List	150,000	CQS	Prior	March-16	
C4/COF/07	Nutrition Knowledge, Attitudes and Practices Survey	150,000	CQS	Prior	March-16	
C4/COF/08	Provincial DLI Program Support	300,000	QBS	Prior	March-16	
C4/COF/09	Rapid Household Survey	150,000	CQS	Prior	March-16	

Environmental and Social (including safeguards)

155. The Project was reviewed from an IDA safeguards policy perspective, with the objective of ensuring the environmental and social soundness of the investments proposed, as well as enhancing outcomes for communities, including the poor, ethnic groups, women and other vulnerable persons. In the case of the IDA, no civil works are anticipated, either new or renovations as these will not be included in the Eligible Expenditure List. Consequently it was agreed that OP 4.12 is not triggered. The other policies which were triggered were 4.01 Environmental Assessment, and 4.10 Indigenous Peoples.

156. The MOH requested the World Bank and the ADB to develop a common safeguard approach in a way that will meet both World Bank and ADB environmental and social safeguard policies. Although the Bank's fiduciary and safeguard policies do not apply to the ADB-financed project, the Bank and ADB have agreed to rely on common government implementation arrangements and to align as much as possible their fiduciary and safeguard requirements in support of the government's program. To this end, the Bank and ADB will rely on common safeguard instruments and operational manual which have been prepared by the Government to satisfy the fiduciary and safeguard requirements of both institutions, and will undertake joint implementation reviews.

Environment Safeguards

157. The Environmental Assessment (4.01) policy is triggered because of any potential environment impact by the project although these are expected to be minimal. The Project will not finance any civil works. There will be no new construction of buildings; rehabilitation or refurbishment of existing health centers or administrative offices or minor repairs (window rehabilitation, wall painting, internal wall demolition, etc.). However, the project under component 3 will promote open defecation free villages, which includes installation of households latrines (self-financed), either through self-construction with locally made materials, or through purchase for trained sanitation suppliers in the target districts. The potential impacts of these are deemed to be minor, site specific and reversible in nature, and for which mitigation measures can be readily designed. Based on MOH's previous positive experience in implementing IDA Projects, to ensure compliance with this policy and to address any environmental impacts from construction of these latrines, measures under the ECOP adopted by Nam Saat of MOH and acceptable to the Bank will be applied. Such ECOP will be included as part of any Operational Manual prepared for this support (including any Operational Manual prepared to specifically guide village level activities). The Project TA requirements were also evaluated with a view to determining if they would have any environmental impact as a result of consultancy assignments to be undertaken. The Bank policy applies for any TOR that are prepared for any technical assistance that has environment and social implications.

Social Assessment

158. A Social Assessment confirmed that access to and quality of health services vary significantly among ethnic groups. Ethnic minority women, due to topographical and social/cultural reasons, are less likely to receive anti-natal care or give birth with the assistance

of a trained professional. The Project will support activities in areas with diverse ethnic groups, thereby triggering OP/BP 4.10 on Indigenous Peoples. TA financed under the Project will need to include provisions to follow IDA safeguard policies, including OP4.01 in the relevant TORs. The TORs and outputs will need to include provisions to follow IDA safeguard policies, including OP 4.10.

Monitoring & Evaluation

159. The NPCO will be monitoring, on a quarterly basis, the progress of Provinces towards their targets under DLIs for the coming year. Timing of the implementation support will be provided, to the greatest extent possible, to coincide with regularly scheduled meetings wherein such progress would be reviewed by MOH and its development partners. The semi-annual progress report for the Project, which will report on progress against indicators (including those gender and community engagement) and be made available sufficiently in advance of the reviews to allow for planning to include relevant expertise required.

Role of Partners

160. The Project was designed and will be implemented in parallel with support from the ADB to the Program. Implementation support will be provided jointly, and will be timed, to the greatest extent possible to coincide with regularly scheduled meetings on support held between the MOH and its development partners. The MOH's existing Technical Working Groups will provide the fora for interactions amongst the development partners, and this mechanism will be utilized to explore solutions, exchange experiences, and coordinate efforts. Implementation support will be provided jointly, and will be timed, to the greatest extent possible to coincide with regularly scheduled meetings on support held between the MOH and its development partners.

Annex 4: Implementation Support Plan

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

Strategy and Approach for Implementation Support

161. The World Bank will provide formal implementation support [jointly with the ADB and Lux-Development] on a semi-annual basis. The semi-annual progress reports prepared by the DPIC will form the basis of such reviews, and be undertaken in coordination and collaboration with other development partners supporting the sector. The World Bank team will include the task team leaders (Senior Health Economist and Health Specialist; the former is region-based, and the latter is in-country based) along with procurement, and FM support provided through the Vientiane office. Safeguard specialists based in-country will be included on the team periodically to follow-up on implementation of the safeguard aspects. Expertise from the Health, Nutrition, and Population Global Practice will be drawn upon for international expertise, in particular with respect to DLIs.

162. Training and knowledge sharing will be provided by the World Bank from its own resources, and additional resources will be sought for relevant support as and when the need arises. The team will also draw upon the expertise in-country from various United Nations technical agencies such as WHO, UNICEF, and UNFPA; the experience of other development partners will also be sought to better inform the implementation of activities. The possibility of leveraging support from these sources, and to coordinate and collaborate to gain efficiencies will continue to be explored during implementation

163. Specialists on DLIs from the Health, Nutrition, and Population Global Practice team will be consulted if the progress report highlights/indicates any need on specific topics. The World Bank's Water and Sanitation Program will provide additional non-lending TA to sanitation activities under Component 3, specifically on the supply side for sanitation.

Implementation Support Plan

164. The following table provides a view of the anticipated needs during the implementation period. Areas are tentatively identified as

Table 4.1: Main focus during implementation

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	• MNCH • DLI • SBCC • Village Level Activities • Financial Management	• Health, Nutrition and Population • DLI • Communication • Sanitation • Social Sector Specialist	$200,000	• ADB • Lux-Development • UNICEF • UNFPA • WHO • IFAD

Table 4.1: Main focus during implementation

Time	Focus	Skills Needed	Resource Estimate	Partner Role
	• Procurement	• Financial Management • Procurement		• FAO • Save the Children
12-48 months	• MNCH • DLI • SBCC • Village Level Activities • Financial Management • Procurement • Environment	• Health, Nutrition and Population • DLI • Communications • Social Sector Specialist • Financial Management • Procurement • Environment Specialist	$300,000	• ADB • Lux-Development • UNICEF • UNFPA • WHO • IFAD • FAO • Save the Children

Table 4.2: Skills Mix Required (5 years)

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Task Team Leader	40	18	
Financial Management	24	10	
Procurement	10	10	
Social Sector Specialist	20	10	
Environment Specialist	10	10	
Health, Nutrition and Population Specialist	24	10	
Gender/Social Safeguards	10	10	
Sanitation Specialist	10	10	Water practice staff to be financed by complementary non-lending TA

Table 4.3: Partners

Name	Institution/Country	Role
ADB	Development Bank	HSRF Program
Lux-Development	Luxembourg	HSRF
UNICEF	UN Agency	Nutrition (SBCC, outreach)
UNFPA	UN Agency	Reproductive Health
WHO	UN Agency	HMIS, Health Care Financing, MNCH
European Union	European Union	Nutrition (governance)
IFAD	UN Agency	Nutrition (agriculture)
FAO	UN Agency	Nutrition

Annex 5: Sector Analysis

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

165. **Lao PDR is a landlocked country; the majority of the people live in the rural and remote mountainous areas, with challenges of communications, transport, and service provision.** There are 18 Provinces (including Vientiane Capital), comprising 8,716 villages which fall under 148 Districts.

166. **The Lao National Health Sector Reform Strategy was endorsed by the National Assembly in December 2012, followed by the completion in mid-2013 of the Health Sector Reform Framework (HSRF).** The HSR Strategy and Framework, whose goals are to reach the MDG by 2015, and universal health coverage by 2025, identifies improving the health information system as one of the key priority areas of the reform, since it plays a crucial role in tracking the progress of these goals.

Health and nutrition outcomes

167. **Lao PDR has made steady and significant progress on several key population health outcomes over the past few decades**. Life expectancy has increased steadily to almost 68 years in 2012, up from 49 years in 1980. Under-five and infant mortality rates have also declined significantly over the same period: the under-five mortality rate declined from 201 per 1,000 live births in 1980 to 71 per 1,000 live births in 2013. At current trends, Lao PDR is projected to meet the child health MDG which calls for a two-thirds reduction in under-five mortality over the period 1990-2015.[27] Lao PDR appears also to be on-track to attain the maternal health MDG, which calls for a 75 percent reduction in the maternal mortality ratio over 1990-2015.[28]

168. **Like several other countries in the region, Lao PDR is undergoing a rapid epidemiological transition. NCDs now account for the largest share of the burden of disease in the country**. Whereas in 1990 only about 28 percent of morbidity and mortality in Lao PDR was due to NCDs, by 2010 this number had risen to 47 percent. Lower respiratory infections were responsible for the largest share of the overall disease burden, causing 8.8 percent of all disability-adjusted life years lost due to morbidity and premature mortality in 2010. Ischemic heart disease's and stroke's share of disability-adjusted life years has been rising rapidly over the period 1990-2010. Findings of the Global of Burden of Diseases, Injuries, and Risk Factors Study from 2010 found that the three risk factors that account for most of the most disease burden in Lao PDR are household air pollution (HAP) from solid fuels, smoking, and dietary risks. The leading risk factors for children under-5 and adults 15-49 were childhood underweight and alcohol use, respectively.

169. **Despite notable progress in health outcomes on some fronts, considerable challenges remain**. While on-track for the child-health and maternal-health MDG, Lao PDR continues to

[27] Government of the Lao PDR & UN (2013). The Millennium Development Goals Progress Report for the Lao PDR 2013.
[28] WHO/UNICEF/UNFPA/World Bank (2014). Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank, and the United Nations Population Division

have some of the worst MCH outcome indicators, both globally as well as in the East Asia & Pacific region. Under-five and infant mortality rates are below average relative to income level. At 220 per 100,000 live births Lao PDR's maternal mortality ratio is much higher than that of neighboring Cambodia and more than four times the estimate for Vietnam. One explanation for the poor health outcomes is the low coverage of key MNCH utilization indicators such as antenatal care, skilled birth attendance, diphtheria, pertussis, tetanus (DPT), and immunization rates.

170. **Lao PDR is considered to be one of the most inequitable countries for maternal, newborn, and child health interventions**. Of 54 developing countries, Lao PDR has the 5th lowest rank in the composite coverage index, which is the weighted mean of the coverage of 8 essential interventions in the fields of family planning, maternity care, child immunization, and case management. In addition, there are significant economic, urban-rural, geographic, and ethnic-group related inequalities in health outputs and outcomes in Lao PDR. Inpatient and outpatient services utilization is particularly low among the poor, and there is significant variation in health indicators by income and across provinces. Inequalities related to economic status and ethnicity are particularly large: whereas skilled birth attendance amongst the richest quintile was 90.7 percent, it was only about 17.4 percent among the bottom 40 percent; skilled birth attendance among the Lao-Tai was 58.5 percent whereas among Hmong-Mien it was only 17.8 percent; DPT immunization coverage rates among the bottom 40 percent was 36.8 percent, compared to 81.4 percent among the richest 20 percent.

Reproductive Health

171. **Unmet needs on reproductive health and family planning are high.** The maternal mortality rate among women of child bearing age (15-49) is around 4 deaths per 1,000 live births.[29] 54 percent of maternal deaths are due to post-partum bleeding. The total fertility rate is 3.2, with large disparity between urban and rural areas: 2.2 and 3.6 respectively. Adolescent fertility rates vary, being higher for those without education or coming from the lowest wealth quintile. For women of child bearing age, 54 percent receive antenatal care from any skilled personnel, and 43 percent receive no antenatal care. Of those from the richest quintile, only 7 percent receive no antenatal care, while 75 percent of those in the poorest quintile receive no antenatal care. The results from the LSIS indicate that unmet need for family planning remains high at 28 percent, is highest among women in remote rural areas (28 percent), the poorest quintiles (26 percent), the Hmong-Lu Mein (30 percent), and Sino-Tibetan (25 percent) groups.[30]

Nutrition

172. **Chronic undernutrition or stunting in children remains an enormous development challenge in Lao PDR, despite falling poverty.** An estimated 44 percent of children under five are stunted. Undernutrition shows strong inequalities across regions and groups and is associated with poverty in Lao PDR**.** In mountainous rural areas without road access, stunting

[29] LSIS 2011-2012

[30] Accelerating Progress in Family Planning in Lao PDR (National family planning action plan for 2014-2015 and beyond. UNFPA, October 2013

and underweight prevalence are twice those in urban areas. Stunting in children from Hmong-lu Mien and Sino-Tibetan ethno-linguistic groups exceed 60 percent, nearly double those of children from the Lao-Tai group. Wasting varies across provinces by a factor of five. Underweight varies by two to three times across provinces, reaching 46 percent in one province.[31] Prevalence of stunting among children from the poorest households is three times higher than that in the richest households. This gap has widened in recent years, with little progress among the poorest children.

173. **The key determinants of these undernutrition outcomes in Lao PDR[32] include**: (i) IYCF practices are generally poor.[33] Only 40 percent of children under the age of 6 months receive exclusive breastfeeding. The use of formula has more than tripled from 2006 levels. Formula-fed babies in Lao PDR are twice as likely to have diarrhea; (ii) Food diversity and nutrient intake are suboptimal, leading to micronutrient deficiencies. The typical diet is imbalanced, with higher carbohydrate and lower fat and protein consumption relative to WHO-recommended levels. Iron deficiency anemia and vitamin A deficiency are high in young children (42 and 45 percent respectively). Twenty percent of households do not consume iodized salt, and are at risk from iodine deficiency; (iii) the disease burden among young children is still high**.** Infectious and preventable diseases, such as diarrhea, account for around 39 percent of deaths among under-five children; (iv) Poor sanitation and unsafe water are significant factors**.** Stunting affects 51 percent of young children from households with poor water and sanitation, compared to 34 percent of those using improved water and sanitation. Some 38 percent of households still practice open defecation; (v) Female education and health strongly influence child nutrition**.** Stunting rates are four times higher among children of uneducated women than among children of mothers with secondary or higher education. High anemia rates, low contraceptive use and high fertility rates contribute to poor maternal nutrition. High adolescent birth rates among the non Lao-Tai groups (22-39 percent) are another contributor to child stunting; (vi) Lao-specific cultural beliefs and food taboos among different ethnic groups are not always conducive to good nutrition. Infants in their first or second month are often given chewed glutinous rice, a practice associated with stunting and possibly with bladder stones in childhood. In urban areas, lactating women consume a diet excessively based on glutinous rice, which puts infants at risk for vitamin A, C, and thiamine deficiencies.

174. **There are many bottlenecks in addressing undernutrition in Lao PDR.** First, coordination and working multi-sectorally represent a challenge for both Government and development partners. Only until the relatively recent establishment of the National Nutrition Committee, the Government and development partners worked in a fragmented manner, without an organized aligned approach to nutrition. Key interventions have had low coverage and sectoral interventions have not previously aligned or converged on the same communities. Second, government allocations to address undernutrition have been inadequate, and information sharing between partners on spending is not optimal. Currently, total development partners' spending on the 22 key interventions to address stunting is not adequately tracked, making it difficult to assess whether the problem is lack of funding, or a need to spend money differently.

[31] Lao Statistics Bureau, 2012. Lao Social Indicators Survey (LSIS), 2011/12, Vientiane.

[32] Country Note for UN Chief Executive Board Meeting – Lao People's Democratic Republic: Accelerating progress towards improved nutrition for women and children, November 2014.

[33] According to standards recommended by UNICEF and WHO.

Third, there is limited capacity to access remote areas and ensure quality of implementation. Remote areas are difficult to access, and health and nutrition logistics and supply systems are weak.[34] Primary health centers are practically understaffed. Fourth, female illiteracy, strong traditional beliefs and the lack of awareness on nutrition impede efforts to change behavior. The different languages and food taboos amongst the 49 ethnic groups pose challenges. In areas without road access, only 41 percent of young females (15-24 years old) are literate.

Organization and Governance

175. **The health care delivery system is a Government-owned system with three administrative levels – central, provincial and district levels, although the private sector is expanding primarily in cities.** Favorable economic growth has seen a number of private facilities in urban areas including over 2,000 private pharmacies, 600 traditional medicine practitioners and over 200 private clinics[35]. Active civil society organizations include the Lao Women's Union, the Lao Red Cross, and other faith-based organizations; there are also a number of international non-governmental organizations (such as Save the Children) who are working in the sector.

176. **Compared to its neighboring countries, Lao PDR has a relatively low ratio of qualified health workers per 1,000 population.** The number of qualified health care professionals was 3,873, equivalent to 0.69 per 1,000 population. This is significantly lower than the WHO recommended standard of 2.5 per 1,000 population, which has been estimated as the minimum necessary to provide coverage for at least 80 percent of all births with a skilled birth attendant. Not only is there a low level of health workers per 1,000 population, but the gap between the ratio in the capital city and in rural areas is significant, especially for doctors, and has not improved very much in recent years. A Government Decree on financial incentives for attracting and retaining staff in rural and remote settings was recently endorsed, although it remains to be fully implemented.

177. **The lack of capacity in management, especially in FM, planning and budgeting, implementation supervision and M&E and associated systems at all levels remains a governance challenge.** The vast majority of resources – Government budget and OOP health expenses collected from health users – are utilized and managed at the health facility level, yet there is no FM system available which documents how funds are sourced by health facilities and how they are utilized for use by health facility managers or higher levels of the health system or Government more generally. The Government's budget and accounting system (currently responsible for just under 50 percent of total health expenditure) does not enable all budget resources going to a specific health facility to be identified nor does it allow all expenditures financed by the budget to be identified by facility. Further, health facilities do not systematically document the collection of the OOP expenses (currently estimated at over 50 percent of the total health expenditure) and how they are used by facility in a standard format. Thus managers of

[34] Lao PDR Government and the UN, 2013. The Millennium Development Goals Progress Report for the Lao PDR, 2013 Vientiane.

[35] WHO (2014). The Lao People's Democratic Republic health system review. Health Systems in Transition, Vol. 4 No 1.

health facilities do not know what their total revenues (sources of funds) are, and do not document how all funds available to the facility are utilized.

Health Information System

178. **The HSRF has set priority areas for which a number of results are expected**: (a) a set of standardized national indicators with proper data collection; analysis and utilization is established and used; (b) the health information system (DHIS2) as a backbone to planning, policy making, and other management decision making processes; (c) public health facilities are able to provide statistical reports timely and accurately; (d) application of information technology for health information reporting; and (e) compulsory birth and death registration introduced. Under this framework, the MOH has, since 2013, embarked on the development of applying information technology to improve the system, starting with the health management information system.

179. **Lao PDR is among 75 countries that have been characterized as lacking well-functioning Civil Registration and Vital Statistic (CRVS).**[36] Additionally, a foundational National ID system managed by the Ministry of Public Security (MPS) does not cover the whole country. In the areas that ID does not exist, it is replaced by Family Book for official use. Births are registered in the Family Book that is maintained by the Ministry of Public Security (MPS). Typically, birth is reported to the Village Chief who issues a notification form that the family takes to the local MPS officer for registration. In order to obtain a birth certificate, in addition to the notification form provided by health facilities, the signature of the Village Chief along with those of witnesses are required. Nevertheless, the notification, registration and certification processes are not standardized, and different forms are in use. It sometimes takes three visits to the district office to have a birth certificate which is a challenge to families in remote villages. Besides, the birth registration and certification process is not digitalized. In addition, many deaths occur outside of the health system and are not recorded, and in many instances no cause of death identified.

180. **The Government of Laos is taking urgent measures to improve the CRVS system and has incorporated it in the 8th National Socioeconomic Development Plan 2016-25.** A Citizen Management inter-ministerial Coordinating Committee was established to facilitate CRVS coordination among ministries. The Government is committed to get all births and deaths registered by 2025.

Health Financing

181. **Compared to international standards, Government's spending on health is low, and relies more heavily on OOP expenditures and external assistance.** Based on WHO estimates, general government spending on health (MOH budget and social security expenditures on health) as a share of GDP in 2012 was only 1.5 percent in Lao PDR, against 2.2 percent in Nepal, 3.0 percent in Thailand, and 2.8 percent in Vietnam. By relying heavily on OOPs, considerable financial barriers exist for the utilization of health services, which contribute to low levels of

[36] World Bank and World Health Organization. Global Civil Registration and Vital Statistics Scaling Up Investment Plan: 2015-2024. http://www.worldbank.org/en/topic/health/publication/global-civil-registration-vital-statistics-scaling-up-investment

utilization and high health-related financial risks. Although health insurance schemes[37] can play a role in addressing these challenges, the fact that the majority of the population work in the informal sector makes it challenging to expand the coverage of these schemes in the short- or medium-term. In fact the government's Health Financing Strategy for 2011-2015 indicates that increasing, and improving, the effectiveness of existing government health spending would likely be the most viable strategy for improving access to health care services and enhancing financial protection. See Table 5.1 for a set of key health financing indicators between 2000 and 2012.

Table 5.1: Key health financing indicators for Lao PDR, 2000-2012

Indicator	2000	2005	2010	Latest available year (2012)
Total health expenditure per capita	US$11	US$20	US$29	US$40
Total health expenditure as share of GDP	3.3%	4.3%	2.6%	2.9%
Annual real growth rate in total health expenditure in previous 5 years*	8.3%	11.5%	3.4%	13.4%
Annual economic growth rate in previous 5 years*	6.4%	6.0%	7.9%	8.0%
Public expenditure on health as share of total expenditure on health	35.1%	17.0%	46.5%	51.2%
Public expenditure on health as share of GDP	1.2%	0.7%	1.2%	1.5%
Public expenditure on health share of total public spending	5.8%	4.1%	5.4%	6.1%
Social insurance expenditure share of public expenditure on health	1.2%	7.2%	5.5%	4.9%
Private expenditure on health as share of total expenditure on health	64.9%	83.0%	53.5%	48.8%
OOP payments as share of total expenditure on health	59.6%	62.5%	41.8%	38.2%
OOP payments as share of private expenditure on health	91.8%	75.3%	78.2%	78.2%
External share of total health expenditure	29.2%	16.6%	28.7%	22.1%

Source: WHO & WDI (2014); Note: *average 2011-2012 used for year 2012.

182. **The Government spends most of its funds for health on capital and wage-related recurrent expenditures, which hampers spending for non-wage recurrent spending.** Around 60 percent of the health spending has been on capital expenditures over the past decade, and more than 80 percent of this has been financed externally. Between FY2000/01 and FY2011/12, there was an average annual increase of 11 percent in real terms. Most of the domestic financing on health went to cover wages. Although there was a jump in wage-related recurrent expenditure in FY2011/12 from the previous year, there was a similar increase for that period for non-wage related recurrent expenditures.

183. **In recent years, the government has implemented several social health protection policies to increase utilization rates and reduce the health system's reliance on direct OOP payments through Health Equity Funds (HEFs) and Free MCH policy, with aim to attain**

[37] There are social insurance mechanisms for civil servants and private formal sector workers, and there is also some community-based health insurance coverage for the non-poor.

universal health coverage by 2020.[38] [39] The HEFs were established in 2007 to provide free public health care services for the poor by removing major barriers to health facility/health services access such as transportation and costs of pharmaceuticals and other health care costs. There are five separate HEFs schemes currently operating in different parts of the country, with a common core goal: financing the costs of the poor to access health care. Each scheme has differences in the details of how they were designed and operate. Sometimes these differences are quite significant and have implications for overhead costs and on the administrative burden for PHOs and DHOs. The scheme(s) are largely financed by development partners (the ADB in the north, the IDA and Swiss Red Cross in the south and Lux-Development in the central part of the country) with some recent modest efforts by the Government to finance expansion of HEFs to provinces and districts not covered by development partners, using revenues from Nam Theun 2. The current geographic coverage is in 98 districts in 13 provinces, with a balance of around 130,000 poor households (55 percent) who do not have access to free health care.

184. **The Free MCH Policy, endorsed by the Prime Minister (Decree Number 178/PM), makes all pregnant women and children under the age of 5 years exempt from fees related to deliveries and child health at all health centers and public hospitals.** On the supply side, the Policy provides fixed-fee reimbursement to health facilities depending on the type of service and the location of service provision. The free MCH package consists of antenatal care, postnatal care, and institutional deliveries, well-baby clinic examination (including inpatient and outpatient services) for children under-five, and adolescent health interventions. Implementation was rolled out in 2013, first in poor districts and government-focus sites for development.

Other Multi-sectoral Determinants of Health

185. **Household Air Polution (HAP) from inefficient use of solid fuels is the top health risk factor in Lao PDR[40], and is worth 3.5 percent of GDP, assuming lost productivity using GDP per capita.** Women and children suffer the greatest burden of disease from biomass smoke. While the country is 87 percent electrified, 96 percent still use firewood and some charcoal for cooking. One reason is that firewood is abundant while liquid gas is expensive and has limited distribution. In recognition of this risk, Government's National Renewable Energy Development Strategy has included the move toward clean cookstoves as one of the strategies to be pursued, and a high level Inter-Ministerial Lao Clean Stove Initiative Task Force was formed in 2012 to formulate how best to address this health risk. Technical solutions to address the health challenge exist, which include options for "clean" cooking, including using electricity, gas, or gasified stoves (which are the most advanced type of biomass), which emit little or no particulate matters including black carbon, carbon monoxide, and greenhouse gas. These clean stoves and fuels, however, are not affordable to all.

186. **Water and Sanitation is a critical determinant for improved health and nutrition.** In rural areas, only 63 percent of the households have access to safe drinking water, and only 59.2

[38] Government of the Lao People's Democratic Republic (GOLPDR) (2012). Decree on National Health Insurance, No 470/GO. Vientiane

[39] WHO (2014). The Lao People's Democratic Republic health system review. Health Systems in Transition, Vol. 4 No. 1

[40] Global Burden of Disease, 2010

percent have access to improved sanitation, with levels of open defecation as high as 45 percent. Only 12.7 percent of households in the poorest quintile use improved sanitation, compared to 99 percent in the richest quintile (LSIS, 2012), while open defecation within the poorest quintile stood at 81.6 percent, while it was 0.3 percent in the richest quintile. The economic and health impact of poor sanitation, is estimated to be 5.6 percent of Lao PDR's GDP[41] and the severity of stunting of children under-five years old is found to be significantly associated with a lack of improved sanitation at community level[42]. Key sanitation challenges include (a) reluctance among particular non-Lao Tai ethnic groups to utilize sanitation facilities; and (b) poor quality of latrine construction. Recognizing the negative impact of poor sanitation, the National Action Plan for Rural Water Supply and Sanitation (2012-2015) has been formulated, and recognized the importance of transitioning from a construction-focused, full subsidy approach to a programmatic approach that emphasizes (a) generating community demand and behavior change/social norms for stopping open defecation; (b) strengthening local businesses to market low-cost latrines to households; and (c) effectively using partial subsidies in a targeted manner for poor communities and/or households.

Relevant Government Strategies

187. **Accelerating progress in nutrition is a high priority in the eighth National Social and Economic Development Plan (2015-2020), especially for achieving the Government's objective of graduating from LDC status.** Recognizing the need to engage ministries and partners across sectors, the Government established the National Nutrition Committee under a Prime Ministerial Decree, with the goal of developing and implementing the new MFNSAP 2014-2020. The Action Plan has two distinct features, designed to increase the impact of interventions and reduce coordination costs, it: (a) proposes focusing interventions on 46 high risk districts (out of 72), sequenced in two phases (2014-15, and 2016-2020); and (b) substantially reduces the number of interventions to be targeted at these districts (from 99 in the previous plan to 22). Four sectors (agriculture, education, and health and WASH) are responsible for intervention selection, and the interventions are consistent with those advocated in the Scaling-Up Nutrition movement, to which the Government is a participant. The MFNSAP combines so-called "nutrition-specific" interventions (those which address under-nutrition directly and which operate primarily out of the health sector), with "nutrition-sensitive" interventions (that address the causes or determinants of under-nutrition, which are located primarily in the agriculture, education and WASH sectors). An important element of the MFNSAP is to converge development partner activities to reduce under-nutrition in 26 districts in 7 provinces over the next 2 years. [43]

188. **Nevertheless, there is currently no national integrated strategy to deliver SBCC for nutrition.** There is fragmentation of the delivery of behavior change communications messages and the development of materials and tools across the different units within MOH as well as

[41] Hutton et al, 2009
[42] Quattri et al, 2014
[43] Luang Namtha Province (Sing, Long, Viengphouka and Nalae); Oudomxai Province (Nga, Beng, Hoon, Pakbeng); Saravan Province (Ta Oi, Lao Ngarm, Samuoi); Phongsaly Province (May, Samphanh, Nhot Ou); Houaphan Province (Xiengkhor, Viengthong, Huameuang, Xamtay, Sopbao); Xienkhouang Province (Kham, Nonghed, Khoune, Phookood); and Sekong Province (Lamarm, Kaleum, and Dakcheung).

across related ministries and sectors. The development of an integrated package of BCC for health center outreach workers and Village Health Volunteers for health and nutrition is perceived as immediate gap that could be addressed through Component 3, under guidance of the Center of Information and Education for Health (CIEH) under the DHHP (following National Policy on Health Communication). In addition national-level mass media and advocacy measures are also needed; however, this might be better addressed through other development partners' support. Preparation and implementation of the delivery of integrated behavior change communication to address undernutrition in Lao PDR was identified as one of four priorities in the United Nations' Chief Executive Board.

Annex 6: Economic Analysis

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

The project's expected contribution to development

189. The twin goals of IDA are to end extreme poverty and to promote shared prosperity by fostering the income growth of the bottom 40 percent for every country. The health sector contributes to these goals firstly as a channel for human capital investments through improving the nutrition and health status of the population. This allows for the fuller realization of an individual's, and through positive externalities, a community's educational and economic potential, through a reduction in cognitive impairments related to chronic undernutrition and participation in work opportunities unconstrained by illness. It also provides financial risk protection against catastrophic or impoverishing health expenditure, whereby a household could otherwise fall back into poverty or fall deeper into poverty due to unavoidable healthcare costs.

190. Gaps in these investments are particularly acute in Lao PDR, a natural resource-rich nation, for which gains in GDP growth are not commensurate with economic gains at the household level. This is in part due to unrealized potential in human capital in the long term and protection from the risk of impoverishing health expenditure in the short term. Hence, a recent report by the World Bank[44] finds that although 'poverty has fallen by 4.3 percentage points' between 2008 to 2013, 'the rate of poverty reduction was slow compared with the rate of economic growth as the high rate of GDP growth in Lao PDR did not translate into proportionately high rate of poverty reduction', and that inequalities are increasing such that 'consumption among the bottom 40 percent grew at 1.3 percent compared with 2.4 percent among the richest 20 percent'. As a step towards the attaining the government's 2025 target of universal health coverage, whereby all people who need health services receive them without experiencing undue financial hardship, proposed project activities are aligned not only with long-term Lao government aspirations, but also with the twin goals of IDA.

Rationale for public sector financing and provision of health care

191. The key rationale for government intervention in the Lao PDR health sector are (i) to promote efficiency in the sector by addressing market failures (such as information asymmetries) and encouraging investments in public goods with large positive externalities; and (ii) to address equity, which is of particular resonance with the mission of IDA.

The efficiency rationale

192. With regard to promoting efficiencies and investments in public goods with large positive externalities, the interventions proposed in this project – such as promoting maternity care (e.g., through formalizing ante-natal care and post-natal care) and health promotion (e.g., through outreach, nutrition counselling, and social and behavior change campaigns). These interventions in particular both have high returns on investment – literature cites benefit-costs ratios for

[44] World Bank, 2014. *Poverty Profile in Lao PDR.*

investments that reduce stunting (which have lifetime implications on earnings potential) to be between 3.6 to 48 (also see table below) – and have large positive externalities. These interventions provide even larger benefits to society than they would to individuals. Furthermore, due to information asymmetries, healthcare consumers typically would not have full knowledge of the benefits of interventions aimed at improving nutritional status, maternity care, and/or essential primary care services, and hence may not make optimal choices in these investment opportunities. This further contributes to imperfections in the capital markets for basic health care – where long-term investments are sub-optimal from the public perspective.

Table 6.1 Cost-benefit ratios and cost effectiveness of proposed project interventions

Intervention (coverage, %)	Relevant DLI/Component	DALYs averted per year per one million population[45]	Average Cost per DALY averted	Cost per capita (WHO I$)	Benefit-Cost ratio[46]
Skilled birth attendance (50%)	DLI 1	1,264	71	0.09	-
Emergency neonatal care (50%)	DLI 1, 2	226	762	0.17	-
Reduction in stunting	DLI 4	-	-	-	3.6 - 48
Support for breastfeeding mothers (80%)	Component 3	3,682	23	0.08	-

193. The proposed project activities would invest specifically, and would incentivize the matching of domestic funding through DLIs, in providing these interventions (in a manner which allows existing government structures and agents to decide how best to deliver these interventions) to the population sub-groups at the provincial-level who are most at need or for whom such allocations would be most efficient and optimal. Specific population and poverty based formulae are used for resource allocation to provinces.

The equity rationale

194. Access and utilization of health and nutrition services, and health, nutrition, and financial risk protection outcomes are inequitable in Lao PDR (see table below). For example, the prevalence of stunting among the poorest fifth of children is three times that of the richest fifth of children, thus risking the locking-in and perpetuation of economic inequalities. Furthermore, there is some evidence that the incidence of catastrophic health expenditure has been increasing from just under four percent in 2008 to five percent in 2013 (using a 10% share of household expenditure as the threshold). Although some of this increase may be due to appropriate

[45] Adam, T. 2005. "Cost Effectiveness Analysis of Strategies for Maternal and Neonatal Health in Developing Countries." *BMJ* 331 (7525): 1107–0. doi:10.1136/bmj.331.7525.1107. http://www.who.int/choice/results/mnh_wprob/en/

[46] Hoddinott, John, Harold Alderman, Jere R. Behrman, Lawrence Haddad, and Susan Horton. 2013. "The Economic Rationale for Investing in Stunting Reduction." *Maternal & Child Nutrition* 9 (S2): 69–82.

increases in the utilization of health services, this weak financial protection puts at risk gains in the reduction of poverty. These inequities overall provide a strong justification for public intervention and investments in addressing these inequalities, in addition to the efficiency rationales provided above.

Table 6.2: Existing disparities in health and nutrition coverage and outcomes, and health financing parameters (Percent)

	All	Q1 (Poorest 20)	Q2	Q3	Q4	Q5 (Richest 20)
Health and Nutrition Coverage and Outcomes[47]						
Contraceptive prevalence rate	50	39	46	53	57	53
Skilled birth attendance	42	11	24	45	64	91
Post-natal health check for newborns	41	14	25	43	61	84
DPT3	52	13	35	60	89	100
Use of improved sanitation	57					
Moderate and severe stunting prevalence (height for age < -2SD), children under five	44	61	50	42	32	20
Health Financing and Financial Risk Protection						
% of households where total maternal health out-of-pocket expenditure exceeds 20% of monthly household expenditure[48]		57	43	52	39	38

195. In addressing these inequalities, the project proposes interventions aimed at promoting (a) equitable access to health and nutrition services, (b) equitable and effective utilization of health and nutrition services, and (c) equitable protection from financial risk.

196. With regard to equitable access, although the project does not propose the construction of additional health facilities, investments in outreach funded through provincial-level DLIs will allow health workers to reach and provide basic health and nutrition services to rural and remote communities. Nutrition-related social and behavioral change campaigns will further be held at village locations, thus allowing communities access to these activities.

197. With regard to equitable and effective utilization of health and nutrition services, two perspectives are relevant and addressed by project interventions. From the supply-side perspective, funding through DLIs can be used by provincial health authorities to ensure the availability of essential medicines (i.e., that health centers and district hospitals do not have stock-outs of drugs). This is critical in ensuring that utilization of health services can result in improvements in health outcomes. From the demand-side perspective, constraints in optimal utilization due to poor health seeking knowledge and behaviors will be addressed through

[47] Source: LSIS (2012)

[48] Non-national sample. Source: World Bank, 2013. *Maternal Health Out-of-Pocket Expenditure and Service Readiness in Lao PDR*

outreach services to remote locations and the social and behavior change campaign. The reduction of financial barriers impeding utilization will be addressed through user fee waivers discussed below, which are expected to (as observed in Lao PDR during the implementation of the Health Services Improvement Project and the Community Nutrition Project result in increased uptakes in utilization, especially among the poor.

198. With regard to equitable protection from financial risks, the free MCH interventions which will receive investments under Component 2 will expand the geographical coverage of user fee waivers (and for certain services, cash transfers to cover transportation and opportunity costs) for these essential health services, which previously resulted in substantial and variable costs[49]. Although the depth of health services to be covered is limited to MCH services, these interventions will reduce (or even eliminate) out-of-pocket expenses for these essential services, and considering that poorer households spend a greater proportion of their household income on out-of-pocket expenses for maternal health services, this will provide some degree of equity financial risk protection.

The financing gap and mal-distribution

199. Public financing for health care has increased substantially since fiscal year 2011/12, from US$63 million to US$197 million in 2012/13, equaling approximately 1.9 percent of GDP or 7.5 percent of total Government expenditures. A large proportion of this increase is due to increases in wages following government reforms of civil service compensation, however, non-wage recurrent expenditure has also increased substantially. Nonetheless, spending per capita was low compared to other lower middle income countries and out of pocket (OOP) spending remains high at 38 percent of total health spending.

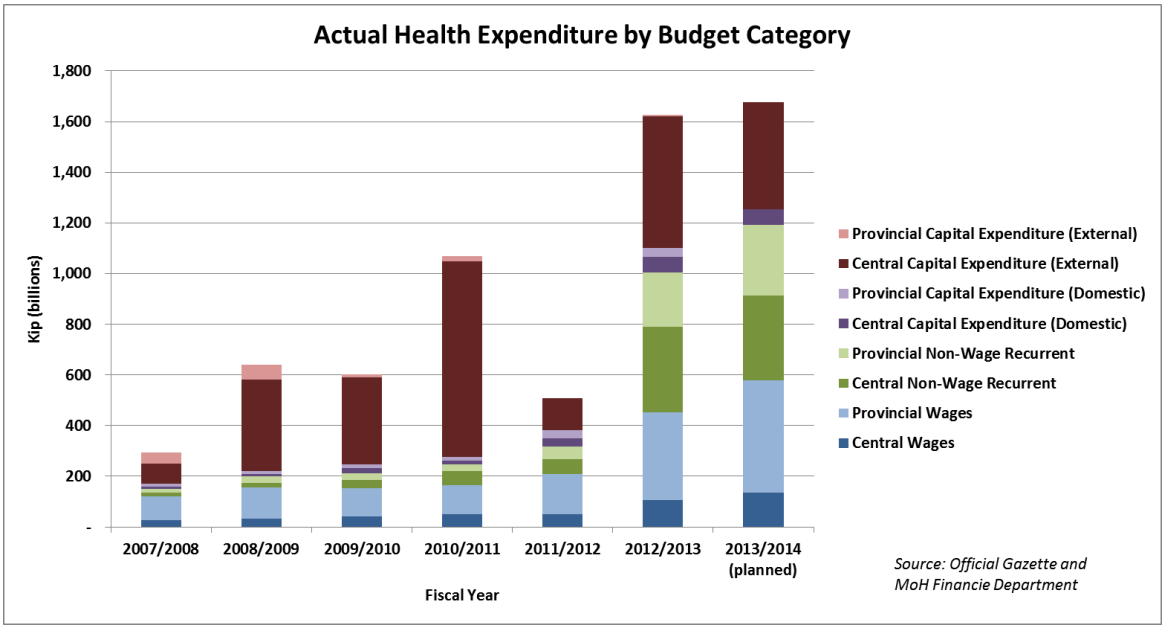
Table 6.3: Government Expenditures on Health by Category (US$ million)

Chapter	Expenditure Category	2009/10	2010/11	2011/12	2012/13	2013/14 *
10+11	Remuneration and benefits	18.2	20.5	26.2	58.2	71.7
12+13	Operational Costs	6.8	9.9	12.7	59.1	63.9
	Recurrent Expenditure	**25.0**	**30.4**	**38.9**	**117.3**	**135.6**
15+16+17	Domestic Capital	4.1	3.5	8.2	12.1	7.5
	Total Domestic Budget	**29.1**	**33.9**	**47.1**	**129.4**	**143.1**
15+16+17	External Capital	42.0	98.4	15.9	68.0	58.2
	Total Health Budget	**71.1**	**132.3**	**63.0**	**197.4**	**201.3**

Sources: Official Gazette and MOH Finance Department, 2013/14 – Plan.

[49] World Bank, 2013. *Maternal Health Out-of-Pocket Expenditure and Service Readiness in Lao PDR*

Figure 6.1: Actual Health Expenditure by Budget Category



200. Per capita spending on health was approximately US$ 28 per capita in 2013/14. IDA financing over the five years would be around US$ .80 per person per year, an affordable increase given the country's growth. IDA financing from Component 2.2 which allocates funds directly to the 14 Target Provinces based on an allocation formula which used population, poverty, and number of health facilities would average about US$ 1 per capita per year over the first three years of the Project, a 15% increase from the current US$5 per capita expenditure in the Target Provinces. (Table 6.4)

201. A small portion of these funds appears to reach health facilities. In a recent study[50], health centers reported average annualized non-wage recurrent expenditures of US$ 1 – 2 per capita population. Given these low levels of investments in frontline facilities, it is unsurprising that service readiness, for example the availability of essential drugs, is low and that almost none of the health center in a recent nationally-representative survey reported full availability of all essential medicines.[51] In addition, the utilization of essential health services is low, that health and nutrition outcomes are so poor and inequitable, and that households are exposed to the risk of impoverishing health expenditure.

[50] World Bank, 2015. *Government Expenditure on Health in Lao PDR (unpublished).*
[51] Joint WB and WHO-funded survey in 2014. Preliminary results (report forthcoming).

Table 6.4: Budget (2013/2014) and Estimated Annual DLI Payment per Province (US$)

Province	Budget – 2013/2014			Average Annual DLI Payment	
	Total Population 2015	Recurrent total (Chapter 12-13)	Recurrent Per Capita (Chapter 12-13)	Total	Per Capita
Phongsaly	**182,870**	1,200,750	6.57	254,673	1.39
Luang Namtha	**185,481**	1,584,500	8.54	206,641	1.11
Oudomxai	**337,126**	2,204,625	6.54	422,562	1.25
Bokeo	**186,834**	1,721,375	9.21	198,759	1.06
Luang Prabang	**459,964**	3,273,000	7.12	439,254	0.95
Houaphhan	**324,091**	1,888,250	5.83	456,292	1.41
Sayaboury	**395,215**	1,916,625	4.85	354,559	0.90
Xiengkhouang	**278,045**	2,393,125	8.61	229,692	0.83
Savannakhet	**1,027,041**	4,009,000	3.90	849,672	0.83
Saravan	**413,516**	1,766,875	4.27	355,241	0.86
Sekong	**119,396**	1,182,125	9.90	135,033	1.13
Champasak	**742,770**	3,619,625	4.87	490,403	0.66
Attapue	**148,133**	1,717,250	11.59	165,810	1.12
Xayxomboun				108,078	
Total	**4,800,482**	**28,477,125**	5.93	**4,666,669**	0.97

Additional value-added of the IDA support

202. Firstly, most of the financing for this project (especially for Component 2) will be provided directly to provincial health authorities which are closer to the frontlines, and for filling in specific gaps (e.g. medicines and other health/nutrition commodities, and equipment) in the provision of services, not towards salaries and other overheads. This engagement further builds on prior and current experience in engaging with the health sector in Lao PDR through projects focused on MCH (such as HSIP-AF) and nutrition (such as CNP), and related AAA. Secondly, unlike traditional input-based financing mechanisms, these provincial health authorities (and central health authorities) will be held accountable for delivering results in the form of health outputs, through mechanisms designed to measure and track the performance of provinces using the DHIS2 health information system tool, which will be strengthened as part of the proposed project activities. This would be in addition to developing the capacity of governance systems for procurement and financial management (of particular relevance to Components 1 and 3).

203. Thirdly, the involvement of the IDA in projects or knowledge products, in sectors beyond health, which have impacts on health and nutrition outcomes, such as in water (e.g., the Water and Sanitation Program), agriculture (rice and food security-related projects: Lao Uplands Food

Security Improvement Project and Rice Productivity Improvement Project), education (Early Childhood Education Project) and infrastructure (e.g., Poverty Reduction Fund II), will allow greater cross-sectoral linkages and synergies to be reaped. Through the Tenth Poverty Reduction Support Operations (PRSO10), the IDA is also involved in policy dialogue on financing HEFs and Free MCH. Fourthly, this project represents a major institutional advancement compared with past externally financed health sector projects, as from the outset during project preparation, collaboration and coordination with other major DPs and donors (chiefly ADB and Lux-Development) has been done to ensure less duplicative financing and filling of gaps (at the very least, due to a transition away from a regional sub-division of the country by donors).

Annex 7: Clean Household Air, Clean Stoves, and Health

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Health Governance and Nutrition Development Project

204. Clean air in households is key contributing factor in the health and well-being of women and children in the developing countries. According to the most recent Global Burden of Disease Assessment and the World Health Organization (WHO), over 4 million people, most of them women and children, die prematurely from illness attributable to HAP from cooking with solid fuels worldwide.[52] The key pollutant responsible for this health damage is fine particulate matter referred to as PM 2.5[53]. Unlike malaria, tuberculosis, and HIV/AIDS, for which the death toll is declining, the number of premature deaths linked to HAP is on the rise. Illnesses from HAP are expensive to treat, cannot be addressed through vaccines, and result in more deaths of women and children annually than HIV AIDS, malaria, tuberculosis and malnutrition combined.[54]

205. In Lao PDR, HAP from poor combustion of solid fuels is the top health risk factor in Lao PDR (Global Burden of Disease Study 2010) costing 3.5 percent of GDP, assuming lost productivity using GDP per capita. Women and children suffer the greatest burden of disease from biomass smoke. While the Lao population is 87 percent electrified, 96 percent of the population is estimated to still use firewood and some charcoal for cooking as electricity is expensive. Firewood is abundant while liquefied natural gas is expensive and has limited distribution network. Without reductions in HAP through cleaner stoves and fuels, measures supported by the Health Governance and Nutrition Development Project may not achieve optimal effectiveness. Hence a "clean air- clean cookstove" initiative is an important complement to programs to improve the health of women and children.

206. The GOL recognizes this problem by including clean cookstoves in the National Renewable Energy Development Strategy and by convening an Inter-Ministerial Lao Clean Stove Initiative Taskforce (the "Taskforce") to oversee the mult-isectoral clean cookstoves initiative. The Vice Minister of Health made a policy pledge to promote clean cookstoves on behalf of Lao PDR at the November 2014 Cookstoves Future Summit convened by Hilary Clinton and organized by the Global Alliance for Clean Cookstoves. At that Summit, the WBG committed to mobilizing a US$60 million global partnership with the Global Alliance for Clean Cookstoves to spur the adoption of clean and efficient cooking and heating solutions world-wide.

207. In January 2014, the Taskforce authorized and sponsored a detailed assessment of the practicability and cost-effectiveness of introducing near smokeless "super-clean" cookstoves into households in the poorest rural communities of Lao PDR. The World Bank supported this unique research program using World Bank-managed trust funds, as a contribution to the preparation of the MCH and nutrition investment program and to lay the foundation for a first-of-a-kind results-based financing program under which private investors would pre-finance super-clean cookstoves, clean air and improved health outcomes in Lao PDR on a large scale against a

[52] Source: WHO, 2014. Household air pollution and health. http://www.who.int/mediacentre/factsheets/fs292/en/
[53] PM 2.5 is also a large fraction of Black Carbon, a serious short-lived climate pollutant (SCLP).
[54] Source: International Institute for Sustainable Development (IISD), 2013. Post-2015 Development Agenda Bulletin, Volume 208. http://www.iisd.ca/download/pdf/sd/crsvol208num10e.pdf

forward sale of ADALYs[55] and other marketable attributes of the use of such stoves, including carbon and black carbon reductions.

208. Fieldwork focused on poor rural households in Savannakhet, measuring PM 2.5 in the baseline of cooking on open fires and following introduction of high efficiency super clean cookstoves that gasify wood, effectively eliminating smoke for much of the cooking cycle. Pollution reduction results available from two-thirds of intensively studied 72 sampled households in the research population in Xonbouli District of Savannakhet are encouraging and are provided below. In the 72 household research population, women used the new stove about 95 percent of the time, and reported strong acceptance of the technology. Reductions in kitchen level HAP was about 75 percent, and while reductions in personal exposure of the women cooks averaged much lower levels, exposure reduction is significant.

209. These PM2.5 exposure reductions have been input to an on-line global data base, the HAP Intervention Tool, of exposure-response relations from longitudinal studies of health outcomes from HAP created by the Household Energy, Climate, and Health Research Group School of Public Health of University of California, Berkeley[56]. Correlated diseases covered by HAPIT are acute lower respiratory illness, Ischemic heart disease, chronic obstructive pulmonary disease, and lung cancer. Using the HAP Intervention Tool the estimated ADALYs from use of super clean cookstoves suggest that this "clean stove-clean air" intervention is a cost-effective means of reducing the burden of disease amongst the rural poor of lowland Lao PDR[57]. Notably, in a 5-7 year clean stoves project, the great majority of ADALYs results from reducing the incidence of child pneumonia. The measure of cost-effectiveness derives from WHO guidance[58].

210. Preliminary financial modeling of the cost of a 50,000 super clean stoves distribution program in Lao PDR indicates that private sector financing is plausible assuming buyers could be found amongst the donor and private social impact community willing to pay in the range of 1-2 times the GDP per capita of Lao PDR. The newly capitalized Base-of-the-Pyramid Impact Exchange Fund, and a major international investment bank through its social impact funding, have expressed interest in financing a large-scale cleanstoves project in Lao PDR if forward contracts are in place with creditworthy buyers of ADALYs. Such buyers could include IDA and other multilateral development bank's output-based aid trust funds, private sector foundations focused on women's and children's health, and bilateral development grant initiatives in results-

[55] The program of fieldwork was undertaken with support from all levels of government by local non-governmental organizations (Stichting Nederlandse Vrijwilligers, the Lao Institute for Renewable Energy, and the University of California Berkeley, the private company Berkeley Air, with guidance from C-Quest Capital, a social impact investment company based in Washington, D.C.

[56] HAPIT weblink: www.cleancookstoves.org/HAPIT

[57] In the highlands, the habit of heating in winter with open fires significantly reduces the benefit and cost-effectiveness of low smoke cookstoves.

[58] A WHO initiative CHOICE (Choosing Interventions that are Cost-Effective) project was developed in 1998 with the objective of providing policy makers with evidence for deciding on interventions and programs which maximize health for the available resources. http://www.who.int/choice/cost-effectiveness/en/. Following the recommenda-tions of the Commission on Macroeconomics and Health, CHOICE uses GDP as a readily available indicator to derive the following three categories of cost-effectiveness: Highly cost-effective (less than GDP per capita); Cost-effective (between one and three times GDP per capita); and Not cost-effective (more than three times GDP per capita) http://www.who.int/choice/costs/CER_thresholds/en/.

based financing. In addition to measuring ADALYs from PM2.5 reduction as health outcomes, CO2 and black carbon emissions reductions are being measured, potentially generating revenue from the sale of all three products as a means of financing the distribution of cleanstoves that would otherwise be beyond the reach of the poor.

211. Clean household air from use of clean cookstoves will complement the MCH and nutrition improvements supported by the proposed project and program increasing the sustainability of nutrition and child care interventions. Cleaner and more convenient cookstoves fit well also with specific measures to improve nutrition, such as MOH Priority Nutrition Intervention #8, Food Safety's Cooking Demonstration with the use of Clean Cookstove; United Nations (UN) Recommendations for MFNSAP 2014-2020, WASH Sector 3. Household water treatment and storage, by boiling water with clean cookstove. Addressing HAP and promotion of clean cookstoves will be included in SBBC in IDA financing.

212. Implementation of a large scale super-clean stoves project would include independent third party verification of the location and use of all such stoves, of the level of reduction in HAP using PM2.5 measurements as the proxy, and of reduction in carbon and black carbon emissions. Monitoring and verification would result in publically available annual monitoring reports and third party verification reports. An on-line database would record the GPS location of the household using the stove and a picture of the woman stove user, the stove serial number and other household information.