

Indigenous Peoples Planning Framework: Ethnic Group Development Plan

June 2015

Lao PDR: Health Sector Governance Program

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

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CURRENCY EQUIVALENTS

(as of 11 May 2015)

| | | |
|---------------|---|------------|
| Currency unit | – | kip (KN) |
| KN1.00 | = | \$0.000123 |
| \$1.00 | = | KN8,096 |

ABBREVIATIONS

| | | |
|-------|---|--|
| ADB | – | Asian Development Bank |
| BCC | – | behavioral change communication |
| CBA | – | child bearing age |
| CDC | – | communicable disease control |
| DMF | – | design and monitoring framework |
| EG | – | ethnic group |
| EGDP | – | Ethnic Group Development Plan |
| GMS | – | Greater Mekong Subregion |
| GoL | – | Government of Lao PDR |
| HC | – | health center |
| HEF | – | health equity funds |
| HSDP | – | Health Sector Development Project |
| HSGP | – | Health Sector Governance Program |
| HSRF | – | Health Sector Reform Framework |
| IEC | – | Information, education and communication |
| LECS | – | Lao Economic and Consumption Survey |
| LNF | – | Lao National Front |
| LSIS | – | Lao Social Indicator Survey |
| LWU | – | Lao Women's Union |
| M&E | – | monitoring and evaluation |
| MDG | – | Millennium Development Goals |
| MNCH | – | maternal, neonatal and child health |
| MoH | – | Ministry of Health |
| NCAW | – | National Commission for the Advancement of Women |
| NESDP | – | National Economic and Social Development Plan |
| NTFP | – | non-timber forest products |
| PHC | – | primary health care |
| SPS | – | safeguard policy statement |
| VHV | – | village health volunteer |
| VHW | – | village health worker |
| WB | – | World Bank |

NOTES

- (i) The fiscal year (FY) of the Government of Lao PDR and its agencies ends on 30 September. "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2011 ends on 30 September 2011.
- (ii) In this report, "\$" refers to US dollars.

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Executive Summary

1. The proposed Health Sector Governance Program will be implemented nationally with the overarching goal to increase access, quality, and utilization of essential health services, with a focus on maternal, neonatal, and child health care, particularly in poverty areas. This will lead to improved health and nutrition in the Lao People's Democratic Republic, particularly among the poor, women and children, and ethnic groups, in remote rural communities in all provinces.
2. The Social Impact Assessment conducted under the Health Sector Governance Development Project design identified the need for an Ethnic Group Development Plan (EGDP) due to the high number of ethnic minorities (referred to as ethnic groups) living within the project area. According to the Department of Planning and Cooperation of the Ministry of Health, ethnic groups (EGs) comprise some 34% of the total national population. In certain provinces such as Sekong in the south, and Phongsali in the north, the EG population may comprise up to 89% and 80% of the provincial population respectively.
3. As confirmed by the 2012 Lao Social Indicator Survey, EGs do not use health services as frequently as mainstream Lao due to numerous factors including physical location and distance from services, lack of Lao language and illiteracy, lack of cash, customs, and local beliefs. The impact of lower service utilization rates compared to mainstream Lao is higher infant, child, and maternal mortality rate as well as higher rates of malnutrition and stunting in children.
4. The purpose of this document is to identify the impact of the HSGP activities upon ethnic minority people and prepare an EGDP with appropriate measures to ensure that EGs (i) receive culturally appropriate social and economic benefits, (ii) do not suffer adverse impacts as a result of projects, and (iii) can participate actively in projects that affect them. The formulation of the EGDP draws from data and information contained in the project concept note as revised in March 2015, and the Social Impact Assessment, conducted by project consultants in November and December 2014. It is also based upon the findings from public consultation and due diligence carried out in March 2015 by the Asian Development Bank, and also World Bank consultants designing the complimentary Health Governance and Nutrition Development Project in March 2015.
5. The EGDP provides mechanisms with which to provide equality and equity for EG communities. The EGDP specifies EG training, and management targets for the project at all levels, and also requests scholarships for EG health science students. The EGDP also specifies actions to be taken to enhance the participation of EGs, especially EG women including measures such as strategic outreach, arranging times for separate community level men and women's discussion groups, participatory evaluations of project interventions.
6. The project has been categorized as Category B for Ethnic Minority Groups – likely to have limited impacts. No specific negative impacts are envisaged as a result of project implementation. This EGDP has been prepared in order to mitigate the risk that EGs may not be able to fully participate and capture the same level of project benefits as mainstream Lao, a situation which could, if not mitigated, increase their vulnerability.

I. Introduction

1. The purpose of this report is to present the due diligence that has taken place to assess any ethnic group (EG) impacts that will be expected to occur on the project; and to provide an approach to ensure that all project activities equally benefit EGs as per Safeguard Requirement 3. This Ethnic Group Development Plan (EGDP) will form part of the project administration manual (PAM).

A. Project Description

2. The Health Sector Governance Program (HSGP) aims to support the implementation of the Lao Peoples Democratic Republic (PDR) Health Sector Reform Framework (HSRF) which aims to (i) improve access to basic health care and financial protection by 2020, and (ii) achieve universal health coverage by 2025.¹ The proposed program modality comprises a policy based loan; an investment loan and a grant. This RF covers all three modalities.

3. The policy based loan uses a programmatic approach with two subprograms: subprogram 1 to be implemented from October 2015 to September 2018 and subprogram 2 to be implemented from October 2018 to September 2020. Two subprograms are proposed to facilitate monitoring and implementation of reforms, and to provide a clear policy and financing framework for the government.

4. The proposed program will support key elements of the HSRF: (i) securing sufficient financial resources for basic health services provision (particularly for the poor, women, and children); (ii) human resources strengthening; and (iii) improving health services financial management. The capacity development support will strengthen both national and subnational levels to design and implement the Government's reforms. National roll-out will focus on poorer provinces and districts will be considered as an implementation priority.

5. The World Bank will also support the HSRF. It intends to focus on health service delivery including: (i) strengthening the district health information system; (ii) operational/budget support for service delivery (basic package of services); and (iii) village-based nutrition improvements.

B. Project Outcomes

6. The program impact will be improved access to health care. The benchmark of the impact will be progress in (i) increasing proportion of deliveries assisted by skilled health staff; (ii) reducing out of pocket expenditures; (iii) increasing the health equity fund (HEF) and free maternal, neonatal, and child health care (MNCH) coverage; and (iv) improving staffing of the district hospitals and primary health care facilities. The program outcome will be strengthened national and subnational public health sector management.

7. The outputs are (i) increased financial protection of the poor and improved health services delivery, particularly MNCH; (ii) strengthened human resources management capacity; and (iii) improved health system financial management. These outputs will be key policy pillars under the proposed program. The program will support the roll out of the reforms in the national, and principally, in the provincial level.

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

8. The HSGP will provide significant benefits for the poorest groups, including improved health care for women and children, disadvantaged EGs, the poor, and those living in remote areas; and an increase in the number of deliveries with either a skilled birth attendant and/or in a health facility. The project should result in:

- (i) increased use of health services and health care facilities by the poor;
- (ii) improved nutritional status of children through active community nutrition program;
- (iii) expansion of the number and scope of model health villages, particularly in the poor districts of the country;
- (iv) reduction in the costs of pharmaceuticals and thus the costs of accessing quality health services;
- (v) improve the skills of health personal, particularly those posted to districts and health centres; and ,
- (vi) increased budget resources which will enable sustained and comprehensive outreach programs and should enable targeting of services to those most in need and disproportionately benefit those with the poorest quality services and health workers.

C. Project Location

9. The program will be implemented nationally, through the Ministry of Health (MoH) and its line agencies at provincial and district levels. It will involve health learning institutions at central and provincial levels and also health facilities at provincial, district, and health center levels. There are 18 provinces and 148 districts in the Lao PDR. Each province has at least one provincial level public hospital and most districts will have one public hospital. In addition, there are about 950 health centers nationwide. The project will focus on improving service delivery in poorer areas; therefore HSGP implementation will be rolled out according to priority needs criteria.

II. Background Information

A. Ethnic Groups in the Lao PDR

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

11. In Lao PDR, there are 49 EGs that are officially recognized by the government. They are categorized according to four ethno-linguistic families.² The Tai-Kadai family includes Lao, Lue, Phoutay, and other lowland groups, and account for 67% of the national population. The Mon-

² The actual number of ethnic groups may be as high as 236 depending on the level of classification used in regards to groups and subgroups within the main ethno-linguistic families (Chamberlain et. al.1996)

Khmer family includes groups such as the Khmu, Khuan, and Samtao that account for 23% of the population. The Hmong, Yao, and other Hmong-Tien groups account for 7%, and the Sino-Tibetan groups account for 3% of the national population.

12. Nationally, EGs make up approximately 34% of the total population of Laos.³ The four main ethno-linguistic families are often re-categorized according to three topographic locations reflecting the traditional and preferred environments in which they live, and these three terms are commonly used by both government workers and civil society when describing the classification of the non-Lao EGs (although use of these three categories is now officially discouraged, they remain the most widely used in practice):

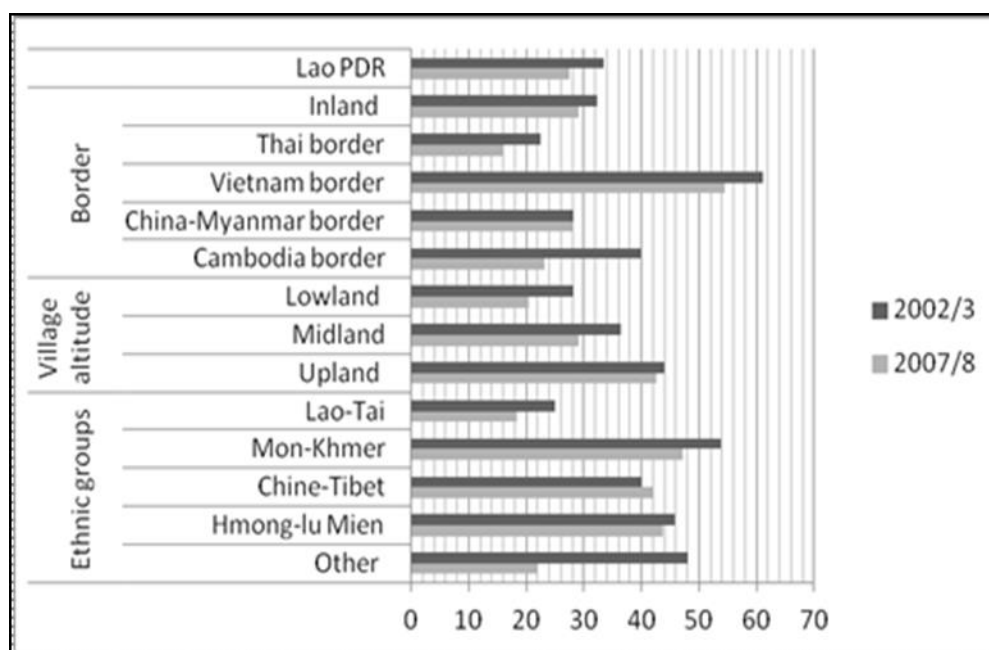
- (i) Lao Loum - Lowland Lao (mainly Lao Tai), groups traditionally living in the lowland, valley floor regions of the country that historically have cultivated paddy, practiced Buddhism, and are integrated into the national economy. These correspond to the Lao-Tai group and represent approximately 65% of the population.
- (ii) Lao Teung – Upland (slope) Dwellers (mainly Mon-Khmer), groups traditionally dominating the middle hills and for the most part practice swidden agriculture (rain fed upland hill rice, maize), many raise cattle, most are reliant on forest products, and to some extent are isolated from the dominant lowland culture. Many groups exhibit varying degrees of assimilation and adaptation to Tai-Lao culture. These groups are the original inhabitants of Southeast Asia and consist of the Austro-Asiatic or Mone-Khmer ethnic groups (approximately 25% of the population).
- (iii) Lao Soung - Highland Lao (Sino-Tibetan Burma and Hmong-luwmiens), groups dwelling in the highland areas practicing swidden agriculture growing mainly hill rice, maize, and traditionally, many have grown opium. Many of these groups are historically relatively recent arrivals from Southern China and Vietnam and form about 10% of the population.

B. Poverty and Ethnic Groups

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

³ 2014 estimates from the Department of Planning and International Cooperation, Ministry of Health.

Figure 1: Ethnicity, Location and Poverty



Source: Lao Bureau of Statistics: Poverty in Laos 2008

Table 1: Estimated National and EG Population

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

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

III. Legal and Institutional Framework for Ethnic Groups in Laos

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

A. Constitution of the Lao PDR

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

16. Party policy relating to ethnic minorities remains relatively unchanged from that announced by Party Central in 1992, which identified three essential tasks for EG development:⁴

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

B. National Economic and Social Development Plan

17. The 7th National Economic and Social Development Plan (NESDP),⁵ which runs from 2011 until 2015, calls for authorities to integrate smaller villages, particularly in the more remote areas, to facilitate administration and allow better provision of services. This relocation can have significant effects on EG communities as they move to areas of lower altitude and flat land, which entail different livelihood and farming systems. The NESDP calls for the authorities to:

- (i) Integrate small scattered villages to be merged and reorganized to become bigger villages and establish new communities (small town) to become a model in rural and remote areas with 1–2 towns per province.
- (ii) Resettle displaced people by developing permanent new agricultural lands and living facilities, completely halt (and reverse) deforestation, and stop shifting cultivation.
- (iii) Continue village grouping (kumban) as an anti-poverty and rural/human resource development approach.

⁴ Contained within the Resolution of the Party Central Organization Concerning Ethnic Minority Affairs in the New Era (GoL, 1992)

⁵ Ministry of Planning and Investment. 2011. *National Economic and Social Development Plan, 2011–2015: Targets for 2015*. Vientiane.

C. Lao Women's Union

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

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

D. National Committee for the Advancement of Women

20. The National Committee for the Advancement of Women (NCAW) was established under the Prime Minister's Decree No. 37/PMO, dated 1 April 2003, and is tasked with implementing the 2nd National Strategy for the Advancement of Women (NSAW) which outlines gender related goals and targets for each sector, and has established a basic structure in each ministry comprising the Government of Laos. NCAW's mandate is to support Sub-committee for the Advancement of Women (Sub CAW) networks in line ministries for the advancement of women and to integrate gender into the planning, budgeting, and monitoring and evaluation (M&E) cycle of line ministries. NCAW plays a lead role in coordination of gender development both internally and with international partners. The NCAW, through its Sub CAW network, also has the responsibility as the main focal point for the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and Child Convention work within the Government of Lao PDR.⁶

21. The 2nd NSAW contains specific targets focused on women's and children's health under Program III: Ensuring Gender Equality and Women Empowerment to Participate in all Fields. The activities indicated under these programs are to be implemented through the Sub CAW network within each line ministry and includes increasing mother and child health care network from the central down to grass-root levels, and therefore including EG communities, by implementing safe motherhood project to cover poorest districts; ensure provision of mobile service with integrated mother and child health care package; organize training skilled health workers and traditional birth attendants, provide health care service in each locality appropriately.

IV. Social Assessment Findings

22. As in the Greater Mekong Subregion (GMS) in general, the inclusion of EGs in the countries' economic development have largely been left behind. One key reason is the

⁶ United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly; United Nations Convention on the Rights of the Child, 1990.

significantly higher costs of developing infrastructure in isolated and upland areas, resulting in boom town development along valley floors compared with little change in upland areas. A comparison of poverty incidence and ethnic minority demographic maps confirms that ethnic minorities make up the poorest communities (refer Annex 1 and Fig 1 above).

A. Relocation

23. EGs have been relocated to lowland areas under government policies. Although officially, the relocation is done in order for the government to provide basic services such as education and health care, and environmental protection, there is also relocation of communities to eliminate poppy growing, and granting of land concessions for agribusiness, mining, and hydro power leases. In some cases, EG communities have lost access to traditional livelihood areas where they have grown rain fed crops, hunted, and gathered forest vegetables and other non-timber forest products, as well as obtaining timber for building houses.⁷

24. Highland and upland communities who are relocated to flat lowland areas encounter higher temperatures and more sources of stagnant water than they have been accustomed to previously. The previous highland dwellers do not have as much experience or knowledge regarding mosquito borne infection prevention and how to prevent malaria and dengue as mainstream Lao, resulting in frequent infection.⁸ A survey of 67 displaced villages in six provinces of Lao PDR found there have been devastating epidemics (particularly from malaria), as well as loss of assets, debt accumulation, rice deficits, intensified competition for land, and lack of government resources to provide assistance to relocated communities.⁹

B. Education and Literacy

25. The Lao Social Indicator Survey 2012 (LSIS) found that EGs are disadvantaged with regards to access to education and healthcare due to isolation and difficulty to travel, and lack of cash. A lack of education combined with geographic isolation results in lower levels of literacy and awareness. Women from minority communities are even more disadvantaged, being held back by tradition and social mores and practices in many cases.

26. The 2012 LSIS reports that children from non-Lao-Tai EGs living in rural and remote areas have the lowest indicators of primary education. While 89% of students in the capital Vientiane who enroll in grade 1 stay in school long enough to advance to grade 5, less than half of them do in the most disadvantaged provinces (e.g. Sekong, Saravan). These differences in enrollment and survival are reflected in youth literacy rates in the Lao language. For example, 90% of 15–24 year olds in urban areas are literate, compared with only 41% of those in rural villages without road access. These are the areas most usually inhabited by EGs. Educational disparities widen at the intersection of gender and ethnicity. Literacy rates for young males of Lao-Tai ethnicity are 84%, but only 63% for Mon-Khmer. The disparity increases for ethnic females, with 81% of Lao-Tai ethnicity but only 45% of Mon-Khmer ethnicity are literate in the

⁷ Included in the rationale of ADB-IFAD. 2010. *Sustainable Natural Resource and Productivity Improvement Project*. Manila.

⁸ Field notes, Ket Nam Hon, Feuang District, Vte Prov, AusAID-WB “Lao Upland Agriculture Development Project”, 1991

⁹ United Nations Development Program (UNDP), 1997. *Basic Needs for Resettled Communities in the Lao PDR*. UNDP Vientiane.

Lao language.¹⁰ This is explained by lower rates of enrollment and greater drop-out rates for rural women in remote areas (usually inhabited by EG communities). At the end of the 2010 school year, some 91.7% of primary school aged girls were enrolled at school, but this rate drops significantly to 55.5% for lower secondary school and only 30.4% for upper secondary school.

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

C. Health

28. In 2014, the MoH Department of Planning and Cooperation has estimated the national population to have now increased to 6,909,584 of which 3,558,436 are female (51.5%). Of the total population some 2,364,017 (34.2%) are ethnic minority. Of the total female population, MoH estimates that some 1,589,204 (44.67% of women) are women of child bearing age (CBA - defined as within 15 to 45 years of age). Within the total number of women of CBA, there are some 543,724 who are of minority ethnicity, accounting for 34.25% of total.

29. Significant inequalities persist along rural–urban lines and geographic areas (north, center, and south), and amongst ethnic groups in regards to access to quality healthcare. The Lao PDR's maternal mortality rate is still among the highest in the world at 357 deaths per 100,000 live births according to the 2012 LSIS and the 2014 UNDP Millennium Development Goal (MDG) report. This high rate suggests that access to and quality and uptake of emergency obstetric and skilled birth attendant at delivery pose major challenges for the country to achieve the MDG goal of 260 per 100,000 live births, but shows a marked improvement from the 1995 baseline of 796 per 100,000 live births. The under-5 mortality rate remains high at 79 per 1,000 compared to the 1993 baseline of 170 and the MDG target of 70. Infant mortality per 1,000 is 68 compared to the 1993 baseline of 114, and MDG target of 45. Health service quality and access vary widely, particularly between rural and urban areas, with service quality being inversely proportional to degree of isolation.

30. A household survey in 2011 on MNCH¹¹ in six central and southern provinces demonstrates that financial factors were the most-reported constraint on health service utilization by women. Forty-five percent of all women reported that obtaining money for treatment was a barrier to receiving medical advice or treatment. Not wanting to go alone, and/or not being allowed to go alone, and physical access and transportation were additional problems reported.

31. The 2012 LSIS found that fertility is highest among rural women at 3.6 compared with urban women at 2.2; highest for those living in areas without roads and formal education; and lowest among urban educated women. According to a household survey conducted in 2014

¹⁰ Department of Planning, Ministry of Education and Sports. 2014. *Ethnic Groups Development Plan for the Second Global Partnership for Education Project*. Vientiane.

¹¹ World Bank. 2013. *Maternal health, child health, and nutrition in Lao PDR: Evidence from a survey in six central and southern provinces*. Vientiane.

across 12 provinces by the Communicable Disease Control Project, Phase 2 (CDC2), about 35% of pregnant women self-delivered at home. In regards to birthing, some 54% of women aged between 15 and 49 years who gave birth in the two years preceding the survey received antenatal care from a health professional, and nearly half (48%) did not take any iron tablets during their pregnancy. In the same group, only 42% of women who gave birth in the previous two years were assisted at the time of delivery by a health professional and fewer deliveries in the Northern region were assisted by a health professional (31%) than in the South (33%), and Central regions (53%).

32. Home birth is unavoidable for many women due to distance and time to access the health service, and in most instances of maternal death, the woman has not presented at the health center until it is too late. When problems arise at a home birth the first resort is traditional treatment, whatever is available in the community. When the situation starts to become desperate, the woman is taken to the health center, and in many cases the child is born either in the village or before they arrive at the health center. Case records show that in many cases the death is caused by post-delivery blood loss. An obvious priority for village health workers is to detect early warning signs in order to get women to the health center before problems get serious. The problem of travel and physical access will, however, still remain a major issue for women in isolated areas.

33. For non-Lao-speaking EGs, language can be a significant barrier to accessing health information. This was demonstrated in the CDC2¹² project when separate men's and women's EGs were presented with information, education, and communication, (IEC) and behavioral change communication (BCC) poster materials being used by various projects and programs under MoH, to assess their understanding of the health messages being conveyed. The posters had been designed with minimal text, however, rates of understanding amongst these groups averaged around 20% of the material presented, indicating that the materials were badly designed. Follow up checking within MoH indicated that the materials had not been field tested prior to printing and distribution.

34. A further observation from the CDC2 gender consultant is that the literate EG women living in rural areas are younger women who have attended some school. Most of the older minority women did not attend school and their incidence of illiteracy is much higher. This has an impact on the selection of village health volunteers or workers, and village midwives, as the older women who have more social capital, are less likely to be literate compared to young and adolescent women who have the benefit of some schooling but lack social capital.

35. Most EG women give birth at home with little, if any, pre or post natal care. Malaria, dengue fever, water borne illnesses (such as diarrhea, intestinal parasites), and respiratory illnesses are the main health issues affecting ethnic minorities and the burden of nursing the sick falls on the mother. Isolated upland and highland minority communities more often than not lack clean water supply for drinking, and easy access to water supply for sanitation (flushing and cleaning toilets, hand washing). In response, the MoH has launched various projects including the ADB funded CDC2 Project, and the Model Healthy Village initiative (which includes the training of village health volunteers and midwives) to introduce basic primary health care at village level and particularly in ethnic minority communities.

36. Cultural divides have proven to be especially challenging when the health worker and the patient population are from different ethnic groups with different languages, cultures, and

¹² CDC2 Gender and IP Specialist Field Report, Sept 2012.

beliefs. There are issues of comprehension and then adoption as tradition can prevent the utilization of newly acquired knowledge. Some EGs have traditionally required women to give birth unassisted in the forest. According to the 2012 LSIS, rural members of Lao-Tai ethnic groups are 10% more likely to seek care than populations from non-Lao-Tai ethnicities.

37. Health facilities in rural areas, and particularly remote areas, are rudimentary and lack adequate staff, drugs, equipment, and associated facilities. In 2013 there were a total of 747 trained midwives, with 4.32% at central level, 3.5% at provincial hospitals, 48% at district hospitals and 44.2% at health centers. In 2014 the total number has increased to 1,020. MoH targets are to staff each health center with 5 to 7 staff, and in 2014, the number of health centers with only 1 or 2 staff had been halved to 229 (22.6%). Around 90% of health centers still have less than 4 staff. There are a total of 950 health centers nationally. Language and translation for EGs are common problems reported by health center staff.

D. Ethnic Group Health Workers

38. According to MoH Personnel Department records from 2014, health staff nationally number 19,704 of which some 62.8% are women. Of this total, some 11,811 are posted in health facilities. Women in management positions account for some 49.3% compared to men occupying 50.7% of management positions. Most health staff are ethnic Lao (79.2%) and some 3.7% belong to the Khmu group and 3.1% the Hmong. Considering that ethnic minorities make up roughly 34% of the Lao total population, there is the need to draw many more ethnic group personnel into the health service sector.

39. The exact number of village health volunteers (VHV) established nationally is not known but runs into several thousands, with many in remote areas. The 8 northern provinces in which the Health Sector Development Project (HSDP) is implemented report a total of 5,704 VHV in a total of 3,167 villages, of which there are some 1,233 women VHVs (21.6%). There are a total of 3,027 EGs included in the total number of VHVs. Of the 3,167 villages, some 953 villages (30%) have at least 1 female VHV.

E. Ethnic Group Health Service Needs

40. The Social Analysis prepared under the policy and advisory technical assistance identified several key needs that must be addressed in order to optimize the participation of EGs in the proposed project and improve the access to, and utilization of, healthcare services. These needs include improved physical access, language and communication, increased sensitivity to EG members by healthcare workers, more ethnic women to ethnic women healthcare, improved capacity and service quality from village health workers and volunteers. Annex 2 contains additional recommendations identified by the CDC2 gender and EG Specialist on how to facilitate the participation of EG communities.

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

- (i) establishing health care centers in remote locations
- (ii) establishing and training village health workers, village mid wives and also village health volunteers
- (iii) increasing the number and capacity of women to women healthcare.

V. Consultation and Participation

42. Consultative meetings were held in March 2015 by the ADB pre-fact finding team with key departments at the central level including Cabinet and the MoH SubCAW, Planning and International Cooperation, Personnel, and Education and Research departments. All confirmed the need to improve primary health care and MNCH service delivery, particularly in remote areas, and the need to employ more EG members in the health services. Development partners had provided tuition scholarships for EG medical students, and 2014–2015 was the first year in which MoH had used government budget to waive tuition fees for EG medical students in an attempt to draw more into the medical professions. The department also reported that EG sensitivity was addressed in the ethics section of their curricula. All meetings confirmed the government's support for increasing the number of EG members in the health service and the importance of being able to provide EG to EG services, and particularly women to women services.

43. Consultation with health agency authorities and minority communities regarding health and health service needs, access and communication difficulties, was also conducted in Saravan province from March 23 to 25, visiting Samouy and Lao Ngarm districts. Interviews with the acting Director of the Provincial Health Office and key staff confirmed the EG health issues discussed above adding that:

- (i) EGs were benefitting from health service improvements and the use of healthcare facilities was increasing and especially in regards to MNCH services,
- (ii) constraints to wider utilization concerned insufficient staff, inadequate facilities and equipment, language literacy and communication, and also a lack of trained EG health workers,
- (iii) the province has already initiated a local scheme whereby partial scholarships are provided to students including EG members from the Champassak Medical School. In exchange for scholarships, recipients agree to work at health center level for 3 years (a group of 8 such students were observed working at the Nong Kae HC in Lao Ngarm district).
- (iv) the health agency had made special efforts to get support of the traditional healers for outside interventions in healthcare and not to act so as to prevent or discourage people from seeking healthcare
- (v) availability of emergency cash was still a constraint as transportation allowances paid under the government free birthing were based upon local bus fares to the health facility whereas a small vehicle has to be hired to bring the patient and relatives. The allowance is about 1/3 of the amount needed.

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

- (i) has previously relied upon traditional healers within the community, using herbal remedies and spirit worship as integral parts of their indigenous healthcare (this degree of reliance in modern Laos varies considerably with remoteness, there are however still elements to be found in all EG communities);
- (ii) village traditional healers and spirit men will not interfere with people going to seek outside healthcare, however people will still consult with the spirit man before leaving the village to get healthcare. This is done to “cover all bets”, for safety whilst traveling, and peace of in appeasing the spirits;

- (iii) Kado men would have to accompany their wife and children on any visit to the health center or hospital. They also reported that they would let the doctor examine and treat their wife without their presence in the treatment room;
- (iv) both men and women agreed that their main priority was for MNCH services and particularly to ensure safe delivery;
- (v) sickness had severe implications on the household labor force needed to grow crops and livestock;
- (vi) important that health agency staff are able to engage those with social capital in the village and obtain their support in promoting modern healthcare;
- (vii) traditional medicines are a valuable resource and their use has an important place in indigenous healthcare systems.

45. Discussions were also held in a village of mixed ethnicity in Lao Ngarm district close to the Nong Kae health center, where a group of pregnant women and young mothers were interviewed. Previously birth delivery was done at home with women assuming it was a natural process and not expecting difficulties. However due to a high rate of infant death and following Outreach visits from health staff, most younger women were now looking to giving birth in the health centers as a preventative measure. One young mother had lost two children after birthing at home but was planning to birth at the health center this third time.

46. All village consultations confirmed strong support for project interventions and particularly for improved delivery, MNCH, and under 5 years of age packages and expanded HEF coverage.

47. Secondary consultative data was also obtained from the CDC2 project (12 national border provinces), and also the HSDP (8 northern provinces), both with a majority of EG populations. The CDC2 project conducted a Knowledge Attitudes and Practice (KAP) household survey in the 12 project provinces where participating households had children under 5 years of age and in project villages not yet declared or established as model healthy villages. A total of 1,497 households were interviewed and mothers were the target respondents. Main results from the survey indicated that 66.3% of respondents had received some ante-natal care during pregnancy, 67.6% received iron pills and 82.4% received anti tetanus shots. Some 96.7% breastfed and 65.3% of respondent's children under 5 received vitamin A capsules. Only 18% received post-natal care. The survey demonstrated that EG women are using health services in increasing numbers.

48. Results from the HSDP indicate that more people are seeking treatment at government facilities and that an increasing number of women are having deliveries attended to by qualified medical staff. The project notes that whilst improved health facilities and better skilled staff such as skilled birth attendants are available, physical access constraints remain in remote areas particularly in the rainy season. The percentage of health staff from ethnic groups is increasing but still limited which may prevent certain individuals from ethnic groups to use services. Behavioral change demonstrated by increased health facility use indicates the local communities' demand and support for improved health services, and good health.

49. Free, prior, and informed consultations were also made by the World Bank Health Governance and Nutrition Development Project (HGNDP) in March 2015, whereby more extensive field visits were carried out in three provinces (Saravan, Oudomxay and Bolikhamxay). The local consultations documented high levels of support for the proposed HGNDP, as well as a wide variety of cultural practices, especially with regard to method of delivery, and post-natal practices. With respect to nutrition, the consultations highlighted the

variations in understandings of nutrition across the communities. Like maternal and child caring practices, the findings emphasized the need for flexibility in the HGNDP's nutrition messaging to ensure local relevancy. Health centers where the staff spoke ethnic languages were much more accessible to villagers because they were able to communicate effectively with staff.

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

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

51. The result of the World Bank team public consultation was universal support for the project to improve access of remote villagers to health services and particularly MNCH services and nutritional outcomes, and no negative impacts on EGs envisaged. There was widespread awareness of the benefits of financial support for free MNCH and the HEF.

VI. Benefits, Impacts and Mitigative Measures

52. Preparation of this EGDP is guided by the ADB Safeguard Policy Statement (2009) and the ADB Operations Manual Safeguard Policy statement (Sec F1/OM - 2013). In accordance with the requirements, anticipated impacts and mitigative measures have been reviewed for both policy and project subprograms. There are no negative impacts under either; however there are measures needed to ensure that EG members benefit to the same extent as mainstream Lao, as indicated in the policy matrix contained in Annex 2 and also under the project EGDP in Annex 3.

53. The policy matrix and EGDP actions aim to address both strategic and practical needs of EGs within the project framework. At a strategic level, the policy matrix and EGDP provide actions to increase the number of EG men and women employed in the health care sector and improve the quality of their human resource development and training. There are also measures to increase the number of EG men and women in health care management positions therefore providing EGs and especially ethnic minority women with a voice in planning and budgeting. On the practical level, free MNCH, under 5 programs, and the expansion of the HEF will increase health care accessibility as will the increase and improvements in skilled birth attendants, VHVs,

and village health workers (VHWs) at village level. The increase in women to women health care will help improve the sensitivity to women's health issues. Improvements to health care facilities will contribute to overall service improvement.

54. The benefits to EGs will be improved health of men, women, and children, with reductions in infant, child, and maternal mortality through increased use of health services and assisted birthing; free MNCH, under 5 services, and HEF; reduced expenditure on healthcare; and also overall improvements in primary health care, nutrition, and village hygiene.

55. There are risks that EGs will not benefit as equally as mainstream Lao from program interventions for various reasons. The following table details possible risks with regard to the intended outcomes which have been addressed in the policy matrix and in formulating the EGDP.

Table 2: Benefit and Risk Issues

| Intended Outcome | Benefit to EGs | Risk / Issue |
|---|----------------|---|
| i) increased use of health services and health care facilities by the poor; | Yes | Lower participation rates due to language and literacy issues. Lack of understanding of information disseminated regarding service and entitlements and particularly free services. Low number of EG health service staff and especially EG women staff. Tradition and custom constrain expanded use. |
| ii) improved nutritional status of children through active community nutrition program; | Yes | Lack of participation by EG women due to language and literacy issues as well as inconvenient meeting schedules. Lack of understanding of information disseminated. Lack of resources to adopt recommendations. |
| iii) reduction in the costs of pharmaceuticals and thus the costs of accessing quality health services; | Yes | Lower participation rates due to language and literacy issues. Lack of understanding of information disseminated regarding service and entitlements and particularly free services and lack of knowledge of how to access benefits. |
| iv) improve the skills of health personnel, particularly those posted to districts and health centres; and , | Yes | Lack of EG staff working at district and health center levels. Quality staff do not wish to be in isolated areas. Low numbers of EG women working in health sector. Lack of funds to hire EG health center assistants/translators. Low number of female EGs trained as VHWs, midwives. |
| v) expand budget resources for: a) sustained outreach programs including to regular periodic markets, b) development of district and provincial operational plans and budgets to those most in need and with the poorest quality services and health workers. | Yes | Political will required to divert resources to areas of priority need; poorest geographic areas also have highest concentrations of EGs who have lowest levels of socio-political capital. Outreach funding not afforded priority. |

56. Annex 3 contains key EGDP activities, indicators, and targets to be mainstreamed under the program and this will also form the basis for monitoring EGDP implementation and

evaluation. The activities, indicators, and targets in the EGDP should be not be considered as fixed, rather, they should be reviewed and adjusted in line with the realities encountered during implementation.

VII. Grievance Redress Mechanisms

57. Although no grievances are envisaged under the proposed HSGP, the ADB Safeguard Policy Statement (2009) does require a grievance redress mechanism. In the Lao PDR, the judicial system starts at the local level with the Village Committee (VAC), which is normally used for grievances against local government agencies, civil actions, and minor criminal matters. In the case of most EG communities there is a more informal but very influential Village Elders group that includes individuals with social capital and influential social position in the community. The Village Elders should also participate in the grievance hearing and resolution at the village level.

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

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

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

Table 3: Grievance Procedure

| Stages | Activities/Procedures |
|---------------|--|
| Stage 1 | At the village level, AP files a complaint/grievance verbally or in writing to VAC/VE at village level. If unwritten the VAC/VE will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received. |
| Stage 2 | If no solution or understanding is reached within 5 days, the AP can bring the complaint at the district level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint. |
| Stage 3 | If the AP is still unsatisfied or has not received any decision from the GRC at the district level, he/she can seek redress at provincial GRC that should |

| Stages | Activities/Procedures |
|---------|---|
| | decide the issue within 10 days. |
| Stage 4 | The AP may elevate the complaint for hearing at the PMO if still unsatisfied with the decision of GRC at the provincial level. The PMO will ensure to resolve each complaint within 10 days after receiving the appeal. |
| Stage 5 | As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory. |

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

VIII. Capacity Building

61. The EGDP activities are mainstreamed into project implementation activities which will be implemented by the district and provincial health management and service teams working at hospital, outreach and health center level. In order to ensure the EGDP is disseminated and that each level understands the actions and activities proposed under the EGDP and the grievance procedures; and that all understand their corresponding role and responsibilities; pre-start up training for provincial and district managers is recommended. This will facilitate the meeting of staffing targets for women and EGs. Following project startup, gender and EG sensitivity and awareness training at all levels is required and this would include dissemination of both the gender action plan and EGDP. It is important that all health staff providing services at provincial, district, and health center levels receive both gender and EG sensitivity training.

IX. Institutional Arrangements

62. The program is implemented through the Department of Planning and International Cooperation, MoH, and project activities implemented by the participating provincial and district health offices. Management coordination and support units will be established at provincial and district levels. The MoH, provincial and district managers have responsibility to ensure that EG staffing targets are pursued and also that field teams are adopting recommendations and the special measures contained in the EGDP in respect to working with EGs. Provincial and district level teams should assign one person at each level to act as the focal point for social safeguards work. Safeguard oversight will be provided through the Project Management Unit (PMU) with guidance from the Chief Technical Advisor (CTA) who will provide 36 months of intermittent input to the project and support from the international Safeguard Specialist who will provide some 3 months of intermittent input. The CTA and Safeguards Specialist will cover all three safeguard areas of resettlement, EGs, and environment. Technical assistance is required to ensure safeguard plans are implemented and monitored correctly and also to raise local capacity in regards to understanding the rationale and triggers for safeguard measures.

X. Budget

63. The costs associated with implementing this EGDP are minimal as the cost of technical assistance is allocated across all three safeguard areas (resettlement, EGs, and environment) for the Safeguards Specialist and across the entire project for the CTA. Activities under the EGDP are mainstreamed into project component activities and rather than requiring specific budget, require changes to working methodology at village level and increased sensitivity to EGs at all levels of the health service. Many of the EGDP activities can be combined with routine village visits. Scholarships for EG Public health students could cost around USD\$5,000

per awardee over the average study period of four years including living allowances and tuition, textbooks, etc.

Table 4: Budget Needs

| Item | Cost |
|---|-------------|
| Scholarships – 22 people over 4 years (1 to 2 per province) | USD\$80,000 |
| EG sensitivity and awareness training and EGDP training | USD\$20,000 |
| Conducting participatory service evaluation surveys with EG men and women | USD\$30,000 |
| Production of IEC and BCC materials for EGs | USD\$20,000 |
| | |

BCC = behavioral change communication, EG = ethnic group, EGDP = Ethnic Group Development Plan, IEC = information, education, and communication

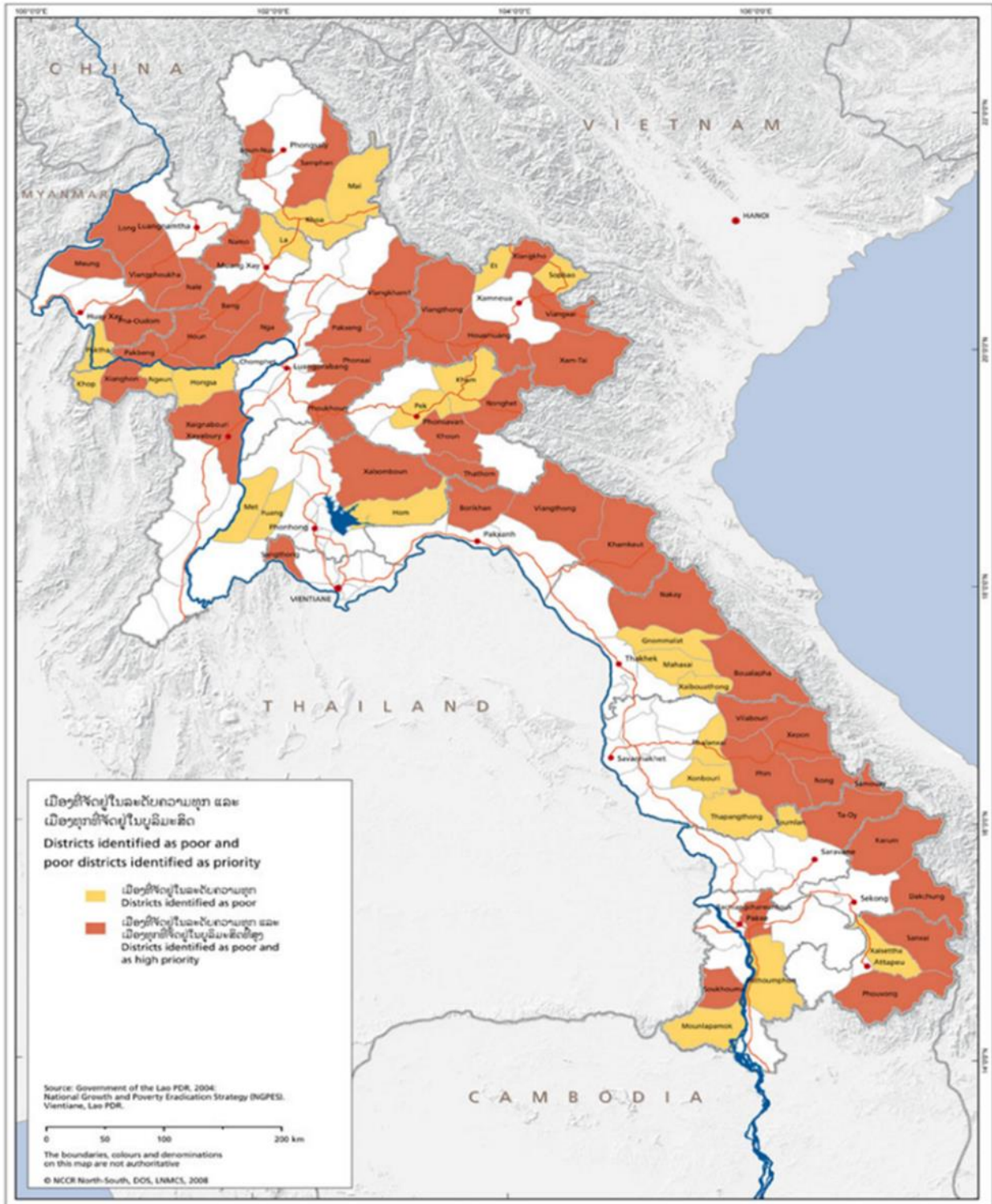
XI. Monitoring and Reporting

64. The executing agency (EA) will take action to ensure that a monitoring and evaluation system is formulated and implemented. As mentioned earlier, the EGDP contains suggested activities with indicators and targets which must be included in the M&E system. The CTA and Safeguards Specialist will assist the PMO M&E officer to ensure that all EGDP indicators are properly identified and defined and included in the project M&E system. The PMO M&E officer will receive updated reports from the provincial coordination unit and safeguard focal point, and prepare quarterly reports for the EA at central level using the design monitoring framework which is prepared and submitted to ADB on a quarterly basis.

XII. Disclosure Arrangements

65. The EA will endorse the EGDP. The EGDP is also to be summarized in local languages and made available to EG communities in an appropriate form and manner. The disclosure will provide sufficient information to ensure that all community members (women and men of all EGs) are made to understand the roles, responsibilities, and processes of the VAC in regards to dispute resolution, the involvement of the LNF, and also of the additional avenues available should local mediation fail. ADB will disclose the endorsed EGDP on their web site upon receipt.

Poverty Map of Laos



Source: GoL National Growth and Poverty Eradication Strategy, 2011.

Policy Matrix Ethnic Group Action

| Subprogram 1 Policy Actions (October 2013 to September 2015) | Indicative Policy Actions for Subprogram 2 Triggers in Bold (October 2015 to September 2018) | Medium-Term Objectives of the Health Sector Reform Framework (HSRF) (phase 2016–2020) | Mitigative Action for Ethnic Groups |
|---|---|--|--|
| 1. Improved access to health services for the poor | | | |
| <u>1.1. Health Sector Reform</u> | | | |
| <p>1.1.1 In December 2013, the National Assembly approved the Strategy on Health Sector Reform (HSR), which aims to achieve universal health care by 2025: affordable, reliable and accessible health services for all. The HSR prioritizes free maternal, neonatal, and child health care (MNCH) services and allocation of funding to rural and remote areas and enhancing the human resources for health.</p> <p>1.1.2 In January 2014, the Prime Minister issued the Decree 29/GOV establishing the National Commission on HSR to assist the Government and the Prime Minister to implement the HSRF.</p> | <p>1.1.1 The National Commission on HSR, established, and fully operational by 2015 and will continue to oversee implementation of the HSR for the period 2015–2020.</p> <p>1.1.2 The National Commission on HSR will meet at least twice a year to discuss and approve yearly HSR implementation plan.</p> | <p>The phase 2016–2020 of the HSR aims to ensure that essential services of reasonably good quality are accessible and utilized by majority of the population</p> | <p>Areas of greatest poverty and needs include geographic areas with higher proportions of ethnic group (EG) populations which should be prioritized for roll-out.</p> |
| <p><u>1.2. Access to health services for the poor</u></p> <p>1.2.1. MOH established the principles, rules and measures for the management and the implementation of the policy to subsidize the free delivery of maternal, neonatal and child health care (MNCH) through Prime Minister’s Decree No.273 in August 2014:</p> | <p>1.2.1 MOF will mobilize additional resources to scale up the provision of free MNCH and HEF to the entire target population across the country through joint funding (Government and official development assistance), with the goal of all MNCH services free of charge to users, nationwide and 80% of the poor covered by HEF (2014 coverage: 43%). Government will ensure an appropriate (incremental) budget as a commitment to</p> | <p>The Government will (i) increase the coverage of HEF to 80% of the poor population; and (ii) ensure that all MNCH services are free of charge to users, nationwide (<i>HSRF Priority area 2: Health financing</i>).</p> <p>The out of pocket expenditures is 35% of the</p> | <p>Scaling up of HEF and free MNCH to focus on priority poverty areas which include higher numbers of EGs.</p> <p>Information of HEF and free MNCH and Under 5 services must be disseminated to EG communities in EG</p> |

| Subprogram 1 Policy Actions (October 2013 to September 2015) | Indicative Policy Actions for Subprogram 2 Triggers in Bold (October 2015 to September 2018) | Medium-Term Objectives of the Health Sector Reform Framework (HSRF) (phase 2016–2020) | Mitigative Action for Ethnic Groups |
|--|---|--|---|
| <p>1.2.2 In October 2013, MOH rolled out the free MNCH program in 80 districts for maternal care and in 35 districts for children care (out of 143 districts) in October 2013. In addition, the Ministry of Health (MoH) extended the additional coverage under the HEF safety net program to 109,000 poor families (45% of poor families).</p> <p>1.2.3 In 2014, the MOH: (i) issued an agreement on the role of Health Insurance Bureau (HIB) under MoH, Department of Finance, and its branches, and (ii) strengthened the capacity of the HIB, including training of HIB staff on costing, and the implementation of HIB branches in 2 pilot provinces. Total of 16 participants trained of which 5 were female.</p> | <p>MNCH and HEF</p> <p>1.2.2 MOH will assess the impacts and gaps in access to existing free MNCH and HEF schemes and their financial management, monitoring and provider payment mechanisms and issue a decree harmonizing the existing schemes by September 2018.</p> <p>1.2.3 The MoH will further develop and approve the governance arrangements for HIB and its provincial branches, including the development of institutional management structure, definition of mandates and roles, implementation of capacity development for the staff.</p> | <p>total health expenditure (HSRF Priority area 2: Health financing).</p> | <p>language where possible as well with appropriate non-text media. Separate men and women's groups used for community dissemination using local translators.</p> <p>The review will also ensure that EG needs and sensitivities and addressed included in the harmonization.</p> <p>HIB branches must ensure access to EG language capability to ensure accurate dissemination of information to EG members.</p> |
| 2. Strengthened human resources capacity at central and subnational level | | | |
| <p>2.1 As part of the HSR implementation, the MoH has drafted and initiated internal review of the draft roadmap describing key reforms in strengthening health human resources, including their sequencing, and technical assistance and capacity development requirements. The review highlights the implementation of gender and equity policies to ensure recruitment and retention of health workers from ethnic populations and disadvantaged</p> | <p>2.1 MoH will approve the roadmap for reforms in strengthening health human resources and establish monitoring mechanism of the reforms for the period 2015-2025. The roadmap supports the deployment of staff in rural and remote areas.</p> | <p>The Government will ensure that (i) all health centers are staffed with at least one mid-level midwife and/or community midwife, and (ii) district and provincial hospitals will have at least the minimum staffing levels and specialists defined in the health coverage plan.</p> | <p>Priority will be given to hiring appropriately qualified EG personnel to serve in areas with high EG populations.</p> <p>Scholarships will be provided to select EG medical students.</p> |

| Subprogram 1 Policy Actions (October 2013 to September 2015) | Indicative Policy Actions for Subprogram 2 Triggers in Bold (October 2015 to September 2018) | Medium-Term Objectives of the Health Sector Reform Framework (HSRF) (phase 2016–2020) | Mitigative Action for Ethnic Groups |
|--|---|--|--|
| <p>locations and sets priorities for improving living and working conditions in remote areas.</p> <p>2.2 In 2014, the MOH has further rolled out the computerized Personnel Management Information System (PMIS) in the province, which provides quarterly information on number, allocation and skills of the health staff. Number of health staff increased from 17,636 in 2013 to 19,426 in 2014.</p> <p>2.3 In 2014, on MOH request, the Ministry of Home Affairs, despite macroeconomic constraints and wage freeze, increased the quota for health staff by 4,000 to ensure deployment of the health staff in the provinces. In addition, efforts made to address the gap in the supply of community midwives from 747 in 2013 to 1020 in 2014, as a result, the ratio of midwives per 10,000 population has doubled from 0.5 to 1.12.</p> <p>2.4 In 2013 and 2014, the MOH has further developed the development of a regulatory framework for licensing nurses and midwives.</p> | <p>2.2 The MOH will improve the accuracy of the PMIS, include in the system data related to training, gender and ethnicity, and strengthen the capacity of the provincial health office to use the data generated by the system for planning purpose.</p> <p>2.3. The provincial health offices will formulate and implement workforce plans (including, gender and equity policies and monetary and social incentives) to guide the allocation, management and education of health personnel with emphasis on deployment of staff in remote and hard to reach areas.</p> <p>2.4 The MOH will ensure that the Health Professional Council (HPC) and its boards have sufficient resources, expertise and effective management structure to enable it to deliver its responsibilities as stipulated in the Health Law.</p> <p>2.4.1 The MOH will issue a decree defining licensing and registration system for health</p> | | <p>Records will disaggregate by sex and ethnicity.</p> <p>Equity requirements to ensure opportunities for EG members and priority to assigning EG staff to remote areas to service EG communities.</p> <p>Regulatory framework and HPC acknowledge equality and equity for qualified EG members.</p> <p>Access to HPC and boards available to professionals in remote provinces.</p> |

| Subprogram 1 Policy Actions (October 2013 to September 2015) | Indicative Policy Actions for Subprogram 2 Triggers in Bold (October 2015 to September 2018) | Medium-Term Objectives of the Health Sector Reform Framework (HSRF) (phase 2016–2020) | Mitigative Action for Ethnic Groups |
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| | professionals, including requirements for maintaining registration. | | |
| 3. Improved health system financial management for the health sector | | | |
| <p>3.1 As part of the HSR implementation, the MOH has drafted and initiated internal review of the draft roadmap describing key reforms in health system financial management, including their sequencing, and technical assistance and capacity development requirements.</p> <p>3.2 MOH continued to strengthen staff capacity to adopt multi-year budgeting and budget framework, and trained 188 staff in 2014, of which 106 were female.</p> <p>3.3 The Prime Minister issued the Decree No 349/Gov. in December 2013 on The Management and Use of Service Charge Money in publically owned health facilities, and set the rule for accounting and utilization of the money collected from services charges on health consultation, diagnostic and treatment.</p> <p>3.3.1 MOH has issued Decree Implementation Guidelines (No728/MOH May 2014), which includes (i) rules for collection of</p> | <p>3.1 MOH will approve the roadmap for reforms in strengthening health system financial management and establish monitoring mechanism of the reforms for the period 2015–2025.</p> <p>3.2 MOH will ensure budget allocation no less than 9% of general government expenditures to the health sector in FY 2015–2016 and beyond, based on the National Assembly July 2014 Resolution to sustain at least 9% of total government expenditure for health (including ODA expenditures).</p> <p>3.3 MOH to adopt a system to account for the sources and application of funds at the health facility level in compliance with the requirements of Decree 349.</p> <p>3.3.1 MOH to implement a system for documenting the sources and application of funds is developed for all health facilities with an initial focus on district and</p> | <p>Domestically financed health expenditures are not less than 9% of General Government Expenditure (GGE) from 2015 and rise to 13% by 2025</p> | <p>Financial reforms to be rolled out in areas demonstrating greatest need which includes provinces with highest concentrations of EG populations.</p> <p>Budget progress reporting allows tracking of expenditure by province .</p> |

| Subprogram 1 Policy Actions (October 2013 to September 2015) | Indicative Policy Actions for Subprogram 2 Triggers in Bold (October 2015 to September 2018) | Medium-Term Objectives of the Health Sector Reform Framework (HSRF) (phase 2016–2020) | Mitigative Action for Ethnic Groups |
|--|--|--|--|
| <p>services charges; (ii) management of the service charges revenues; (iii) management of the funds and (iv) use of service charges money following the instructions contained in PM's Decree 349. –</p> <p>3.4 MOH has produced and published National Health Accounts (NHA) for 2009–2010, and 2010–2011 to document and analyze the sources and the utilization for funds at national and sub-national levels.</p> <p>3.5 MOF has approved the program funding mechanism for supplementary program support to provincial and MOH key departments for free MNCH and HEF and health service delivery improvements in June 2015.</p> | <p>provincial level hospitals</p> <p>3.3.2 To ensure quality and cost-effectiveness of pharmaceutical supply in the provinces, the MOH will establish guidelines for pharmaceutical supply management.</p> <p>3.4 MOH to continue to publish NHA for 2011/2012 and 2013/2014.</p> <p>3.5 MOH will adopt a new system and set of procedures to align development partner financing with government plans and budget, consistent with Government chart of accounts.</p> <p>3.5.1 MOH to establish an expenditure monitoring system to document annual and quarterly expenditure reports of provinces and central level health departments together with reports on budget disbursements.</p> | | |

Program Ethnic Group Development Plan

| Design Output | Ethnic Group Activities to be Mainstreamed |
|---|--|
| <p>1. Increased financial protection of the poor and improved health services delivery, particularly mother and child healthcare.</p> | <p>Facility attendance and treatment data to be disaggregated by ethnicity and gender. Training, meeting attendance and participation data is disaggregated by ethnicity and gender. materials prepared for non-Lao reading audiences to disseminate information on HEF and FMCNH and utilisation EGs receive timely information on how to access the HEF and the benefits provided. EG men and women's group meetings to disseminate information about HEF, MNCH and under 5 basic package and the benefits provided. MNCH services are included in comprehensive outreach programs. Promotion of EG women to EG women services particularly in MNCH. EG community level men's and women's group meetings for evaluation of health services packages, inclusion and ways to improve. EG women's group meetings convened at village level to identify the optimal times and locations for holding meetings with health staff as well as timing health delivery services by outreach teams. Outreach teams provide EGs with advance notice of planned visits and services offered.</p> <p>Village Health Committees (VHC) established in EG villages include 30% women as committee members.</p> |
| <p>2. Strengthened human resources management capacity</p> | <p>Health service personnel data is to be disaggregated by ethnicity and gender. Increased numbers of EG staff at all levels of service management EGs to be given equality of opportunity in receiving training to upgrade awareness, knowledge and technical skills and account for 30% of total project staff training participants. Project management units receive EG sensitivity and EGDP training EG awareness and EGDP training is provided to staff at all levels of health facilities. EG women to EG women healthcare service provision to be given priority and reflected in recruitment and training. Priority given to recruitment of EG and particularly EG women in order to provide ethnic and gender balanced teams at health facilities at all levels and particularly at district hospital and health centers. Health training institutions to include EG awareness, sensitivity and mainstreaming in all curriculum areas. EG scholarship program to support 7 EGs to study health health. EG provided equal opportunity in registration as licensed health practitioners Participatory impact evaluations to be convened with separate EG men's and women's discussion groups to assess community satisfaction with health service.</p> |
| <p>3. Improved health system financial management</p> | <p>Planning and budgetary process to include funding for EG sensitivity and awareness training and other activities identified in the EGDP.</p> |

EGs = ethnic groups, EGDP = Ethnic Group Development Plan, HEF = health equity fund, IEC = information, education, and communication, MNCH = maternal, neonatal, and child health care, VHMGs = village health management groups, VHV = village health volunteer, VHW = village health workers

Issues and Recommendations in Ethnic Group Participation and Training

Participation

| Issue | Impact | Action |
|---|--|--|
| Staff and community lack awareness of linkages between health and gender. | Reduced efficiency in planning of training. Inaccurate identification of target participants or beneficiaries Low adoption or behavior change rates Low participation of especially EG women. | 1. Training in use of gender analysis tools for planning and targeting 2. Training on gender awareness and identifying causal links – gender and health |
| Staff lack of capacity in participatory methods | Reduced operational efficiencies Low adoption or behavioral change rates Top down priorities Lack of feedback from project target beneficiaries in regards to activity effectiveness and impact Lack of sensitivity to EG culture/tradition | 1. Training in EG sensitivity is mainstreamed into participatory methodology. 2. Annual participatory evaluations with separate EG men’s and women’s focal discussion groups needed as routine procedure 3. Sex and ethnicity disaggregated in reporting |
| Lack of EG health center staff | Lack of sensitivity to EG issues - reduced service effectiveness Lack of ability to speak EG language – reduced communication efficiency EGs lack trust in health centers – confirmed through “negative events” such as death, reduces EG visits | 1. Train all staff in EG awareness and sensitivity. Raise awareness of EG culture, taboos, custom and identify workable solutions. 3. Hire more EGs as health staff. New health staff categories, e.g. health center assistant – reduced level of qualification, reduced level of responsibilities, or, Health Center translators – hire local EGs as translators for health centers full time – can also train up as health center assistants. 4. Use of EG staff to promote role and function of the health center especially with women and community leaders, VHV/VHWs |
| Lower rates of Participation by EG women | Health messages not conveyed Reduced rates of Behavior change | 1. Use of interactive and participatory methods and media - Facilitates health message transfer and improves individual knowledge: e.g. i) Young Women’s Health Groups – peer discussion and support groups. ii) Use of film and video media “starring” local EG personalities 2. District outreach staff, community trainers, hold separate men’s and women’s focal group meetings for planning, promotion, training, feedback and evaluation |
| Selection criteria for VHV include literacy | Lack of EG women as VHV as high % are illiterate | 1. Relaxation of literacy criteria in EG communities if needed. 2. Use of younger, literate EG women as apprentices to older illiterate women. |

| Issue | Impact | Action |
|---------------|--|---|
| IEC/BCC media | Lack of understanding of promotion and health message material. Lower rates of adoption or behavior change | 1. Training in gender analysis, Participatory consultation 2. Non-text IEC/BCC material design and field testing |

BCC = behavioral change communication, EGs = ethnic groups, IEC = information, education, and communication, VHV = village health volunteer, VHWs = village health workers

Training

| Subject | Issue | Action | Remark |
|-----------------------------------|---|---|---|
| Community focal groups | Best to use separate men and women's groups for discussion and consultation | If a gender related issue then separate discussion groups are mandatory – eg: reproductive health issues | Monitor the number of men and women in each group |
| Discussion group facilitators | If a gender neutral issue, men or women may facilitate either group | If a gender related issue – a woman must facilitate the women's group, - a man must facilitate the women's group | Use local EG translators |
| Ethnic minorities consultations | Best to use separate men and women's groups for discussion and consultation | If a gender related issue then separate discussion groups are mandatory | Monitor the number of men and women in each group |
| Ethnic minority discussion groups | Do men in the community speak, read and write Lao? | If not, ensure that a local EG translator is available. For men's group the translator should be an EG male. Do not distribute materials that rely on written text to transfer knowledge. | |
| | Do women in the community speak, read and write Lao | If not, ensure that a local EG female translator is available for the women's group. Only if a woman EG translator cannot be found should a male translator be used. Do not distribute materials that rely on written text to transfer knowledge. | Monitor the number of men and women in each group |
| Ethnic minority training delivery | EMGs have different customs and taboos | Check with EG translator to ensure that venue and materials are appropriate and non-offensive to EGs. | |
| | Discussion and training delivery technique. | Many EGs feel inferior as they are often poorer, undereducated, do not know technology. Open criticism of the EG will reinforce feelings of | Trainers must not act condescending, must not get impatient if messages are not |

| Subject | Issue | Action | Remark |
|---------|----------------------|--|---|
| | | inferiority, resulting in negative impact in knowledge transfer and BCC. | understood clearly. EG people have equal rights and have the right of mutual respect. |
| | Use of Peer learning | Due to issues of literacy, tradition and capacity, many EGs feel that they cannot develop as well as mainstream Lao. There is a much greater impact if they see that some “of their own” have been successful. | Where possible invite members of the EG from different communities who have successfully developed to assist and act as group facilitators and guest speakers. Identify successful men and women. |

EGs = ethnic groups