



Lao People's Democratic Republic

Peace Independence Democracy Unity Prosperity

Ministry of Health

Health Governance and Nutrition Development Project

Additional Financing

Ethnic Group Development Plan

Revised

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1. Overview

1. The Project support the implementation of the Government's overall health sector program embedded in the Health Sector Reform Framework, 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 Asian Development Bank (ADB), Lao-Lux and bilateral partners (Korea, Japan, USA). In particular, the Bank-financed project will be closely aligned and coordinated with a complementary project which is financed by an ADB policy-based loan, investment loan and technical assistance grant, and which supports 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 financial management. 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

2. Specifically, the WBG project would seek to strengthen health information system, provide MCH/ nutrition services and behavior change communication, whereas the ABD project would support the strengthening of the overall health care system including the planning, financing, reporting, monitoring of health care services, and top up the health equity fund. The MOH requested the Bank and the ADB to develop a common safeguard approach, and expressed a commitment that the ADB funded project would address environmental and social risks associated with the implementation of the project in line with the World Bank environmental and social safeguard policies. While the environmental and social management instruments for the ADB project are still under development, the ADB social and environmental specialist confirmed that the safeguard instruments developed for this WBG funded project are overall compatible with the ADB's environmental and social safeguard policies.

3. As part of the framework of the on-going project (any project which supports civil works/ rehab of health center et), the Environment Code of Practice was developed to strengthen the capacity of MOH to build/ rehabilitate health centers/ support villagers to build latrines, even though the existing project, and the new project, would not finance any civil works.

4. The technical assistance envisaged under the IDA support has been contracted to carry out improvements to the existing management information system, supporting the design of a social and behavior change campaign to address nutrition issues, verifying results under the Service Delivery (DLI financed) component, designing a supervision checklist, and carrying out studies to inform that component. Terms of References (TORs) for all analytical works, development of decrees, regulations and guidelines, and any other works supported under the Technical Assistance

programs financed by the Component were assessed and confirmed of their compliance with OP 4.01. The draft reports and products of such analytical works will be consulted with the public, and the comments received will be incorporated in the final products.

5. The Ethnic Group Development Plan (EGDP) of 2014 provides a strategy and a programmatic approach to ensure and enhance the inclusion of different ethnic groups in the Health Governance and Nutrition Development Project (HGNDP). The EGDP also ensures compliance with policies of the Lao People's Democratic Republic concerning ethnic groups, as well as the World Bank's Operational Policy 4.10 on Indigenous Peoples.

6. The World Bank Operational Policy 4.10 on Indigenous Peoples aims to ensure that ethnic groups are afforded opportunities to participate in, and benefit from, the project in culturally appropriate ways. As the HGNDP will be implemented nationally, it will cover remote and rural areas, where many ethnic groups are concentrated, it has been designed in a manner that is fully consistent with Operational Policy 4.10 and is expected to positively impact ethnic groups. The EGDP will describe in detail the socioeconomic and demographic characteristics of ethnic groups in project areas and the manner in which the project's core activities will be carried out to ensure ethnic groups benefit from the project.

7. Lao people's Democratic Republic (Lao PDR) is one of the poorest and least developed countries in East Asia. With a population of 6,200,894 and a GDP per capita of US\$1,208 in 2010, it is classified as a lower middle income country (WDI 2010). Poverty in the country has been reduced significantly, with the poverty headcount declining from 46 percent in 1992/93 to 34 percent in 2002/03 and to 28 percent by 2007/8, and expected to reach the related MDG target of 25 percent by 2015 (Lao DoS 2010).

8. However, considerable differences in poverty rates persist among different geographic areas and ethnic groups. The three major non Lao-Tai groups, (Mon-Khmer, Sino-Tibetan and Hmong-Mien), who together constitute about 33 percent of the population (2010 Lao DoS), still record poverty rates above 42 percent, compared to 25 percent among Lao-Tai (considered the majority group). Lao PDR has 49 different ethnic groups, making it the most ethnically diverse country in Southeast Asia.

9. When national averages are taken as a measure of overall progress, significant improvements in MNCH-related health indicators over the last two decades can be observed. According to the UNDP Millennium Development Goals progress report (2015), under-five mortality has been reduced from 170 per 1000 live births in 1993 to 79 per 1000 live births in 2011. Maternal mortality has reduced from 796 per 100,000 live births in 1995 to 357 per 100,000 births in 2012. Fertility has shown marked declines from a Total Fertility Rate (TFR) of 6 births

per woman in 1990 to 3.2 births per woman in 2012¹ (reductions in overall fertility rates has a marked impact on reducing maternal mortality). Unfortunately, these national-level improvements in MNCH indicators mask significant inequalities in MNCH health outcomes between population groups based on ethnicity, poverty, geography and access to MNCH services, with those from rural, poor areas and belonging to non-Lao Lum ethnic groups experiencing markedly lower MNCH health outcomes than those in the ethnic Lao Lum majority.

10. Overall malnutrition rates have not shown parallel improvements: Lao PDR has one of the highest stunting rates in the region with 44 percent of children under five being stunted and 27 percent of children under five being underweight (UNDP, 2015). In this area of health status significant urban/rural inequalities can also be seen. When comparing percentages of children under five from urban and rural sites who are classified as “Moderately to severely stunted” (LSIS 2012), in urban sites the rate is 27%, in rural sites it is 48.6%. Severe stunting shows even greater urban/rural disparity, especially when remote rural sites without roads are compared to urban sites: the rate of severe stunting in urban sites is 8.3%, compared to rural sites without roads at 28.4% (LSIS 2012).

1.1 The Health Governance and Nutrition Development Project

11. The proposed HGNDP will be supporting the Government’s Eight National Health Sector Plan Development Plan 201-2020, and the guiding document HSR Framework with the goal of reaching the Millennium Development Goals by 2015, and universal health coverage by 2025. Five priority areas are identified, including governance (including those related to decentralization, known as the “3 Builds”), management and coordination, service delivery, and health information system, for which the ADB and World Bank will be providing support in parallel. (Component 1 addresses system challenges, and includes support for the health management information system (DHIS2), which is the tracking system for MOH’s performance on health indicators. Component 2 covers service delivery for women, children, and the poor, including integrated outreach (which incorporates nutrition related activities), as well as availability of nutrition and family planning commodities. Component 3 aims to support the nascent efforts at multi-sectoral nutrition activities. Component 4 supports the project management, monitoring and evaluation including contracting the verification institution for DLIs, as well as relevant studies to support Component 2

12. The World Bank Project development objective is to increase coverage of reproductive, maternal and child health, and nutrition services in target areas. It will support aspects of the health management information system (DHIS2), service delivery (utilizing disbursement linked indicators to pay for agreed outcomes currently tracked by the Government such as maternal,

¹ TFR refers to the number of live births that a woman would birth if she was subject to the current age specific fertility rate over her reproductive years (15-49 years) (LSIS, 2012).

neonatal and child health, and nutrition in target Provinces), supporting the multisector nutrition efforts by financing the design of a social and behavior change communication campaign, and implementation of the campaign at village level in Government's priority districts. Financing to support and verify the disbursement-linked indicators is also provided. The ADB support will contribute to financial management reform strengthening governance, improving the quality of health education and training institutions, building the quality of health service management and delivery and extend access to healthcare through expansion of the Health Equity Fund social protection program, support the roll out of free child delivery and MNCH with the Under 5 Years of Age Basic Package of Services. The project will strengthen the district PHC capacity and improve outreach services and also provide targeted support to remote rural communities establishing Model Healthy Villages which will include WASH. No civil works are financed under both Projects.

13. Aspects of the Project will cover 14² of the 17 Provinces in Lao PDR, excluding the three Provinces currently receiving similar support from Lao-Lux Development, and excluding the Capital, Vientiane. Coverage would be to 4.9 million people out of the total population of 6.9 million estimated by DPIC. There are no adverse impacts expected from HGNDP on non Lao-Tai ethnic groups. The least developed villages belong to ethnic groups in the more remote update sites that are not readily accessible to the formal health system. Many of the communities in remote rural sites have strong cultural practices around pregnancy and childbirth, (food taboos, entrenched beliefs about where birth should occur, and so on), some of which are not medically justified. Moreover, some of these cultural beliefs and practices are contributing factors to the negative MNCH outcomes experienced in such sites. Remote rural communities are already disadvantaged in terms of greater poverty, less access to development (such as roads, schools, and health clinics), and have a lower literacy in the Lao language than do Lao and related Lao-Tai ethnic groups. These differences will be taken into account during the implementation of the HGNDP. This Ethnic Group Development Plan of 2014 provides measures and activities that support the participation of ethnic groups in ways that are appropriate within the respective cultural systems. Two key recommendations were made in this EGDP which aims to mitigate the risk that remote communities may not benefit from the project to the degree that less remote communities will. The first pertains to language barriers in accessing health services, and the second pertains to devising participatory community mobilization to improve MNCH and nutrition outcomes using the WHO Individuals, Families and Communities model.

² Attapu, Bokeo, Champasak, Houaphanh, Luangnamtha, Luangprabang, Oudomxay, Phongsaly, Salavan, Savannakhet, Xaysomboun, Xayabouly, Xekong, and Xiengkhouang.

1.2 Project Background and Results

Project development objective and results

15. The original IDA Grant (D073-LA) and Credit (5676-LA) became effective on October 12, 2015 with total financing of SDR18.8 million (US\$26.4 million equivalent). The PDO is *to help increase coverage of reproductive, maternal and child health, and nutrition services in target areas in Lao PDR*. The Project uses a combination of results-based financing (through DLIs) and conventional financing – with 70 percent of total project value being invested through DLIs of which a large part is disbursed directly at the provincial level, and the remaining 30 percent is shared across strengthening information systems, nutrition behavior change and project management costs. The Project is expected to benefit approximately one million pregnant women, family planning users, and children age 0 to 23 months across 14 provinces³. In addition, children in high priority nutrition districts⁴ are benefiting from changed behaviors and practices of their caregivers, resulting from intensive SBCC.

16 Nineteen months after project effectiveness, HGNDP has contributed to significant achievements in the Lao PDR health sector. Under Component 1, the project has supported extensive use and expansion of the DHIS2 as a tool to monitor the DLIs; as a result, its use has substantially expanded and MOH has embarked on a single approach to HMIS through the use of DHIS2. To accelerate this process, the first draft of the Health Information Strategic Plan (2017-2025) has been completed along with a first draft of an eHealth Strategy. Under Component 2, the use of DLIs as a mechanism to improve health outcomes and address critical health system constraints has been widely accepted by the GoL - both at central and subnational levels. The piloting of DLIs through this project has introduced the concept of results-based planning and budgeting at both the central and provincial levels and has enhanced the capacity of the provinces for better planning in line with the GOL policy of devolvement. This is therefore an approach which the GoL has expressed its strong commitment to further expand. Under Component 3, the project has been supporting the development and implementation of an SBCC strategy both at central and village levels, along with directly contributing to health and nutrition service delivery through an integrated approach. At central levels, the focus has been on delivery of strategic SBCC messages through mass media; this will be scaled up under the AF. Lastly, component 4 has contributed to intensified supervision and monitoring at the provincial levels as well as introducing independent verification of the data collected through the DHIS2, thereby increasing the confidence of senior management in reported data.

³ These provinces are: Oudomxai, Phongsaly, Luang Namtha, Bokeo, Xienkhouang, Luang Prabang, Houaphan, Sayaboury, Savannakhet, Champasak, Saravan, Sekong, Attapue, and Xaysomboun.

⁴ Initially Component 3 was to target approximately 800 villages in three priority nutrition Provinces: Luang Namtha, Oudomxai, and Saravan; however, after approval of the original project, this has been expanded to four provinces: Phongsaly, Oudomxay, Huaphanh and Xiengkhuang.

1.3 Proposed Changes under the Additional Financing

A summary of the anticipated changes to activities as a result of the AF is below:

Component 1: Health Sector Governance Reform (US\$1.5 million)

17. Component 1 has been supporting: (i) the development, implementation and maintenance of an improved HMIS of MOH through the DHIS2; and (ii) technical support and capacity building for MOH staff at all levels to use such system. The first draft of a Health Information Strategic Plan includes establishment of a Center for Health Information, aiming towards creating a separate organizational and physical structure. The data platform for malaria, tuberculosis (TB) and HIV/AIDS has been fully integrated into DHIS2 while the previous vertical HMIS systems for these programs are in the process of being merged into DHIS2. Data formats for Human Resources and for the Expanded Immunization Program (EPI) have already been included in the DHIS2. Likewise, financial management information data format has been created in the DHIS2 and its full inclusion is planned. The AF will continue to support the MOH through implementation of the Health Information Strategic Plan, and integration of HMIS for all vertical programs into DHIS2. Support will include provision and maintenance of IT equipment, technical assistance and training of staff at all levels to ensure data quality and use of information for planning and decision making purposes. It is also envisaged that the Village Health Information System will be integrated into DHIS2 and that the AF will support this process.

Component 2: Service Delivery (US\$11.0 million)

18. Financing of this component has been provided based on results tracked by DLIs, with two sets of DLIs adopted: (i) four DLIs at central level focusing on management and health systems actions in support of decentralized service delivery and achievement of project objectives; and (ii) seven DLIs at provincial levels focusing on service delivery in the 14 target provinces. Despite being the first attempt to use DLIs in the country, the component has overall performed well and disbursed better than anticipated, and the DLI approach has gained wide support from both central and subnational levels as a way to achieve desired outcomes.

19. Given the frontloading arrangement for the first three years, and funding for one central DLI to be limited to two years, additional funds are urgently required to cover the last two years (last three years for central DLI4) to ensure adequate funding to achieve the targets.

20. A new provincial-level DLI on improved immunization coverage will be added to align the focus of the component targets with the current development of a basic service delivery package for UHC. Through support to building sustainable capacity for delivering essential immunization packages, the Project aims to better integrate this previously donor dependent program into government service delivery, financing and monitoring mechanisms. It is proposed that this new DLI as well as the funding of existing DLIs targeting improved integrated outreach, including immunization, will be co-financed by the recipient-executed component of the IDFHDF TF as complementary financing to IDA. The anticipated amount from this TF is US\$4 million, subject

to formal approval by the Australian government. As is the case with PHRD, the approval from Australia will be sought as part of this AF process.

Component 3: Nutrition Social and Behavior Change Communication (US\$1.2 million)

21. This component supports the development and implementation of a nutrition-related SBCC Strategic Action Plan at the national level as well as the village level (approximately 800 villages in 4 provinces). Despite the delays during the start-up period, there has recently been significant progress in the implementation of SBCC at the national and village levels. At the national level, the nutrition-related SBCC package and materials have been finalized and used to train village facilitators across the country. At the village level, SBCC interventions have been rolled out in 120 villages, and the MOH is committed to expand the implementation of village-level SBCC interventions in an additional 240 villages later in 2017. Hence, nearly half of the total villages in 4 provinces will receive nutrition enhancing interventions by the end of this year.

22. Given the high priority that the Government of Lao PDR has given to nutrition-related SBCC activities, the MOH has requested for additional financing to (i) support additional priority activities that were not adequately financed in the original plan, particularly around the development and delivery of SBCC campaign concept and umbrella slogan, and a set of integrated campaign tools that include mass media tools (television spots, videos, radio programs, posters, banners, social media applications, and collaterals); (ii) strengthen the implementation at the village level, particularly to provide additional human and financial resources to support supervision and coaching targeting DHO staff, health center staff, and village facilitators.

Component 4: Project Management, Monitoring and Evaluation (US\$1.3 million)

23. This component includes provision of technical and operational assistance for the day-to-day coordination and administration, procurement, financial management, environmental and social safeguards management, monitoring and evaluation of the project including the independent verification of results achieved under component 2. As the component is fully disbursed/committed already, additional funds are required to expand the independent verification to cover all five years of the project as well as to support the midline Knowledge, Attitude, and Practices (KAP) Survey in the areas that receive nutrition-related SBCC interventions. The AF will further strengthen the TA for capacity building of MOH staff at provincial and district levels for the planning, monitoring and reporting to better achieve DLIs, as well as capacity building of MOH staff at all levels in health program planning and implementation. In addition, the Component will support planning and supervision costs for NPCO to manage the day-to-day operation, as well as the EPI managers who will now assume the overall responsibility of implementing the existing and new DLIs associated with immunization. The AF will also support TA to efficiently strengthen the NHIB to increasingly manage the payment of the basic service package including Free MCH as well as TA to strengthen financial management at district level. With regard to the implementation of the EGDP, the AF will provide support to: i) conduct consultations in the expanded districts and villages; ii) train safeguards to all relevant staff especially at the village level; and iii) establish a simplified FRM data and information system to ensure effective monitoring and management of feedback and resolutions.

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

24. Since this is a provisional zero allocation, no additional funds will be added; however, the principle remains and this Component will be triggered if in case a need to provide an immediate response to an eligible crisis or emergency arises.

2. Background Information

2.1 Ethnic Groups in the Lao PDR

25. Lao PDR is one of the most ethnically and culturally diverse countries. The official terminology, for describing the diverse population of the Lao PDR is ‘ethnic group’ and was introduced in the 1991 Constitution. The term “indigenous people” is not used in Lao PDR. Therefore the EGDP will use the official terminology of the Government of Lao PDR (GoL). Based on data and analysis from the LECS4, the Lao-Tai groups make-up 66% percent of Lao’s population, followed by the Mon-Khmer (21.5%), the Hmong-Mien (8.8%) and the Sino-Tibetan (3.1%) (Lao DoS 2010).

26. Despite the fact that the number of ethnic groups have changed over time, specialist agree on the ethnolinguistic classification of ethnic groups produced by the Lao Front for National Construction (LFNC) which contains 49 categories and over 160 subgroups.

27. According to the official categorization of the LFNC, ethnic groups in Lao PDR can be categorized into four ethnolinguistic categories:

- The Lao-Tai (also referred to as ‘Tai-Kadai’) which includes the ‘ethnic Lao’ group and lowland Tai/Thay speaking groups;
- Mon-Khmer ethnic groups, which includes the Khumic, Palaungic, Kautic, Bahnaric-Khmer and Vietic speaking groups;
- Hmong-Mien, including the Hmong and the Mien speaking groups.
- Sino-Tibetan (also referred to as Chine-Tibet), which includes Chinese Ho and Tibeto-Burman speaking groups.

28. It has been established that these groups meet the Bank’s definition of ‘indigenous people’, that is, they possess the following characteristics:

- a) Self-identification as members of a distinct indigenous cultural group and recognition of this identity by others;

- b) Collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories;
- c) Customary, cultural, economic, social, or political institutions that separate them from those of the dominant society and culture; and
- d) An indigenous language, often different from the official language of the country.

29. Ethnic groups, especially those living in rural and remote areas, generally have a higher poverty incidence than the Lao-Tai group. The LECS4 survey analysis found that people belonging to the Mon-Khmer, Sino-Tibetan, and Hmong-Mien ethnic groups have a poverty incidence that is two-and-a-half times higher than the Lao-Tai (Table 1). Food poverty, defined as the ability to ensure the supply of food to meet daily nutritional needs, is double the rate amongst ethnic groups, suggesting that ethnic groups are more vulnerable to food insecurity and malnutrition than the Lao-Tai majority.

Table 1: Socio-economic indicators of Lao Ethnic Group at the National Level
(Source: *Lao Department of Statistics, 2010*)

Ethnic Group	Share of total population	Poverty Headcount	Food Poverty
Lao-Tai	66%	18.4%	17.4%
Mon-Khmer	21.5%	47.3%	39.3%
Sino-Tibetan	3.1%	42.2%	32.5%
Hmong-Mien	8.8%	43.7%	39.8%
Other	0.6%	22%	34.9%

30. Furthermore, health indicators for non-Lao ethnic groups are low compared to the rest of the country, due to the fact that non-Lao ethnic groups typically face significant health-care-related disadvantages: they live in remote, isolated areas not readily accessible to the formal health system, they are often poorer, have a lower literacy rate in Lao language, and generally lack access to roads, schools, markets, and other services.

2.2 Legal and Institutional Frameworks on Ethnic Groups in Lao PDR

31. According to the 1991 Constitution, Lao PDR is defined as a multi-ethnic state, with “equality among all ethnic groups.” Article 8 of the Constitution reads:

“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”.

32. The intention of the Constitution is to grant equal status to all ethnic groups, and to this end no reference is made to distinctions between highlanders (Lao Soung) and lowlanders (Lao Loum) and midlanders (Lao Theung). That is, from this point on, the terms Lao Loum, Lao Theung, Lao Soung are no longer recognized as official terminology.

33. The 1992 ethnic minority policy, Resolution of the Party Central Organization Concerning Ethnic Minority Affairs in the New Era, focused on gradually improving the lives of ethnic minorities, while promoting their ethnic identity and cultural heritage. It is the cornerstone of current national ethnic minority policy. The general policy of the Party concerning ethnic minorities can be summarized as follows (Pholsena 2005):

- Build national sentiment (national identity).
- Realize equality between ethnic minorities.
- Increase the level of solidarity among ethnic minorities as members of the greater Lao family.
- Resolve problems of inflexible and vengeful thinking, as well as economic and cultural inequality.
- Improve the living conditions of the ethnic minorities step by step.
- Expand, to the greatest extent possible, the good and beautiful heritage and ethnic identity of each group as well as their capacity to participate in the affairs of the nation.

34. The implementation of the Party’s policy on ethnic minorities is tasked to the Lao Front for National Construction (known colloquially as Neo Hom).

35. In relation to health care, the policy calls for protection against and eradication of dangerous diseases and to allow ethnic groups to enjoy good health and long life. The Government, it states, should provide appropriate investments to enlarge the health care network by integrating modern and traditional medicine.

36. The Ethnic Minorities Committee under the National Assembly holds the responsibility to draft and evaluate proposed legislation concerning ethnic minorities, lobby for its implementation

as well as implementation of socioeconomic development plans. Research on ethnic groups is the responsibility of the Institute for Cultural Research under the Ministry of Information and Culture. The lead institution for ethnic affairs is the mass (political) organization, the LFNC, which has an Ethnic Affairs Department.

3. The Ethnic Group Development Plan of 2014

37. HGNDP is not expected to cause negative social impacts. However, there may be issues associated with ensuring equitable access to project benefits and there are concerns that some villages will benefit more than others due to proximity and ease of accessibility to intervention Health Centers. A number of constraints in accessing health care services have been identified by local populations, especially challenges related to physical access, the high cost of services, and the cost of transportation. Furthermore, the opportunity cost of abandoning crops in order to seek maternal and childcare services are especially high for ethnic groups living in remote villages. Moreover, cultural barriers to accessing health services have been identified as a significant barrier to increasing MNCH outcomes. To ensure equitable access to project activities, the 2014 EGDP provided an action plan that addresses the challenges faced by ethnic groups and ensures they benefit in a culturally appropriate way.

38. In compliance with Operational Policy 4.10, the EGDP built on a Social Assessment, as well as extensive secondary data detailing the cultural and material barriers rural populations face in increasing their access to MNCH services and on “free, prior, and informed” consultations with a sample of ethnic groups conducted for this EDGP. The findings from these three processes were outlined below.

39. This EGDP drew upon data from three sources. First, a social assessment consisting of a review of relevant government policies and key government research reports on health and ethnic communities (See Appendix B). Second, an extensive review of secondary sources detailing recent research into the cultural practices of various ethnic groups in Lao PRD regarding MNCH and nutrition. Third, a consultation process with a selected number of villages detailing their attitudes to MNCH service access, and nutritional beliefs and practices.

3.1 Summary of Social Impact Assessment

40. From the relevant GOL policies and research reports a number of key themes related to ethnic people’s access to MNCH services were identified. These themes included public health workforce characteristics; rural/urban disparities in social indicators; poverty precedence and distribution; gender; access to health services and policies on ethnic minorities. Each of these themes is detailed below.

41. Public Sector Health Workers: MOH records for 2014 show a total health staff of 19,703, of which 62.8 percent are women, and 11,811 are posted to health facilities. Management positions held by women (49.3 percent) compare more favorably than many other ministries. The health staff is predominantly Lao-Tai (79.2 percent). There are 747 community midwives with 44.2 percent at Health Center level, 48 percent at District Hospitals, 3.5 percent at Provincial Hospitals, and the remainder at the central level. Of the 950 Health Centers, 90 percent have less than 4 staff, and around 22 percent have only 1 or 2 staff.

42. Rural and Urban Communities: The 2012 Lao Social Indicator Survey (LSIS) provides information that highlights quality of life differences between urban and rural communities. Those who live in the urban areas typically are assisted by a doctor during delivery (75 percent), while those in the rural areas without roads are only assisted around 9 percent of the time; a relative or friend assists 10 percent in urban areas, and 41 percent in rural areas without roads. Nationally, some 70 percent of the population uses an improved source of drinking water – 88 percent in urban areas and 64 percent in rural areas. The proportion of the population using an improved source for drinking water varies from a low of 48 percent in Savannakhet to a high of 98 percent in Luangnamtha. It takes less than 30 minutes for 31 percent of the households to collect water and return home, while it takes 6 percent longer than this. Of those who collect water away from their house lot, 71 percent are adult females, and 12 percent are under 15 and mainly girls. Around 57 percent of the population live in households with improved sanitation, while 38 percent of the population have no sanitation facilities at all; 88 percent of the urban residents had access to improved sanitation, while 75 percent of those in rural areas without roads had no access to sanitation facilities.

43. Poverty: Poverty affects many rural Lao, regardless of gender or ethnicity, although it must also be acknowledged that the poorest do include a higher proportion of ethnic minorities, and the poorest of the poor includes many, if not most, single women who are also heads of household. The poor lack land, labor resources and money for investment, and is not confined to a specific gender or ethnicity. However the poor do include many women headed households, as well as the smaller ethnic groups. The poorest areas are those inland and along the Vietnam border and are upland (midland) and upland (highland) communities; the LECS V reported the highest rate of poverty (38.4 percent) in areas bordering along Vietnam. Poverty rates are still higher in the non Lao-Tai groups who have seen a slower decline in poverty. The LSIS found that children from poorer households, and children of uneducated mothers were likely to suffer from diarrhea.

44. Gender: There is strong commitment by the Government to gender equality, as evidenced by Party Decree IX, as well as various laws and policies. The Government is also signatory to a variety of international treaties such as the MDGs and the Convention on the Elimination of All Forms of Discrimination Against Women. In addition to the establishment of the National Committee for the Advancement of Women, the Lao Women's Union (LWU) is also an important representative of women. However, many inequalities remain. Gender gaps in education, starting with enrolment, are largest in poor, remote, and in districts which are mainly from smaller ethnic

groups. In these regions, education quality is poor and dropout rates, especially among girls, are consistently high. Women's employment lags far behind men, and is variable across key ministries: in Agriculture, women account for 24.5 percent of total employees and only 17 percent of management; women in Public Works account for 18.2 percent, and only 4.2 percent are in management, while women comprise 47 percent of the staff in Education, with 20 percent in management. Gender disparities in the Lao PDR have started to narrow but the country lags behind many others in this respect. The Lao PDR ranked 138 out of 187 countries in the United Nations Development Program's Human Development Index in 2012. Figures for the 2012 Gender Inequality Index show the Lao PDR ranked 100 among 195 countries. Key issues of concern include (a) high maternal mortality; (b) limited access to reproductive health services; (c) gender disparity at all levels of education; and, (d) limited access to training, employment, finance, and opportunities for economic advancement. The LSIS of 2012 reported literacy rates for women aged between 15-24 years to be 68.7% compared to 77.4% for men of the same age, while the LECS V reported national literacy rates for the poor as around 82 percent for men, as opposed to only around 58 percent for women.

45. Health Issues: A household survey in 2011 on mother and child health⁵ 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 getting money for treatment was a barrier to obtaining 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.

46. The 2012 LSIS found that fertility is highest among rural women (3.6) compared with urban women at 2.2, and is highest for those living in areas without roads and formal education, and is lowest among urban educated women. The maternal mortality rate among women of child bearing age (15-49) is around 4 deaths per 1,000 live births, and highest among the 25-34 age group. These deaths account for 19 percent of all deaths of women aged 15-49. The LSIS results show that 19 percent of married women want to have a child later (and could be considered as potential family planning users), and more than 50 percent want no more children. Of those desiring no more children, 61.2 percent are from rural areas without roads. Adolescent fertility rates vary, being higher for those without education or coming from the lowest wealth quintile. For women of child-bearing age, 54.2 percent receive antenatal care from any skilled personnel, and 43.8 percent receive no antenatal care; 75.2 percent of those in the poorest quintile receive no antenatal care.

⁵ Maternal health, child health, and nutrition in Lao PDR: Evidence from a survey in six central and southern provinces, World Bank, 2013.

47. The LSIS found only 41 percent of newborns in the last 2 years received either a health check or postnatal care visit within 2 days of delivery and only 40 percent of mothers received either a health check after delivery or a postnatal care visit within 2 days of delivery. Vaccination campaigns appear to do better in lowland areas where it is easier to access villages: the LSIS reports that the proportion of children aged 12-23 months who had received vaccinations by the age of 12 months was 77 percent for BCG, Polio 3 was 49 percent, DPT-HepB – HiB 3 was 52 percent, and Measles was 55 percent. When all vaccinations are considered (BCG, DPT, HepB, HiB 1 – 3, Polio 1 – 3, and Measles) – only 34 percent of the target population had completed the vaccination course, with 15 percent having received no vaccinations.

48. The DPIC information indicates that around 2 million of the population are considered poor, 56 of the Districts have been classified as poor and 59.2 percent of their population comprises the smaller minority groups. Gaps in health outcomes are unequal between urban and highland areas where poverty is the highest; this is attributable in part to the remoteness, a lower level of education, less agriculturally productive land, and limited health services. Only 33 percent of rural areas have road access, and access to sanitation and electricity also contribute to the vulnerability of remote populations. In addition, the Lao Social Indicator Survey found that 12.5 percent of the urban residents, 36.1 percent of the rural residents, and 33.5 percent of the rural with roads use unimproved drinking water; the percentage jumps to 58 percent for rural areas without roads.

49. Ethnic Minorities: The population comprises a diverse ethnicity with the last census identifying 47 distinct ethnic groups in the country⁶. While the last census identified 47 ethnic groups, Government officially recognizes 49, which are separated into four ethno linguistic families⁷. The Tai-Kadai family includes Lao, Lue, Phoutay and other lowland groups, and accounts for 67% of the national population. The Mon- 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%; see Table 2 for ethnicity by Province (located in Appendix 1). The Lao-Tai group comprises 52.5 percent of the population and live primarily in the lowlands, while the non-Lao Thai live predominantly in the highlands. This diversity poses challenges to the delivery of health care, due to cultural and linguistic barriers⁸.

50. The 1991 Constitution refers to the “multi-ethnic Lao people” and the official terminology for describing the diverse population of the Laos is “ethnic” groups. Article 75 of the Constitution specifically indicates that the Lao language and script are the official national language and script. The lead government agency in relation to ethnic minorities is the Lao Front for National

⁶ Lao People’s Democratic Republic Health System Review, Health Systems in Transition Vol. 4 No. 1, 2014

⁷ The actual number of ethnic groups may be as high as 236 depending on the level of classification applied to groups and subgroups within the main ethno-linguistic families (Chamberlain et. al.1996)

⁸ Lao People’s Democratic Republic Health System Review, Health Systems in Transition Vol. 4 No. 1, 2014

Construction, Department of Ethnic Affairs. Policy relating to the non-Lao Tai remains relatively unchanged from that announced by Party Central in 1992⁹, which identifies three essential tasks for their development: (a) strengthening political foundations; (b) increased production and opening of channels of distribution in order to convert subsistence-based economics towards market-based economics; and (c) a focus on the expansion of education, health and other social benefits.

51. Ethnic groups living in rural and remote areas, generally have higher incidence of poverty than the Lao-Tai groups. Incidences of poverty in people belonging to the Mon-Khmer, Sino-Tibetan, and Hmong-Mien ethnic groups have been found to have incidence of poverty that is two-and-a-half times higher than the Lao-Tai groups. Food poverty, the ability to ensure the supply of food to meet daily nutritional needs, is double the rate amongst the Mon-Khmer and Hmong-Mien ethnic groups, suggesting that these ethnic groups are more vulnerable to food insecurity and malnutrition (ADB, 1999; MOH 2005). Furthermore, health indicators for non-Lao Tai groups are low compared to the rest of the country, due to the fact that these groups typically face significant health-care-related disadvantages: they live in remote, isolated areas not readily accessible to the formal health system; they are often poorer; have a lower literacy rate in the Lao language; and generally lack access to roads, schools, markets, and other services (MOH, 2005; MOH/WB, 2012).

3.2 Summary consultations during project preparation

52. As part of the preparation of this project, focus group discussions were held at community level. In keeping with the principle of “free, prior, and informed”, consultations were held with eighteen ethnically distinct villages in a sample of three provinces from the project area. Selection of districts and village was purposive in order to select villages that represent a considerable portion of the ethnic groups’ population and with poverty incidence rates of 60 percent and higher.

53. Within a series of focus group discussions, village authorities, pregnant women, women with children under 5 years of age, women of reproductive age, men who have a pregnant wife, men who have children under 5 years of age, grandparents and village health volunteers shared their views and experiences with respect to childbirth, pre- and postnatal care, the local clinic and hospital and contact with the government health care system.

54. The local consultations documented high levels of support for the proposed HGNDP, especially with regard to method of delivery, and post-natal practices and the role of midwives in supporting safe delivery. With respect to nutrition, the consultations highlighted variations in

⁹ Contained within the Resolution of the Party Central Organization Concerning Ethnic Minority Affairs in the New Era (GoL, 1992)

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.

55. There were a number of barriers to increased MNCH service access and nutritional improvement raised in focus groups across all three provinces. These are detailed below:

- 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.
- Post Natal Care was seen by a vast majority of FGD participants as not necessary. They stated that they would only attend PNC if their baby was sick.
- 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.
- Home birth entailed poor cord care, with most participants reporting that the cord was cut with unsterilized instruments which risks infection.
- 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.
- Many FGD participants requested health education material to be tailored to ethnic groups, with local language material and pictorial educational material.

56. In Bolikhamxay and Oudomxay, the following issues were reported which were not reported in Salavan:

- Local traditional birth attendants offered ANC services to villagers, and so villagers did not seek ANC from qualified skilled birth attendants at the Health Center.
- Breastfeeding was not initiated within one hour and colostrum was expelled in many cases because villagers believed that it was dirty.

57. In Salavan, there were some interesting differences in the data collected during focus groups, with contrasts between the perspectives of different group composition (male focus group participants v's female focus group participants) as well as contrasts between the views of those in Salavan and the other two provinces.

58. The following points raised by the FGD participants in Salavan were not raised by participants in Oudomxay or Bolikhamxay:

- Some remote villages still practice forest birth where the woman is not assisted by anyone, (neither family nor birth attendants).
- Some Hmong villagers required women to give birth in purpose built huts to avoid spiritual and physical pollution of the home space.

59. The focus groups in Salavan revealed some interesting differences in views held by groups of different composition. Groups were divided by gender, with male groups (village authorities and fathers) and female groups (Mothers, women of reproductive age, pregnant women and grandmothers).

- With regard to workloads for women during their pregnancy, participants in all-male groups stated that workloads should be reduced during pregnancy; in contrast, the female participants reported that women's workloads were NOT reduced during pregnancy.
- Regarding breastfeeding, female participants supported immediate breastfeeding after birth including giving the baby colostrum; men stated that babies should not be given colostrum because they believed it caused stomach problems.
- Men and women held different beliefs about what danger sign would signal that medical help was required during a home delivery. Women stated that they did NOT know what the danger signs were because they had not been informed by Health Center staff or doctors. Men stated that the following were danger signs: bleeding, stomach ache and convulsions.

60. There was universal support for the project to improve access of remote villagers to MNCH services and nutritional outcomes. There was widespread awareness of the benefits of financial support for free MNCH.

61. The following describes some of the positive program impact and address some of the concerns arising from the SA.

- The impact of the Project on the poorer, rural areas where the preponderance of non-Lao/Tai groups live is expected to be positive, since the Project is expecting to see an increase in service personnel in the more decentralized areas, and an increase in the integrated (maternal and child health, nutrition and family planning) outreach which is conducted from the Health Center level to communities. The expansion of free maternal and child health services should also have a positive effect on access to these services by those in remote areas. With the introduction of monitoring supervision from the Provinces to Districts to Health Centers, it is expected that the quality of services will improve and result in those being served having more confidence in seeking care. Finally, the support to the design of a social and behavior change communication strategy on nutrition (which will take into consideration the WHO Individuals, Families and Communities model)

should see benefits accruing to those not typically reached through traditional information, education and communication campaigns; the strategy would include how to reach difficult to reach areas and how to tailor messages to smaller ethnic groups.

- This Project's support to Government's policy on free MCH and nutrition is expected to be highly beneficial to poor ethnic women and children, through reduced costs for services (ante- and post-natal care, 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 Thai ethnic group staff, course content that is sensitive to gender and ethnicity, and includes an emphasis on MCH, 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.

3.3 Summary of Findings from Secondary Data Review

62. Recent studies have shown that both MNCH service delivery and demand for MNCH services by individuals, families and communities could be strengthened in order to make MNCH services more accessible to those in remote rural areas. Each of these aspects will be detailed below.

3.3.1 MNCH Service Delivery issues

63. Four recent MNCH service evaluations provide a comprehensive picture of the challenges faced by remote ethnic communities in accessing quality MNCH services: the internal and external evaluations of the National Strategy for MNCH Service Provision 2009-2015 and the World Bank Health Services Improvement Project (HSIP) Ethnic Group Development Plan (2005) and consultations held for HSIP additional financing in 2014.

64. Both the internal and external reviews of the MNCH Strategy 2009-2015 argued that current MNCH program interventions are channeled through an existing health system that struggles to support universal basic health services. The capacity at the different levels and in various elements of the health system varies widely depending on two key dynamics: first, the level of facility (central level hospital, provincial hospital, district hospital or village-level Health Center), and second, the level and type of development partner assistance in supporting MoH staff

in program implementation, supply of health equipment and consumables and support for infrastructure development. Generally, health services are better funded and supported at Central and Provincial level, with highly significant decreases in support (both funding and personnel deployment, training and supportive supervision) when District and Village level services are evaluated. More support for the health system aimed at strengthening capacity of staff to provide high quality basic health care at district and village levels could contribute significantly to engaging communities to seek health care from health facilities, including MNCH services.

65. Many fixed site health facilities are not adequately provisioned with MNCH related drugs, personnel and equipment, so encouraging women to deliver at facilities where the standard of care is inadequate will not necessarily improve MNCH outcomes, and is likely to discourage others in the community from delivering at the site in the future if one or more community members have a negative birthing experience while at a health facility. This finding is supported by the WB HSIP consultations, which was based on wide community consultations and stated that beneficiaries involved in the consultations reported that staff at Health Centers were rude to people accessing free services, staff did not keep facilities in a clean and reasonable condition and that equipment related to MNCH was dirty or broken. The internal evaluation of the MNCH Strategy found that staffing at Health Centers was inadequate to supply basic MNCH health care, with only 30% of all Health Centers nationally having a trained Skilled Birth Attendant (SBA) on staff. The gender of SBA is also a significant issue in enabling access to MNCH services for ethnic women in Lao PDR. In many ethnic communities it is considered inappropriate for women to receive obstetric treatment from a male, therefore, training and deploying male SBAs risks investing in a workforce that may not increase ethnic women's access to MNCH services (WHO 2014, Albone 2011, WB 2014).

66. The physical environment of the delivery rooms was another barrier to greater service utilization cited in the external evaluation. It was argued that the design of birthing rooms across the country, with stirrup beds that require women to give birth in a prone position is not in line with current international standards and is antithetical to many rural women's traditional birthing practices (which do actually reflect current, international best practice in birthing protocols, such as giving birth in a supported squatting position) (UNFPA 2005). For rural (and indeed urban) women to give birth in the prone position with their legs secured in the air is highly uncomfortable, both physically and culturally. Cost-effective, yet well designed alternatives to the current standard of stirrup beds can be readily developed and deployed, making the design of birthing rooms across the country more medically appropriate and in line with current international best practice standards, which aim to make the birthing space more welcoming for women and less medicalized, without compromising on standards of hygiene or medical care.

67. Where traditional cultural practices are positive and helpful to the birthing process, incorporating and valuing women's knowledge into medical protocols would demonstrate that women's cultural practices are recognized and valued by the medical establishment and would be very empowering for women. This recommendation is supported by the findings of the evaluation

of the midwifery component of the SBA development plan (Skinner and Phrasisombath, 2012, pp 48), where they state that:

“The observations of the Health Centers [in remote villages where non-Lao Lum women live] did not reveal any attempts to make the physical environment more culturally acceptable, nor to incorporate any of the non-harmful cultural practices.”

68. Currently, women come to the birthing room at the Health Center or hospital and into an environment that is very foreign to them, with no recognizable or familiar aspects. If some aspects of traditional birth practices could be incorporated into facility design (for example, birthing ‘stools’, ropes that women can hold suspended from the ceiling, comfortable beds), the birthing experience could be much more empowering and positive.

3.3.2 Demand for MNCH Services by Individuals, Families and Communities.

69. In terms of engaging communities with the health system, there are many excellent programs being implemented by MoH personnel, supported by development partners (based on the WHO, Individuals, Families and Communities model of community mobilization). In many sites there is evidence of increased knowledge around MNCH and the need for ANC, delivery at Health Centers, post-natal care and child nutrition (WHO 2014, Albone 2011, De Sa et al 2013, JICA 2015). Yet even in sites where increased knowledge is demonstrated, it does not necessarily equate to behavior change. The external MNCH evaluation found that, in a focus group discussions conducted in Hoay Mong village, Bokeo Province, both women and men clearly stated that they were aware of the importance of exclusive breastfeeding for the first six months of life, but participants said that they did not follow this proscribed behavior because women need to go back to work in the field very quickly after birth and therefore could not breastfeed while working. Because of the perceived need for women to return to work quickly, babies’ diets were supplemented with foods such as pre-chewed sticky rice from as early as one week of age. This example illustrates that there more work to be done in initiating and sustaining behavior change in remote rural communities around health seeking, and MNCH in particular. As mentioned above, strengthening the health system in order to make making visits to health facilities more positive for service rights holders is a key aspect of ensuring sustained behavior change around health seeking behavior for remote community members.

70. It is widely documented (De Sa et al 2013, Albone 2011, Maloney 2011) that Lao PDR is a country with a culture where men hold significantly more power over decision making than women, particularly at community and household levels. These studies report that men hold decision-making power over whether or not members of the household seek medical care, including MNCH related services. This evidence is supported by a recent external evaluation of the MNCH Strategy 2009-2015, where it was strongly recommended that community engagement

be done on the WHO Individuals, Families and Communities (IFC) model, and aim to actively engage men in improving MNCH and nutrition outcomes in their own families and communities.

71. Common beliefs about pregnancy and childbirth in remote rural communities can be a barrier to service utilization, specifically that pregnancy and childbirth are ‘natural’ occurrences and do not require any special treatment or medical intervention. In the results reported in the external evaluation of the MNCH Strategy (2009-2015), many focus group discussions and in-depth interviews respondents involved in the evaluation reported that they would not seek medical care during childbirth unless the mother had been in labor “too long” (by which time it is often too late for health center staff to ensure a positive outcome). This finding is supported by the results of the WB HSIP consultations, which found that respondents reported a lack of understanding of the importance of facility-based delivery and other MNCH services. In addition, the MNCH strategy external evaluation reported that, people in remote rural communities may not be aware of the differences in expertise between traditional birth attendants and SBA, with traditional birth attendants being seen as “qualified” to assist “normal” deliveries and provide ANC.

72. The SIA for the HSIP (2005), and the more recent external evaluation of the MNCH Strategy completed in 2015, found that language (and by extension culture) are major obstacles to women’s access to MNCH services. In several areas villagers reported they were not able to visit the clinic or the hospital without an interpreter. The interpreters are few, and asking them to accompany a patient is a major financial problem as well as a social one of incurring debt according to the norms of reciprocity in the village, usually calculated in terms of labor. The result is that villagers rarely avail themselves of public health services.

73. Where health personnel are available who are themselves members of the same ethnic group, the situation is greatly improved, as with the clinics in Xaysomboun where Hmong is spoken by health service personnel. In this particular instance, Hmong written language could be of value as well since the observed literacy rates in the Hmong language are found to be high. Other written minority languages in the project area are less well-known, but some potential exists for Khmou and Katu and perhaps others. At least it is worth experimenting with on a trial basis.

74. Other than for the Hmong in Xaysomboun, however, non-Lao-Tai ethnic minority personnel in the health service system are rare. One reason for this is the high educational qualifications that are required for admittance. For the lowest level one must have completed lower secondary school and then study medicine for 3 years. The second level requires completion of upper secondary plus 5 years of medical study. And the highest level requires completion of upper secondary and 10 years of additional medical study. Thus the majority of the ethnic minority people are unqualified due to lack of educational opportunity. This lack of opportunity then leads directly to a lack of access to health services for the respective ethnic populations.

4 Summary of Consultations during the Original Project Implementation

75. The original project has started at the beginning of 2016 with an official project launch at central level to inform all participating provinces about the project and its interventions. However, staff at the district and village levels had not participated much in the discussion of the project details until November 2016 when free, prior and informed consultations were conducted at the provincial level.

76. During the original project implementation, the NPCO representatives overseeing components 2 and 3 had worked together with the provincial health officers, provincial health coordinators, district health officers, and health officers at the village health centers to organize a series of free, prior and informed consultations with stakeholders, especially the poor and vulnerable groups including those from various ethnic groups, in all the project target areas. The consultations were organized from November 2016 – May 2017. Delays in the consultations were due mainly to limited capacity and awareness on safeguards among relevant NPCO staff as well as the delay in developing the needed materials to be used for the orientation of component 3 (SBCC). The project will continue to work with the World Bank to improve the overall capacity and knowledge of staff for effective implementation going forward.

77. At the provincial level, NPCO representatives of component 2 service delivery (Disbursement Linked Indicators (DLIs)) organized consultations in all 14 provinces. Participants included all government agencies related to the health sectors including the provincial food and drug division, provincial MCH, provincial statistic unit, provincial personnel unit, and provincial health financing unit, representatives from provincial hospitals, the director or deputy director of district health offices, district project coordinators and district MCH unit. Aside from these government agencies, the NPCO also invited representatives of ethnic and religious groups from the Lao Front Construction, Lao Women's Union, and Trade Union, as well as from NGOs working in the provinces. Invitations and relevant project documents were distributed to the participants one week in advance.

78. At the village health center level, NPCO representatives of component 3 developed relevant IEC materials to be used for consultations and SBCC orientation of component 3. Free, prior and informed consultations were conducted in 40 participating villages as part of the project consultation and orientation in June 2017. The consultations were organized where the health centers are located. This is mainly to ensure that there are proper facilities available for villagers including those who would travel from nearby villages. Participants at these consultations include staff of the village health centers, village heads, heads of village cluster, members of the village health committees, village volunteers, and representatives of ethnic and religious groups from the Lao Front Construction, Lao Women's Union, Trade Union and non-governmental organizations working in the areas. Representatives from the poor and vulnerable groups, not limited to ethnic

groups living in the areas also participated. The designated district health officers sent invitations and relevant project documents to participants one week in advance.

79. At the provincial and village level consultations, representatives of NPCO and designated health officers at the local level provided the overall project objectives, project components with key activities supported by the HGNDP, budget allocations, project duration, potential impacts and risks (both positive and negative) according to the social assessment, the revised EGDP especially the feedback and resolution mechanisms.

80. Overall, there was broad community support for HGNDP from all the consultations. Key issues discussed during the consultations at the village level focused mostly on antenatal care (ANC), postnatal care (PNC), birth assisted by skilled birth attendants, health care for children under five and young child feeding, and nutritional behavior change and communication throughout pregnancy and early childhood at the community level. There is a distinct recognition from participants that the overall barriers related to maternal health and new-born care found in the social assessment were gradually addressed due to more availability of community midwives at health centers. The financial support from component 2 – Disbursement Link-Indicators – has helped improve the health facilities and health centers in remote communities. Due to the delay in the roll-out of component 3 - the SBCC intervention at the community level, consultations at the community level could only address nutrition during pregnancy and child care practice with villagers, but they were unable to determine the level of understanding on these issues. Villagers and participants at the village level requested that the training on SBCC community intervention be provided to village facilitators as soon as possible so that they can carry out village sessions on SBCC and Community Let Total Sanitation (CLTS) in their communities.

81. Consultations at the provincial level, however, focused more on project interventions and how participants, especially representatives from ethnic and religious groups, and other mass organizations could participate more to help the project achieve its DLI targets. Participants from the LFC, LWU and LYU have expressed their willingness to support the project. NPCO representatives encouraged the provincial health department to review their DLI plans and budgets to involve representatives from ethnic and religious groups and mass organizations in the project implementation process, especially in the dissemination of health education and outreach to poor and vulnerable populations in remote areas. There was no report of complaints or concerns during the consultations.

82. Consultations also discussed the importance of outreach to poor and vulnerable communities, not only limited to ethnic groups, at both provincial and village levels. Documentation of the consultations noted that there is limited awareness among concerned health staff at all levels of the importance of making services available to vulnerable populations, including ethnic groups. There is also weak coordination among relevant sectors/agencies at the provincial level leading to low efficiency and effectiveness of project financial management at the

district level. These issues were documented and will be discussed with the NPCO at the national level for the overall project improvement.

83. All consultations including recommendations were documented and submitted to the NPCO at the national level. However, the quality of these consultation reports would need to be improved to provide more details of what has been discussed and addressed at the meetings. Improving capacity of safeguards staff, especially with regard to providing more training and setting up systematic feedback and monitoring, will be addressed during the additional financing period.

5. Assessment of the Implementation of EGDP during the Original Project

84. The World Bank has worked with the Ministry of Health to implement the EGDP during the original project. Key safeguards issues that emerged during the implementation include: i) the government has limited knowledge and capacity to implement safeguards-related requirements; ii) there is no designated government staff or technical assistance (consultant) to provide support in this areas; iii) the current structure of the feedback and resolution mechanisms are often not accessible to the local communities that they are designed to address; there is no FRM reporting system for the government to monitor and manage grievances.

85. Prior to the AF, the government has addressed these safeguards issues by: i) officially appointing safeguard staff and village focal points, and establishing a structure to oversee implementation of social and environmental safeguards plans and activities in February 2017; ii) integrating safeguards into all the relevant staff and training; iii) conducting a series of Free, Prior and Informed Consultations of the original project; the expanded areas under the additional financing will be consulted prior to the implementation of the project; iv) revising the EGDP to provide a clearer plan and guidelines for FPIC, feedback and resolution mechanisms where local communities can get access to information and provide feedback to safeguards focal points at all levels; and v) setting up a simplified reporting system for feedback and how they have been addressed in a timely manner. Budget from the technical assistance component of the AF will be earmarked for enhancing safeguards capacity and efficiency.

6. New Institutional Arrangement for Environmental and Social Safeguards under the Additional Financing

86. On February 9th, 2017, the government has issued an appointment of staff to oversee social and environmental safeguards plan and activities for the project. This announcement has been submitted to all concerned at the national and provincial levels. Key information are as follows:

- a. *At the policy and oversight level:* Dr. Prasongsidh Boupha and Dr. Funkham Rattanavong, Director General and Deputy Director General of Department of Planning and International Corporation, were appointed. They will continue to also oversee other aspects of the project.
- b. *At the technical level:* Dr. Southanou Nathanontry (Deputy Director of the Project), Dr. Chansaly Phommavong (Deputy Director of the Project) Dr. Amporn Keoudom (Project Consultant), Dr. Choulapone Sayasene (Project Consultant) and provincial consultants from the four participating provinces of component 3 were appointed.

The Deputy Director responsible for component 3 of HGNDP will lead the group of consultants hired by the project including 2 consultants resided at DHHP and 4 consultants at 4 selected nutritional provincial health office who responsible for the implementation of safeguard activities based on the EGDP.

- c. *Roles and responsibilities at the technical level involve*
 - i. Planning and conducting activities to fulfill social and environmental safeguard requirements;
 - ii. Work together with the provincial health office (PHO) and provincial coordinators to ensure that safeguards related consultations are implemented in the 14 project provinces and in 120 participating villages of component 3;
 - iii. Produce safeguard consultation report with the project oversight committee to address issues or concerns received from the consultations, and provide report to the World Bank;
 - iv. Develop Feedback and Response Mechanism (FRM) that is appropriate to the local context;
 - v. Ensure that the IEC and training materials produced by the Project address the gender and ethnicity issues;
 - vi. Include the social and environmental safeguard related activities in the action plan and report the progress in project semi-annual report.

7. Framework for Consultations with Ethnic Groups during the AF Implementation

7.1 Consultation objectives.

87. As the HGNDP implemented nationally and covered remote and rural areas, where many ethnic groups are concentrated, it has been designed in a manner that is fully consistent with Operational Policy 4.10 of the Bank and is expected to positively impact ethnic groups.

The objectives of the consultations are:

- (i) to ensure and enhance the inclusion of different ethnic groups to benefit from project intervention,
- (ii) to provide affected ethnic groups opportunities to voice their concerns and perspectives, and
- (iii) to ensure their informed participation in and broad community support to the project

7.2 Consultation Plan.

88. Consultation with ethnic groups during HGNDP implementation will apply to all 14 provinces for component 2, and in 120 villages of the target 4 provinces of component 3 of project. Under the AF, the project plan to expand its coverage for component 2 in 49 lagging districts and for component 3 in all new villages. Free, prior and informed consultation will be conducted in these areas prior to the implementation using the monthly provincial and district health meetings and the village health center orientation meeting as platform for consultations

7.3 Consultations Procedure.

7.3.1 At the provincial level:

89 The NPCO representative and safeguards focal points from the central level and provincial project coordinator will be responsible for organizing consultations at the provincial level. The consultations will be conducted at provincial health offices in 14 targeted provinces.

Participants:

90 The NPCO will invite representatives from relevant government agencies including the provincial food and drug division, provincial MCH, provincial statistic unit , provincial personnel unit, and provincial health financing unit, representatives from provincial hospitals, Director or Deputy director of district health offices, district project coordinators and district MCH unit, provincial Lao front construction (representatives of ethnic and religious groups) , provincial Lao Women’s Union, and provincial Trade Union (representatives of mass organizations and INGOs).

Methodology:

91. The consultation meetings on social safeguards will be in integrated into existing activities under components 2 and 3. The provincial coordinator who is responsible for organizing a consultation meeting will send invitation and relevant project documents one week in advance to all district health offices and representatives of the mass organizations such as LFC, LWU and LTU.

92. During the meeting, the NPCO representative from the central level will provide the information with regard to: i) project information, objectives, components/activities and scope of implementation using visualized materials (posters, drawings, LCD used to display project and

location); ii) Potential project impacts and risks (both positive and negative) according to the social assessment; iii) the feedback and resolution mechanisms; and iv) inputs/suggestions from participants

93. After the meeting, the provincial coordinator will summarize key discussion points and suggestions from participants, especially the representation from LFC, LWU and the Lao Trade Union. A copy of this summary report will be kept at PHO and one copy will be sent to NPCO.

7.3.2 At the Village Health Center Level

94. The designated NPCO representative and safeguards focal points from the central level will work closely with the district health officers to organize the consultations at the village health centers. It was agreed that consultations will be conducted at the village level where the health center is located to ensure proper facilities are available for participating villagers from nearby villages. For villages that are located far away from the health center, consultation meeting will be organized at on site. Meetings should be organized at the appropriate place and time to ensure high participation/inclusion of targeted male and female participants. The district health officer will send an invitation and relevant project documents one week in advance to all staff of the village health center, village heads, village health committees, village volunteers, representatives of the mass organizations, and INGOs working in the areas, and to representatives from the poor and vulnerable groups, not limited to ethnic groups living in the areas.

Methodology

Before the meeting

95. Heads of village health centers in coordination with the district health coordinator will send invitations/announcements along with project information at least one week in advance to all target participants (see above). In the ethnic areas, coordinators and heads of health centers would need to make sure that ethnic leaders and village volunteers from different ethnic groups assist with the needed communication with respective ethnic groups. It is important that each meeting has relatively equal representation of men and women.

During the meeting

96. Aside from normal SBCC activities for the village level, the contents of social safeguards will be integrated into the content of meeting. The NPCO representative from the central level will present the overall project objectives, project components with key activities, scope, budget allocation and project duration. In addition, the NPCO representative will provide the information with regard to: i) project information, objectives, components/activities and scope of implementation using visual materials (posters, drawings, LCD used to display project and location); ii) potential project impacts and risks (both positive and negative) according to the social assessment; iii) the feedback and resolution mechanisms; and iv) inputs/suggestions from participants.

99. The purpose of the Feedback and Resolution Mechanism (FRM) is to ensure that the project has in place a system to receive feedback from citizens, assuring that the voices are heard from the poor and vulnerable, and that the issues are resolved effectively and expeditiously. Such a system is expected to enable the project to be fully responsive to its beneficiary communities and empower the ethnic groups and poor in villages who are the principal target of the Project.

100. The World Bank and the government reviewed the feedback and resolution mechanisms of the original project and found that the current structure of the feedback and resolution are not often accessible to the local communities that they are designed to address. For example, the system requires that local communities write or provide grievances to the provincial health officer. There are no clear staff and structure of the FRM focal points at all levels. In addition, there is no FRM reporting system for the government to monitor and manage grievances. In response to these constraints, the government agreed to set up a new FRM system with a clearly assigned staff and reporting structure. It was also agreed that this newly established system will be reviewed regularly with the World Bank staff.

8.1 Feedback and Resolution Mechanism Structure and Process

101. At the village level (under component 3): Monthly Village SBCC Meeting at village

- Villages Facilitators (village head, Lao Women Union, Village Health Volunteer) will also act as the village feedback and resolution team. They will be trained on FRM under the IYCF training. Village FRM focal points will:
 - Display contacts of the feedback and resolution focal persons including 3 villages facilitators at the village office at HC catchment areas.
 - Organize monthly meetings to gather feedback/input from villagers. Village facilitators will include information with regard to FRM in the monthly report form. The village reports will be consolidated in the monthly report of Health Center, District Health Office, and Provincial Health Office. The final monthly consolidate report will be sent to NPCO for recording in Project Semi-Annual Report.
 - Review and take actions to all concerns/feedback at the village level within 10 working days. FRM focal points would also seek clarification or referring cases to the district health officer level if necessary.
- Village head (also FRM focal points) will work with representative from mass organizations to gather feedback from hard-to-reach populations in remote areas. In the areas where there are hard-to-reach ethnic groups, village head will work with representatives of mass organizations to ensure these ethnic populations to solicit inputs and report to the monthly village meeting

- Any feedback/input during the home visits will also be included in the monthly village report.
- Feedback will be recorded confidentially. Summary of feedback and responses will be submitted to Health Center for consolidation, then submitted to the District Health Office.

102. At the district level: District Health Officer (DHO) will:

- Provide FRM information and make contacts of district project coordinator and health center staff available to target population in the communities.. Contacts will be displayed at the district hospital and at the village offices in DHO and Health Center catchment areas.
- Attend meetings organized at the health centers. Health center officers will provide reports on the overall feedback and seek clarification or referring cases if necessary.
 - Review and take actions to all concerns/feedback that are referred to the district level within 10 working days. DHO would also seek clarification or refer cases to the national level if necessary.
- Compile all village feedback reports as well as feedback received from phone or emails at the district level into a district FRM report to be submitted to the Provincial Health Officer (PHO) or Provincial Coordinator every month.

103. At the provincial level:

Provincial health officer or Provincial Coordinator will:

- Review and take actions on all concerns/feedback that are referred to the provincial level within 10 working days. Provincial coordinator would also seek clarification or refer cases to the national level if necessary.
- Provide FRM information and contacts to all participants at the provincial meetings, provide information on the district FRM monthly report, and gather feedback from participants. Contacts will be displayed at the PHO. Compile all district FRM reports as well as feedback received from phone or emails at the provincial level into a provincial FRM report to be submitted to NPCO every month.

104. At the national level:

The NPCO will be responsible for:

- Reviewing and taking actions on all concerns/feedback that are referred to the national level within 10 working days.

- Establishing a simplified reporting and database system for the project. Provincial FRM reports will be used to improve the project process.
- Ensuring that safeguards-related staff are properly trained.
- Ensuring that FRM information and responses are included in the project information system, and in the progress and annual reports to be submitted to the WB.

At the semi-Annual Meeting at DHO, PHO and NPCO

105. Participants from health and relevant sectors and mass organizations will be invited to provide feedback. The DHO, PHO, and NPCO officers will be responsible to record the feedback and responses in their semi-annual report.

8.2 Feedback and Response via Telephone and E-mail

106. The government has designed staff at all levels to oversee the feedback and provide responses through phones and emails. Officers at each level will also record feedback received from e-mail and phones in their monthly report and provide direct informant/complainants with answers and information providing solutions to their concerns.

107. At the National Level: The National Program Coordination Office will be responsible for feedback and resolution mechanisms.

108. At the Provincial, District and Village level: The provincial coordinators, district health officers and village FRM committee members are the FRM focal points who will be responsible for gathering feedback and provide responses. Their contact numbers and email addresses will be displayed at their offices and will be distributed to relevant agencies including mass organizations in the areas.

8.3 Type of feedback

109. The NPCO has set up three types of feedback to be reported into the FRM system:

- Feedback in the form of a comment, suggestion or query for project activities.
- Feedback involving complaints against health officers, project staff, and staff of other organizations participating in the project.
- Other feedback which may include feedback involving violations of certain rights or non-performance of obligations.
- Types of feedback will be monitored and discussed with the World Bank during the Implementation Support Missions.

8.4 Acknowledgement and Processing of Feedback

- Feedback and Resolution focal persons are responsible for handling all cases, categorizing them based on the completed Feedback Resolution section in monthly reporting form of each level, and deciding on whom to consult and the subsequent actions.
- When a case/issue has been referred for investigation, the Feedback and Resolution focal persons (VFs) at village will investigate the cases, and discuss and consult with the involved/affected parties.
- All feedback will initially be dealt with at the village level. If a case cannot be resolved at the village level, it will then be transferred to the upper level (district level) for further investigation. If the case could not be resolved at the district level, it would then be transferred to the provincial level.

8.5 Response to Feedback

- The response to informant/complainant feedback will be disseminated and the final results of the Feedback process shared with the community and in particular, with the informants/complainants themselves.
- Cases received/resolved and their status in the resolution process should be reported to the community assuring anonymity at the Village SBCC monthly meeting and semi-annual meeting at health center.

8.6 Feedback Monitoring System.

110. The NPCO will:

- Develop a simplified feedback monitoring system. The system will include appropriate features for entering, tracking, monitoring and addressing feedback on a timely basis. Process of tracking request/complaints and assess the extent to which progress is being made to resolve them.
- Analyze feedback data so that policy and/or process changes can be made to minimize problematic issues in future. Analyzing feedback data helps management reorient project processes in order to increase project effectiveness.
- Report to management which typically includes information on the number of feedback/complaints, geographical spread of feedback/complaints, characteristics of the feedback/complainants, etc.

9. Timeline and budget

111. Time line for safeguards as well as implementation costs will be based on actual timelines and budget from project components 1, 2, 3 and 4. Consultation for the expanded areas would need to be conducted prior to the implementation of the project activities. Consultation at the provincial level could be organized during the NPCO provincial meetings with participants from all districts and from ethnic leaders and mass organizations using budget from component 4. At the village level, the consultation timeline and budget will be integrated into component 3 activities.

112. The technical assistance component of the AF will be used for i) conducting consultations in the expanded districts and villages; ii) training safeguards to all relevant staff especially at the village level; and iii) establishing a simplified FRM data and information system to ensure effective monitoring and management of feedback and resolutions.

10. Monitoring and Evaluation

113 The HGNDP project has a monitoring and evaluation system which is based on an agreed project results framework. The framework consists of six project development indicators and eight intermediate result indicators. Most of the indicators could be monitored and evaluated through a web-based system (DHIS2). Safeguards and activities under component 3 will be monitored and evaluated through surveys and semi-annual reports. The World Bank will conduct project implementation support every six months with the counterparts.

11. Disclosure Arrangements

114. The government has integrated the revised EGDP in the free, prior and informed consultations during the original project implementation in 14 provinces and 120 village health centers during November 2016 – May 2017. It was agreed that the borrower will also make the summary of the revised EGDP available to the affected communities, and district and provincial health offices in an appropriate form and manner. It will be made available in both Lao and English, and will be disclosed on the Ministry's website as well as in local newspapers and distributed to provincial, district and village health center offices.

Appendix A: References

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Appendix B: Government Policies and Strategies

115. The 8th National Social and Economic Development Plan (NSED 8) runs from 2016 until 2020 and incorporates health and nutrition under several of its program objectives. It incorporates a specific focus on mother and child health under the pursuit of MDG 4 and 5. The NSED 8 sets sector targets for all GoL line ministries which are then used as guiding principles for agency annual workplans and budgets.

116. The MOH's 8th Health Sector Development Plan (HSDP8) runs from 2016 to 2020 and seeks to strengthen the capacity and professionalism of health workers and the quality of health facilities and training institutions. It contains a series of activities that include improving health information systems, human resources for health, health financing and a reproductive health strategy.

117. The MOH launched a National Strategy for Human Resources for Health (2010-2020) which provides adequate allocation of staff quotas to Health Centers and additional training for 1,500 community midwives (also known as skilled birth attendants) to address high levels of maternal and child mortality. However health posts allocated by the Ministry of Home Affairs continues to be low (in 2011 only 10 percent of the quota requested was filled).

118. The Health Sector Reform Framework (2013 to 2025) contains 5 priority areas for the reform agenda, namely: (a) human resources for health; (b) health financing (to increase government funding for basic health services); (c) governance, management and coordination; (d) service delivery; and (e) health information system.

119. The current (2nd) National Strategy for the Advancement of Women contains specific targets focused on women and children's health; the National Committee for the Advancement of Women, established in April 2003 by Prime Minister's Decree No. 37/PMO is responsible for its implementation. The National Committee has responsibility to support line Ministries integrate gender into their planning, budgeting, and monitoring and evaluation cycle. Networks are currently being established in all line Ministries, with the aim of having representation at the sub-national levels (down to the District) as well. The MOH has appointed its Committee for the Advancement of Women whose focal point is the Division for Advancement of Women; this office has drafted a Strategy for the Advancement of Women in the Health Sector (2011-2015), which contains both institutional (inclusion of women in training, and management positions) as well as community impact targets. In addition, the MOH's Division for Advancement of Women plays a role in collecting data for compiling health MDG progress reports regarding health.

120. The first National Nutrition Strategy and Plan of Action covered the period 2010-2015, and the follow-on Multisector Food and Nutrition Security Plan of Action (2014-2020) is at an advanced stage of development. It recognizes the importance of a multisector approach to nutrition to address some of the highest stunting rates for under-fives (44 percent). Some of the causes being feeding and care practices, food and nutrient intake, and diarrhea, as well as the nutrition status of the mother. The Plan of Action identifies 28 activities in the agriculture, water sanitation and hygiene, education and health sectors, to be implemented in 26 high priority districts in 7 Provinces.

121. The goal of the National Policy on Health Communication, decreed by the Prime Minister in 2012, is to set up efforts to make health-related information accessible to population and to promote health including the prevention against contagious and non-contagious diseases, new infectious diseases, outbreaks and health emergencies. The MOH has been designated to coordinate with relevant sectors to elaborate and effectively implement this national policy. The Center of Information and Education for Health acts as the focal point of the central level to coordinate with the Ministry of Information, Culture, and Tourism and other relevant authorities. At the provincial level, the provincial health education division acts as the focal point in coordination with the Department of Information, Culture, and Tourism and other relevant authorities. The district health education unit acts as the focal point of the district level in coordination with the district office of information, culture, and tourism and relevant authorities.

122. The LWU established in 1955, was recognized in 1991 under the Constitution of the Lao People's Democratic Republic (Lao PDR). Its mandate is to represent women of all ethnic groups and to "protect women's rights and interests", mobilize and increase women's involvement in national development. It falls under the Party's Central Committee and plays a key role in the development of policies relation to national development and women. It has representation from all ministries down to village level. The provincial and district level representatives are very active in, among other things, village level health. Their vast network has made them logical partners in a variety of activities, particularly those in rural areas.

Appendix C: Provinces and their Ethnic Composition

Province	Total Pop	% EMG	2014 EMG Popn	% and No. of Lao-Tai		% and No. of Mon-Khmer		% and No. of 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
Luang Prabang	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
Xaysomboun	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
Champasak	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
Attapue	143,934	69.3%	87,857	29.2%	25,180	69.6%	61,550	0.0%	0	0.0%	0	0.1%	77
Vientiane 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	54.1%	874,208	28.3%	951,603	4.6%	145,055	11.9%	298,326	0.2%	5,395

