



Technical Assistance Report

Project Number: 41376
November 2008

Lao People's Democratic Republic: Preparing the Health Sector Development Program

CURRENCY EQUIVALENTS

(as of 23 October 2008)

Currency Unit	–	kip (KN)
KN1.00	=	\$0.000116863
\$1.00	=	KN8,557

ABBREVIATIONS

ADB	–	Asian Development Bank
HIV/AIDS	–	human immunodeficiency virus/acquired immunodeficiency syndrome
HRD	–	human resource development
Lao PDR	–	Lao People's Democratic Republic
MCH	–	maternal and child health
MDG	–	Millennium Development Goal
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MPI	–	Ministry of Planning and Investment
PHC	–	primary health care
SDP	–	sector development program
TA	–	technical assistance
VHV	–	village health volunteer

TECHNICAL ASSISTANCE CLASSIFICATION

Targeting	–	Targeted intervention
Classification		
Sector	–	Health, nutrition, and social protection
Subsector	–	Health systems
Themes	–	Inclusive social development, governance, gender and development
Subtheme	–	Human development, public governance, gender equity in capabilities

NOTE

In this report, "\$" refers to US dollars.

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I. INTRODUCTION

1. The Lao People's Democratic Republic (Lao PDR) is a landlocked, low-income country with a scattered population of about 6 million people and a per capita income of \$550 per annum. About 20% of its population lives on less than \$1 per day. Major public health problems and market failure in its health sector affect household productivity and cause serious income erosion for the poor. The Government of the Lao PDR (the Government) identifies the health sector as one of four priority sectors for fighting poverty and achieving the Millennium Development Goals (MDGs).¹

2. According to the long-term strategic framework 2008–2020 (Strategy 2020) of the Asian Development Bank (ADB),² the health sector is not a core sector for ADB, and direct investment in it will be considered case by case. The Lao health sector makes a good case. While the needs are evident, the Government has shown strong leadership in and commitment to the sector. It highly appreciates ADB's leadership role and long-term commitment in the sector. ADB projects have focused on the MDGs and governance and financing reforms and have shown strong performance. The sector remains seriously underfunded, both in terms of domestic resources and a paucity of partners.³ The Government has asked ADB to support the health sector in its transition to a new aid architecture and help ensure that past investments are sustained.

3. The proposed Health Sector Development Program (the SDP) is included in the country operations business plan (2008–2010) for the Asian Development Fund funding of \$22 million in 2009.⁴ The ADB fact-finding mission for project preparatory technical assistance (TA) was fielded from 28 July to 4 August 2008 and reached an understanding with the Government on the program scope and modality and on TA design and implementation arrangements. The design and monitoring framework is in Appendix 1.⁵

II. ISSUES

4. The Lao PDR has made good progress toward the health-related MDGs 1, 4, and 5. The child mortality rate declined from 170 to 98 per 1,000 live births between 1990 and 2005, compared with a target of 55 in 2015. Infants account for three quarters of child mortality. The maternal mortality ratio declined from 750 to 405 per 100,000 live births between 1990 and 2005, compared with a target of 185 in 2015. The malnutrition rate (weight by age), may have declined from 40% to 30% between 1990 and 2005, compared with a target of 20% in 2015. The Lao PDR is surrounded by countries with HIV/AIDS. The Lao HIV prevalence is still increasing but may remain concentrated in high-risk groups. Progress in tuberculosis and malaria control programs are threatened by emerging drug resistance.

5. The Government is committed to "Health for All." The main vehicle for achieving this is to provide all citizens access to primary health care (PHC). The Ministry of Health (MOH) has developed a poverty-focused strategic health-development plan for the period 2006–2010 currently budgeted at \$560 million, or \$22 per person per year, compared to the international

¹ Government of the Lao PDR. 2006. *Sixth National Socioeconomic Development Program (2006–2010)*. Vientiane

² ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank 2008–2020*. Manila.

³ Health sector funding remains low partly because the Government has limited funds for discretionary spending.

⁴ ADB. 2007. *Country Operations Business Plan 2008–2010: Lao People's Democratic Republic*. Manila.

⁵ The TA first appeared in the business opportunities section of ADB's website on 13 August 2008.

minimum standard of \$34.⁶ Current public and private spending is only \$12 per person per year, of which \$7 is out of pocket and \$3 from partners. MOH is proceeding with the preparation of the next strategic sector plan for 2011–2015, which would clearly spell out Government priorities and potential support from partners in various subsectors. The sector remains highly dependent on external funding until broad-based revenue and expenditure reforms have materialized.

6. ADB has been an important partner in the Lao health sector for the past decade. It has assisted MOH to (i) develop PHC in the eight northern provinces, with the World Bank providing similar assistance in the southern provinces; (ii) strengthen provincial health systems nationwide; and (iii) control emerging and neglected endemic communicable diseases.

7. With the support of ADB and other partners, the MOH has established a basic PHC network of hospitals, health centers, and trained village health volunteers (VHVs). The Primary Health Care Expansion Project helped develop this network in 8 northern provinces covering about 2 million people including 56% ethnic minorities.⁷ Between 2004 and 2006, the use of public health facilities as the first place of care increased from 21% to 39% for ethnic minority groups, and from 37% to 50% for others in these provinces. Deliveries in health facilities increased from 5% to 8% for ethnic minorities, and 18% to 28% for others. Immunization coverage doubled. The increase in demand is due to better access, drugs supply, and staff quality, in addition to increased education and affordability. However, the use of health services is still low at 0.45 visits per year, and much lower for some ethnic groups. This is not because of competing services: the mainly urban private sector is small, and the use of traditional health care is low. The public health system itself needs further strengthening in two major areas, namely (i) access, quality, and affordability of PHC; and (ii) sector management and financing.

8. Lao is a low population density country making it difficult to provide good access for remote populations. In 2006, 76% of ethnic minorities had access to VHVs, but only 39% had access to a health center within 1 hour of travel. The Government can ill afford operating a health center in each hamlet, so VHVs play an important role. However, existing health centers and hospitals often lack staff, in particular for maternal and child health (MCH). Achieving MDGs 4 and 5 in Lao PDR will depend on making VHVs and MCH staff available, including specialists, midwives and female staff from ethnic minorities. MOH and its partners are developing specific plans to improve access to MCH according to minimum service standards at all levels. Staff quality also needs further improvement. MOH is preparing a human resource development (HRD) policy and a staff management system to improve training, accreditation, and quality control. In addition, older facilities not included in previous projects require repair and new equipment. The introduction of cost recovery in 1995 improved drugs supply and provided some incentive for staff. However, affordability of health care for the poor has reduced since then. Transport charges, fees, and indirect cost of health care, in particular for catastrophic illnesses such as obstetric emergencies, are often prohibitive for the poor. A caesarian section may easily cost several hundred dollars. As part of the effort to achieve MDGs, pilot health equity funds and other initiatives to make health care more affordable for the poor will need to be scaled up.

9. Low demand and substandard health care is also caused by management and financing problems in the sector resulting in considerable inefficiencies. While PHC receives high priority, the health sector has been input driven and the recurrent budget has remained very low. Low

⁶ World Health Organization. 2001. *Report of the Commission on Macroeconomic and Health*. Geneva.

⁷ ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Lao People's Democratic Republic for the Primary Health Care Expansion Project*. Manila.

salaries are a major reason for staff absenteeism. Recently, more results-oriented instruments have been introduced such as provincial strategic and annual planning and budgeting cycles, and results-based financing. However, a major challenge remains to improve the coordination of programs and projects at central level into a sector approach.

10. Following the Vientiane Declaration on Aid Effectiveness in 2006,⁸ the Government has moved to develop sector-wide approaches with its partners. Progress has been made. The World Bank and its partners⁹ provide support for public expenditure reforms. Public sector fundamentals are being improved through the 2006 budget law and other vehicles. The Ministry of Education and other ministries have pioneered a sector approach, initially with considerable uncertainty. The ministries are now committed to developing this further, in view of it being a more strategic and transparent approach with expected impact and efficiency gains.

11. MOH is planning to develop a sector approach, with support of the Ministry of Finance (MOF) and the Ministry of Planning and Investment (MPI). Major progress has been made in the past two years. MOH and partners have endorsed the new sector coordination framework for health, and there is general agreement on the way forward.¹⁰ The partners are assisting MOH with standardizing maternal and child care and the health management information system. Three task forces are working on health financing, HRD, and PHC (with a focus on MCH).

12. ADB's Health System Development Project,¹¹ approved in 2007 for a period of 4 years is also assisting MOH in preparing building blocks for a sector approach. ADB is helping MOH prepare the HRD policy, improve several training, strengthen provincial planning and budgeting, pilot a results-based approach and health equity funds, and develop the next 5-year plan (2011-2015). The 5-year plan is expected to help with aid coordination and mobilizing funds to address the overall funding gap in the sector, including for PHC. This will require MOH to strengthen and institutionalize its secretariat for the sector working group for health to provide ongoing leadership, resources, information management and coordination.

13. MOH, the MOF, and the MPI asked ADB to consider an SDP modality in support of the next 5-year plan that will contribute to achieving MDGs 1, 4 and 5. Two major priorities for consolidating and possibly furthering ADB's support to the sector are in line with ADB's Strategy 2020, namely (i) maximizing past investments in the 8 northern provinces to achieve MDGs; and (ii) helping develop the sector approach to improve overall sector performance in terms of efficiency, effectiveness and sustainability. The SDP's project investment would support PHC, with a focus on MCH, in the eight northern provinces in terms of improving access, quality, acceptability, affordability, and management. The SDP's program investment would support MOH and the partners to develop the sector approach and provide complementary support for standardizing MCH services, the HRD policy, personnel management, making health care more affordable for the poor through health equity funds, and results-based planning and budgeting. The proposed SDP investment is estimated at \$22 million for a period of 4 years.

⁸ Government of the Lao PDR. 2006. *Vientiane Declaration on Aid Effectiveness*. Vientiane.

⁹ World Bank. 2007. *Third Lao PDR Poverty Reduction Support Operation*. Washington, DC.

¹⁰ The Government of Japan, with support of World Health Organization and the World Bank, is leading aid coordination among partners.

¹¹ ADB. 2007. *Report and Recommendation of the President to the Board of Directors on a Proposed Grant to the Lao People's Democratic Republic for the Health System Development Project*. Manila.

14. MOH has a good track record in implementing ADB health projects with strong leadership and management, close coordination with MOF, and technical support. The joint administration of several projects appears to be working well. However, the policy and administrative environment of projects requires ongoing adjustment. MOH also finds it difficult to hire qualified international and national consultants.

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

15. The TA will result in improved demand for public health services, in particular from women, children, and ethnic minorities. The TA outcome is a draft health SDP proposal by April 2009. An initial poverty and social analysis is in Appendix 2.

B. Methodology and Key Activities

16. The TA will help (i) appraise national and provincial sector development and related governance and financing aspects, including aid coordination; (ii) appraise PHC performance with a focus on MCH care, HRD, and affordability; (iii) conduct a participatory planning process to identify priorities for project and program support under the health SDP; and (iv) prepare the draft health SDP proposal and implementation plan for possible ADB assistance.

17. Toward possible program support, the TA work will include a review of (i) health policy and regulations; (ii) health sector planning and financing; (iii) the sector approach being developed by MOH and its partners and related policy developments and institutional arrangements; (iv) MOH capacity and aid coordination; (v) provincial health system development, including sector coordination and aid harmonization, planning and budgeting, and results-based management; (vi) HRD; (vii) the health management information system; and (viii) financial management.

18. Toward possible project support, the TA work will include a review of (i) needs for upgrading facilities and equipment, (ii) options to improve the quality and acceptability of services with a focus on comprehensive MCH care and the "healthy village," (iii) priorities for implementing the HRD policy and plan,¹² and (iv) the proposed expansion of health equity funds to eight northern provinces.

C. Cost and Financing

19. The total cost of the TA is estimated at \$575,000 equivalent. ADB will finance \$500,000 equivalent. The TA will be financed on a grant basis from ADB's TA funding program. The Government will provide \$75,000 equivalent through in-kind contributions for counterpart staff, facilities, transport, and provincial data collection. The cost estimates and financing plan are in Appendix 3. The Government has been informed that approval of the TA does not commit ADB to finance any ensuing SDP.

¹² Including improving standards and quality control, nursing and midwifery schools, the Louang Phrabang PHC family doctor school, midlevel PHC workers schools, village health workers, the university of health sciences, and public health and professional associations.

D. Implementation Arrangements

20. MOH will be the Executing Agency for the TA. The MOH steering committee, chaired by the Minister of Health and including representatives of MPI and MOF, will review and guide TA work, if and when required. Tripartite meetings of the Government, ADB, and consultants will be held at inception, midterm, and completion of the TA. The Planning and Finance Department of MOH will be responsible for TA implementation. MOH has nominated a project director and a full-time deputy project director for the TA. The project director will provide overall leadership and chair weekly team meetings to guide and coordinate TA activities. The deputy project director will provide liaison with stakeholders, among other responsibilities. In each province, the provincial health team will conduct a basic provincial health account and prepare a provincial 5-year plan and medium-term expenditure framework. Technical working groups for MCH care, HRD, and health financing will provide technical advice, as will experts from other ministries and partners. ADB will administer the TA, engage the consultants, and provide technical backstopping.

21. ADB will support 13 person-months of international consulting services, including a team leader and health sector reform expert (5 person-months), health economist (3), sociologist (2), resettlement expert (1), and engineer and environment expert (2). Fifteen person-months of national consulting services will include an HRD expert (5), financial management expert (5), and engineer (5). All consultants will be engaged through a firm using the biodata technical proposal and fixed budget selection method in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). The outline terms of reference for consultants are in Appendix 4. Equipment will be procured under the TA by MOH in accordance with ADB's *Procurement Guidelines* (2007, as amended from time to time) and retained by it on completion of the TA. MOH will open a separate account to manage the funds for the office, workshops, field work, and data collection.

22. The TA team of consultants and counterparts will prepare an inception plan for the TA based on initial consultations and scoping and submit it within 1 month to MOH and ADB. This will be followed by specific appraisals of relevant subsectors and dialogue with stakeholders to identify issues and options for investment. The midterm report will be submitted after 2 months, including reviews of the Health System Development Project and similar projects, and of progress in building blocks towards a health sector coordination approach. Then the team will conduct a 2-month participatory planning process to prepare a draft SDP proposal, which will be finalized with Government and ADB inputs over the next month. MOH will organize three workshops for stakeholders, at the inception, midterm, and draft final stages. The draft final report will be submitted after 4 months, and a final report and implementation memorandum within 5 months. The TA work will begin on 15 December 2008 and be completed by 15 June 2009.

IV. THE PRESIDENT'S DECISION

23. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$500,000 on a grant basis to the Government of the Lao People's Democratic Republic for preparing the Health Sector Development Program, and hereby reports this action to the Board.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and/or Indicators	Data Sources and/or Reporting Mechanisms	Assumptions and Risks
<p>Impact Improved demand for public health services</p>	<p>Percentage of population using a health facility in the past month increased from 35% in 2010 to 55% in 2014 (disaggregated by age, sex, income, and ethnic group)</p> <p>Percentage of deliveries assisted by trained birth attendants in the past year increased from 25% in 2010 to 50% in 2014 (by ethnic group)</p>	<p>Household surveys and health service surveys in the eight northern provinces in 2010, 2012 and 2014</p> <p>Health facility and village reporting systems</p>	<p>Assumption</p> <ul style="list-style-type: none"> • PHC improvements are sufficient to trigger increased demand for health services from the poor, women, children, and ethnic minorities. <p>Risk</p> <ul style="list-style-type: none"> • Increasing cost of fuel and food may worsen poverty and affect demand for health services.
<p>Outcome An agreed draft SDP</p>	<p>Technically sound SDP design acceptable to the Government and ADB articulated by 15 May 2009</p>	<p>Memorandum of understanding for grant fact-finding and appraisal between the Government and ADB</p>	<p>Assumptions</p> <ul style="list-style-type: none"> • Partners support the SDP design • The Government commits to sustaining proposed SDP policy reform and PHC
<p>Outputs</p> <ol style="list-style-type: none"> 1. Appraised sector development and related governance and financing aspects including aid coordination 2. Appraised PHC performance with a focus on MCH care; and agreed priorities and modalities for program support 3. Completed program design, including policy matrix, SDP framework, design details, and investment plan 	<p>Agreed inception report with details on appraisal and program design by 1 February 2009</p> <p>Satisfactory analysis for sector development; and agreed priorities among stakeholders by 1 April 2009</p> <p>Satisfactory draft program design by 1 May 2009; and program design by 15 May 2009</p>	<p>Inception report Tripartite meeting Comments of partners</p> <p>Mid-term report Workshop report Tripartite meeting Comments of partners</p> <p>Final report Tripartite meeting Comments of partners</p>	<p>Assumptions</p> <ul style="list-style-type: none"> • Adequate data are made available in a timely manner • The Government fully supports consultations in the field and with partners • Partners support planning process
<p>Activities with Milestones</p> <ol style="list-style-type: none"> 1. Dialogue with MOH, other ministries, provinces, ADB, and partners ongoing 2. Preparation of reports: inception in January 2009, midterm in March 2009, draft final in April 2009, and final in May 2009 3. Workshops and meeting task forces at inception, midterm, and draft final stages 4. Desk review of issues and options for improving PHC, HRD, management, sector financing, and sector approach in January–March 2009 5. Preparation of program design, policy and project framework, design details, investment plan, social and environmental safeguards, and economic justification including all appendices in February–April 2009. 6. Preparation of program implementation plan and brief TA report in May 2009. 			<p>Inputs (\$):</p> <p>ADB (\$500,000): Consulting services, equipment, workshops, survey, administration, and contingencies</p> <p>Government (\$75,000) Remuneration and benefits for counterpart staff, office facilities, transport, and data collection</p>

ADB = Asian Development Bank, HRD = human resource development, MCH = Maternal and Child Health, MOH = Ministry of Health, PHC = primary health care, SDP = sector development program, TA = technical assistance.

INITIAL POVERTY AND SOCIAL ANALYSIS

Country and Project Title:	Lao People's Democratic Republic/Health Sector Development Program		
Lending or Financing Modality:	Sector development program Grant	Department and Division:	Southeast Asia Department Social Sectors Division
I. POVERTY ISSUES			
A. Linkages to the National Poverty Reduction Strategy and Country Partnership Strategy			
<p>The Government of Lao People's Democratic Republic (Lao PDR) identifies the health sector as one of four priority sectors. The Asian Development Bank (ADB) Country Operations Business Plan 2008–2010 for Lao PDR gives priority to the health sector. The health sector plays a major role in poverty reduction as poverty rates are high, the cost of medical care is a major reason for new poverty, disease among the poor affects their productivity, income is eroded because of the poor quality of care, and widespread poverty requires government intervention to make services available and affordable.</p>			
B. Targeting Classification			
1. Select the targeting classification of the project:			
<input type="checkbox"/> General Intervention (GI) <input type="checkbox"/> Individual or Household (TI-H); <input type="checkbox"/> Geographic (TI-G); <input checked="" type="checkbox"/> Non-Income MDGs (TI-M1, M2, etc.)			
2. Explain the basis for the targeting classification:			
<p>The sector development program (SDP) will strengthen the provincial health system's ability to provide better primary health care, make health care more affordable for the poor, and make health care more acceptable to women, ethnic minorities, and other vulnerable groups. It will support the sector program approach. The technical assistance (TA) will analyze health service performance, quality of care, human resource development, health financing, and management, and it will propose policy reforms, capacity building, and investments. The purpose is to establish a process of year-by-year upgrading of provincial health services based on needs and results, rather than inputs, to make services more equitable, efficient, and effective. The analysis will include an assessment of physical, social, and financial access to health services and whether health service management is pro-poor and gender-equal. It will assess opportunities for women and ethnic minorities and specific issues for vulnerable groups. The analysis will also assess the potential benefits of reform and investment for the poor.</p>			
C. Poverty Analysis			
1. Poverty impact analysis will be done through household and health service surveys measuring the use of health services.			
2. These surveys are already financed under an ongoing project.			
3. The proposed SDP includes measures to enhance social inclusion through scholarships for ethnic minorities, cross subsidies through health equity funds, and pro-poor governance through better planning and budgeting.			
II. SOCIAL DEVELOPMENT ISSUES			
A. Initial Social Analysis			
Based on existing information:			
1. The services to be improved directly benefit rural people, in particular the poor, women, children, and ethnic minorities.			
2. Measures are taken to improve financial and social access for these vulnerable groups.			
3. The SDP will improve financial access by expanding health equity funds to all eight northern provinces and improve social access by training women, ethnic minorities, and village health volunteers.			
B. Consultation and Participation			
1. Stakeholders include the beneficiaries, in particular the poor, women, children, and ethnic minorities; health staff; provincial governments; and central ministries and partners.			
2. Consultations will involve field visits, meetings with health staff, workshops, and dialogue with government officials and development partners.			
3. What level of participation is envisaged for project design?			
<input type="checkbox"/> Information sharing <input checked="" type="checkbox"/> Consultation <input type="checkbox"/> Collaborative decision making <input type="checkbox"/> Empowerment			
4. Will a consultation and participation plan be prepared? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Please explain.			
The TA includes a sociologist who will ensure adequate consultation with stakeholders.			

C. Gender and Development			
<p>1. What are the key gender issues in the sector and/or subsector that are likely to be relevant to this project or program? The TA will develop a gender strategy and plan to emphasize the needs of women, in particular regarding reproductive health and access to acceptable, affordable, quality health services. It will examine ways to provide employment opportunities and social protection to minority women. The strategy will incorporate the views of beneficiaries, including women from ethnic minorities.</p> <p>2. Does the proposed project or program have the potential to promote gender equality and/or women's empowerment by improving women's access to and use of opportunities, services, resources, assets, and participation in decision making? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Could the proposed project have an adverse impact on women and/or girls or widen gender inequality? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>			
III. SOCIAL SAFEGUARD ISSUES AND OTHER SOCIAL RISKS			
Issue	Nature of Social Issue	Significant/Limited/ No Impact/Not Known	Plan or Other Action Required
Involuntary Resettlement	The SDP will use existing health facilities. Civil works will upgrade existing services and schools. No resettlement issues were identified.	No Impact	<input type="checkbox"/> Full Plan <input type="checkbox"/> Short Plan <input type="checkbox"/> Resettlement Framework <input checked="" type="checkbox"/> No Action <input type="checkbox"/> Uncertain
Indigenous Peoples	The SDP targets ethnic minorities with the purpose of increasing their benefits.	Significant	<input checked="" type="checkbox"/> Plan <input type="checkbox"/> Other Action <input type="checkbox"/> Indigenous Peoples Framework <input type="checkbox"/> No Action <input type="checkbox"/> Uncertain
Labor <input type="checkbox"/> Employment Opportunities <input type="checkbox"/> Labor Retrenchment <input type="checkbox"/> Core Labor Standards	The SDP creates opportunities for the employment of health staff and the training of volunteers to increase their income through a small mark-up on the sale of drugs.	No Impact	<input type="checkbox"/> Plan <input type="checkbox"/> Other Action <input checked="" type="checkbox"/> No Action <input type="checkbox"/> Uncertain
Affordability	One of the aims of the SDP is to make health services more affordable for the poor.	Significant	<input checked="" type="checkbox"/> Action <input type="checkbox"/> No Action <input type="checkbox"/> Uncertain
Other Risks and/or Vulnerabilities <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Human Trafficking <input type="checkbox"/> Others (conflict, political instability, etc.), please specify	The TA will examine if there is any other major risk or vulnerability that may need to be addressed in the program design.	No Impact	<input type="checkbox"/> Plan <input type="checkbox"/> Other Action <input checked="" type="checkbox"/> No Action <input type="checkbox"/> Uncertain
IV. PPTA OR DUE DILIGENCE RESOURCE REQUIREMENT			
<p>1. Do the terms of reference (TOR) for the PPTA (or other due diligence) include poverty, social and gender analysis and the relevant specialist(s)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain why.</p> <p>2. Are resources (consultants, survey budget, and workshop) allocated for conducting poverty, social and/or gender analysis, and consultation and participation during the PPTA or due diligence? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain why.</p>			

COST ESTIMATES AND FINANCING PLAN
(\$'000)

Item	Total Cost
A. Asian Development Bank Financing^a	
1. Consultants	
a. Remuneration and Per Diem	
i. International Consultants	300.0
ii. National Consultants	40.0
b. International and Local Travel	35.0
c. Reports and Communications	10.0
2. Equipment ^b	15.0
3. Training, Meetings, and Workshops	15.0
4. Surveys and Studies	15.0
5. Miscellaneous Administration and Support Costs	20.0
6. Contingencies	50.0
Subtotal (A)	500.0
B. Government Financing	
1. Counterpart Staff	20.0
2. Office Facilities	20.0
3. Transport	20.0
4. Data Collection	15.0
Subtotal (B)	75.0
Total	575.0

^a Financed by the Asian Development Bank's technical assistance funding program.

^b Includes two computers, printer, and photocopy machine.

Sources: Ministry of Health and Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. International Consultants

1. Team Leader and Health Sector Reform Expert (5 person-months)

1. The team leader and maternal and child health (MCH) care expert will have at least 15 years of public health experience in health sector policy work and reform and as a team leader of projects. The team leader will report to the project director, Ministry of Health (MOH), and the mission leader of the Asian Development Bank (ADB). The expert will

- (i) jointly manage, with the deputy project director, technical assistance implementation, including liaison with MOH and other ministries, provinces, development partners, and civil society, providing overall conceptual guidance, overseeing the work of the consultants, and coordinating a participatory planning process, including field visits to meet beneficiaries, consultations, workshops, and tripartite meetings;
- (ii) participate in the sector working group and task forces of MOH and partners and align sector development program (SDP) analysis and plans with the priorities of the task forces;
- (iii) take the lead in analyzing and planning the national program investment in coordination with MOH and partners, including the design of the SDP modality, health policy, and regulatory analysis of health financing, human resource development (HRD) and primary health care (PHC), and in preparing the policy reform matrix, design and monitoring framework, and capacity-building plan;
- (iv) take the lead in planning the project investment in the eight northern provinces to increase benefits to the poor, in particular women, children, and ethnic minorities, by improving the quality, acceptability, and affordability of health care; and
- (v) ensure the timely submission of reports: (a) the inception report after 1 month, including a summary of sector issues, the outcome of initial consultations, the work schedule, the assignments of consultants, and technical assistance implementation arrangements; (b) the midterm report after 2 months, with policy and field analyses (including appraisals of projects and building blocks towards a sector coordination approach) and an SDP outline; (c) the draft final report after 4 months; and (d) the final report after 5 months.

2. Health Economist (3 person-months)

2. The health economist will have at least 10 years of health economic experience and will report to the project director, MOH, team leader, and ADB mission leader. The expert will

- (i) review macroeconomic and fiscal trends, public health expenditures, policies, and support programs and update national and provincial sector financing trends;
- (ii) advise and assist the team leader with the SDP design, including an assessment of modalities for program assistance linked to health sector financing;
- (iii) work with the health-financing task force of MOH and partners, align plans with the task force, and review health sector financing options for the poor and possible scaling up of health equity funds and community-based health insurance;
- (iv) identify policies for program support, including advancing the national sector program, MOH capacity building, and enhancing central and provincial spending on health; assess adjustment costs for proposed reforms; help prepare the policy matrix and the design and monitoring framework; and assess the poverty impact;

- (v) improve guidelines and templates for provincial health accounts, 5-year plans, and medium-term expenditure frameworks and facilitate provinces' use of them; and
- (vi) conduct, using ADB's *Guidelines for the Economic Analysis of Projects* (1997), an economic and financial analysis of the project component.

3. Sociologist (2 person-months)

3. The sociologist (or equivalent, such as medical anthropologist) will have at least 10 years of social development experience in the health sector in the Mekong region. The expert will

- (i) review MOH policies and plans vis-à-vis poverty, gender, ethnic minority issues, and MCH care; assess overall country performance; review past performance of ADB projects on social safeguards; and identify lessons learned;
- (ii) assist the team leader in planning the SDP and ensure that the SDP design adequately addresses gender, ethnic minorities, barriers to health care, and other social concerns;
- (iii) work with the MCH care task force of MOH and its partners and identify and design innovative and appropriate strategies to address the needs of women, children, and ethnic minorities that are practical, safe, adaptable, and sustainable, and that result in the appropriate use of traditional and modern health care; and
- (iv) prepare, based on relevant Government documents, the country gender strategy for the Lao People's Democratic Republic, ADB's *Handbook on Poverty and Social Analysis* (2001), ADB's *Policy on Gender and Development* (1998), ADB's *Gender and Development Plan of Action (2008–2010)*, ADB's *Policy on Indigenous Peoples* (1998), and *Operations Manual*, OM Sections F3/BP, and F3/OP (September 2006), a social analysis, gender action plan, and ethnic minority development plan and provide details on implementation arrangements.

4. Resettlement Expert (1 person-month)

4. The resettlement expert will have at least 5 years of resettlement experience, preferably in the Mekong region. Consulting ADB's *Involuntary Resettlement Policy* (1995) and *Operations Manual*, OM Sections F2/BP and F2/OP (September 2006), the expert will screen sites of facilities targeted for upgrading for any possible involuntary resettlement impacts (using standard ADB involuntary resettlement checklist and categorization forms), including impacts on non-titled people such as loss of legal structures and incomes; prepare a resettlement framework and a resettlement plan for each identified site; and prepare a resettlement report.

5. Engineer and Environment Expert (2 person-months)

5. The engineer and environment expert will have at least 10 years of experience in the health sector, including in the design and construction of health facilities and their environmental aspects and in the handling of medical wastes and waste water management. The expert will

- (i) jointly visit, with the national engineer, the eight northern provinces and assess all proposed facilities for upgrading and a sample of hospitals and health centers;
- (ii) appraise the performance of MOH in civil works and document lessons learned;
- (iii) assess, with MOH and the provinces, justification of the proposed upgrading in terms of demand, access, quality, efficiency, and environmental considerations;
- (iv) determine and report on any resettlement issues;
- (v) assess and validate proposed upgrading and prepare basic sketches;

- (vi) prepare detailed cost estimates based on cost norms, including contingencies, for buildings, installations and furniture, electricity, water management, medical waste facilities, site works, and civil works management;
- (vii) help the Government to prepare an initial environmental examination (as the project is category B in accordance with ADB's *Environment Policy* [2002] and *Operations Manual 20*), including the requirements for environmental assessment and review procedures, environmental assessment of the policy matrix and mitigating measures, and environmental management plans for health facilities based on ADB's *Environmental Assessment Guidelines* (2003); and
- (viii) prepare construction design and implementation arrangements with special attention to waste management, terms of reference of the consultants, the procurement method, and standard bidding documents.

B. National Consultants

1. Human Resources Development Expert (5 person-months)

6. The HRD expert will have a degree in an HRD-related field and at least 10 years of experience in this field. The expert will

- (i) take the lead in organizing the planning workshops;
- (ii) participate in the MCH care task force of MOH and its partners and help prepare the program and project investments for the SDP;
- (iii) take the lead in planning interventions for implementing the HRD policy and plan, including possible support for standards and quality control and improving teaching quality, nursing and midwifery schools, the Louang Phrabang PHC family doctor school, mid-level PHC workers schools, village health workers, the university of health sciences, and public health and professional associations; and
- (iv) prepare a detailed report and cost estimate for the proposed interventions.

2. Financial Management Expert (5 person-months)

7. The financial management expert will have a degree in accounting or business administration and have at least 10 years of experience in this field. The expert will

- (i) assist the economist with updating health sector financing trends nationally and provincially and participate in the health financing task force;
- (ii) assist each province in improving provincial health accounts, the 5-year plan, and the medium-term expenditure framework and prepare a report in 3 months;
- (iii) assess financial management performance based on ADB guidelines, and prepare a report in 3 months;
- (iv) prepare cost estimates for the project investment in the SDP in 4 months; and
- (v) design the fund-flow mechanism and identify appropriate disbursement procedures for the ensuing program in 4 months.

3. Engineer (5 person-months)

8. The national engineer will have a degree in engineering and at least 10 years of experience in this field. The expert will work with the international engineer and environment expert according to the same terms of reference.