

**BOARD
OF
DIRECTORS**

ASIAN DEVELOPMENT BANK

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**TECHNICAL ASSISTANCE TO THE LAO PEOPLE'S DEMOCRATIC REPUBLIC
FOR CAPACITY BUILDING FOR PRIMARY HEALTH CARE**

The attached Report is circulated for the information of the Board. The President approved the technical assistance on 10 August 2000.

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ASIAN DEVELOPMENT BANK

TAR: LAO 32315

TECHNICAL ASSISTANCE

TO THE

LAO PEOPLE'S DEMOCRATIC REPUBLIC

FOR

CAPACITY BUILDING FOR PRIMARY HEALTH CARE

August 2000

CURRENCY EQUIVALENTS

(as of 1 August 2000)

Currency Unit	–	Kip (KN)
KN1.00	=	\$0.0001248
\$1.00	=	KN8,010

ABBREVIATIONS

ADB	–	Asian Development Bank
Lao PDR	–	Lao People's Democratic Republic
MOH	–	Ministry of Health
NGO	–	nongovernment organization
PHC	–	primary health care
SDR	–	special drawing rights
SF	–	Special Funds

NOTES

- (i) The fiscal year (FY) of the Government ends on 30 September.
- (ii) In this report, "\$" refers to US dollars.

I. INTRODUCTION

1. The Government of the Lao People's Democratic Republic (Lao PDR) recently approved the primary health care (PHC) policy to improve the health of the country's citizens based on the concepts of participation, equity, and sustainability. The country operational strategy of the Asian Development Bank (ADB) for the Lao People's Democratic Republic gives high priority to poverty reduction through human development, including health sector development. The ADB-supported PHC Project,¹ which is being implemented in 2 of the country's 18 provinces,² is likely to be expanded to all provinces in the northern part of the country.³ To build capacity in PHC development, the Government has asked for technical assistance (TA); this TA is included in the country assistance plan for 2000. The Fact-Finding Mission⁴ held consultations with concerned ministries, provincial and district health officers, nongovernment organizations (NGOs), and funding agencies. In a wrap-up meeting held on 4 February 2000, the Government and the Mission reached an understanding on the objectives, scope, cost estimates and financing plan, implementation arrangements, and required consulting services,⁵ as documented in the signed memorandum of understanding. The TA framework is in Appendix 1.

II. BACKGROUND AND RATIONALE

2. The Lao PDR is a hilly and forested country located centrally in the Greater Mekong Region. It has a low population density of 21 persons per square kilometer, a total population of about 5.2 million people, and a population growth rate of about 2.5 percent per year.⁶ Eighty-five percent of the population lives in rural areas. The population comprises some 47 distinct ethnic groups. The ethnic Lao constitute about half the population, and mainly live in the fertile lowland. The ethnic minorities mainly live as subsistence farmers in the less accessible hills. The literacy rate of the ethnic minorities especially that of their women, is well below the national average.

3. The Lao PDR is one of the poorest countries in Asia. The current per capita income is estimated at \$283 per year. In 1992/93, 45 percent of the population lived below the poverty line of \$14 per capita per month, and 27 percent lived below a second poverty line that may be considered as very poor.⁷ However, a recent ADB analysis suggests a poverty incidence of 63 percent poor, and 41 percent very poor in 1992/93; this improved to 47 percent poor, and 25 percent very poor in 1997/98. Furthermore, the analysis suggests that the 16 percent decrease in the number of poor over this period was due to a 23 percent growth in consumption, which was dampened by increasing inequality. There was little increase in consumption in the lowest quintile, suggesting that economic growth had less impact on the very poor. The Government is addressing poverty through gradual economic reforms, social services development, and investment in priority infrastructure such as roads and hydropower. In view of the increasing inequality, the Government is giving high priority to social sector development, including the nationwide development of PHC that will mostly benefit the poor. While long-term prospects for the country's economy are favorable, the Government is currently facing a serious financial crisis.

¹ Loan 1348-LAO(SF): *Primary Health Care Project*, for SDR3,404,000, approved on 19 January 1995.

² Including Xaysomboun Special Zone and Vientiane Municipality as "provinces".

³ TA 3058-LAO: *Primary Health Care Expansion Project*, for \$700,000, approved on 20 August 1998.

⁴ TA fact-finding was combined with loan fact-finding for the proposed Primary Health Care Expansion Project.

⁵ The TA first appeared in *ADB Business Opportunities* in May 2000.

⁶ The National Statistical Center. 1997. Results from Population Census 1995. State Planning Committee. Vientiane.

⁷ World Bank. 1995. Social Development Assessment and Strategy. Report No. 13992-LA. Washington D.C. The lower poverty line refers to a level of consumption and expenditures sufficient to buy 2,100 calories of food per person per day, and the second a higher level including an allowance for nonfood expenditures.

4. The people of the Lao PDR, in particular the poor and ethnic minorities, have a low health status compared with other countries in Asia; life expectancy is only 53 years. However, the Government estimates that from 1995 to 2000 the infant mortality rate declined from 104 infant deaths per 1,000 live births, to 85; and that from 1993 to 2000 the maternal mortality rate declined from 656 per 100,000 live births, to 490. Common infectious diseases, malnutrition, and complications of pregnancy and childbirth are still the major public health problems. From 1995 to 2000 the total fertility rate is estimated to have declined from 5.6 to 4.5. About 30 percent of couples are estimated to practice birth spacing, but unmet demand for birth spacing interventions remains high.

5. The Ministry of Health (MOH) is at the apex of the public health system, which includes 18 provincial hospitals, 141 district hospitals, and health centers at the subdistrict level serving clusters of villages. Provincial and district health offices are responsible for implementing PHC services in coordination with at least 12 vertical programs. At the village level, basic curative care is provided by formal and informal private providers, including retired health staff, traditional healers, drugshop owners, and birth attendants. Major issues impeding PHC are limited access to priority services for ethnic minorities, affordability of drugs for the very poor, inadequate staff skills and remuneration, limited management and supervisory capacity, and inadequate financing of the health sector.

6. **Policy Development.** In February 2000, MOH introduced the first PHC policy, which proposes PHC as the core strategic approach for health sector development. It aims to make essential health care, including first referral care, available to the entire population, with a special emphasis on women, children, and the poor. ADB has been helping the Government develop the PHC policy and initial strategic framework, which were presented at a round-table conference in May 2000. Support is needed to develop the strategic framework, investment plan, and guidelines for implementation of the PHC policy. This will include specifying the Government's approach to rationalizing the network of health centers, the package of services to be provided at each level, staff requirements, and health sector financing arrangements.

7. **Planning.** MOH plans to establish PHC coordination units in all provincial health offices; these are to strengthen provincial PHC planning, budgeting, management, and monitoring. The units will aim to integrate and prioritize PHC activities in the provinces provided by the various services, programs, and projects. Strategic priorities will be identified for each province and pursued using rolling plans guided by five-year targets. According to a new Government directive, the district and community levels will be given increasing responsibility to implement these plans. Districts will eventually be responsible for planning and budgeting PHC, and training and monitoring all village health care providers in the catchment area. MOH has already started rationalizing the expansion of health centers based on the identification of underserved populations, feasibility of service delivery, and recurrent cost implications. MOH also plans to improve human resources planning. There is a surplus of general staff in hospitals, and many graduates are not able to find work in the health sector. However, many health centers serving ethnic minorities lack staff, and the proportion of ethnic minorities being trained is very small.

8. **Budgeting.** The Ministry of Finance releases about two thirds of the public health budget directly to the provinces. In consultation with MOH, the provincial governments propose how the provincial health budget will be spent. However, defined provincial health budgets are not available in most provinces, and budgets do not appear to be linked to strategic priorities for service delivery. From what is known, a considerable part of the provincial health budget is spent on infrastructure rather than on recurrent expenditures, and a large share is consumed by provincial hospitals. In addition, the Ministry of Finance has indicated it cannot abolish the

collection of 20 percent revenue from cost recovery until budgeting has improved. The Government is also under pressure to provide expensive services for chronic diseases affecting the urban middle class, as private services are underdeveloped and relatively expensive. However, MOH has clearly given priority to poverty reduction in its health sector spending, and is seeking ways to make services affordable for the very poor.

9. **Management.** MOH considers capacity building for better PHC management a top sector priority. There is a mixture of management and monitoring systems under various services, projects, and vertical programs, running independent of each other; this makes the organization of services cumbersome and inefficient. Most of the information on health sector performance comes from separate surveys and evaluations, and arrives too late for planning purposes. In addition to planning and budgeting, MOH has given priority to streamlining and integrating financial management, organizing and supervising services, and monitoring and evaluation.

10. **Financing.** Total 1997/98 health care financing from all sources in the country is estimated to be about \$11.50 per capita, which falls well short of the estimated \$15.00 per capita required to provide essential PHC alone. While Government financing of health care through direct subsidies has increased since the early 1990s in nominal terms, the effects of inflation have decreased the real purchasing power of these increases. In 1995, to end a chronic drug shortage in public facilities, the Government allowed the introduction of cost recovery in hospitals and user charges in health centers. It also endorsed revolving drug funds at the village level. At present, the Government spends about 3.2 percent of its budget on health services, mainly for salaries. Households contribute about \$6.70 per person per year, mostly for medicines; and aid sources contribute about \$3.50 per person per year. Within such a tight economy, the expansion of PHC needs to be planned very carefully. Most hospitals have managed to provide subsidized services for inpatient care for those who cannot afford it. At the same time, it has been difficult to find suitable arrangements to subsidize health care for the very poor attending health centers. MOH is therefore seeking alternative financing mechanisms in the sector to improve equity and funding, including improving current cost recovery and user fee systems, and testing risk pooling.

11. The World Health Organization and other funding agencies have been assisting with PHC capacity building, but much remains to be done in terms of policy development, system design, and dissemination. ADB is processing a project for PHC expansion⁸ that will support the development of PHC services, implementation of improved management systems, staff development, and financing studies. The Government has requested ADB as a lead agency in the sector to provide TA to strengthen the capacity of MOH to design and develop the PHC system. The Mission has informed the Government that approval and financing of the TA does not commit ADB to financing the PHC Expansion Project.

III. THE TECHNICAL ASSISTANCE

A. Objectives

12. The purpose of the TA is to build MOH capacity for PHC development, in particular to improve services for the poor and ethnic minorities. The TA will support MOH to (i) develop national plans for PHC development based on the PHC policy, (ii) build provincial capacity in

⁸ The proposed Primary Health Care Expansion Project is included in the year 2000 country program as a firm loan of \$20 million.

PHC planning and budgeting, (iii) develop management system designs, and (iv) develop health sector financing studies.

B. Scope

13. The TA supports four components to provide the planning and design inputs that will build MOH's capacity for PHC development, including for the proposed PHC Expansion Project.

14. **Plan for PHC Development.** This component will assist MOH to develop (i) the national strategic plan for PHC, (ii) the national investment plan for PHC, and (iii) guidelines for implementation of the PHC policy. These plans and guidelines are already under development and need to be improved.

15. **Build Provincial PHC Capacity.** The second component will assist MOH to (i) build planning, budgeting, management, and monitoring capacity in the provinces, (ii) develop provincial PHC coordination units, and (iii) help provincial health services to strengthen the annual planning and budgeting cycle using a rolling plan guided by five-year targets. The provinces will also be helped disseminate the PHC guidelines to the districts, and build up district capacity in PHC management.

16. **Design PHC Management Systems.** The third component will help MOH plan improved management systems. The plan will include (i) evaluation of the various management systems currently in use, (ii) selection and adaptation of the most suitable systems, and (iii) development of training programs to disseminate the product to the users. A participatory, consensus-building approach will be used with the stakeholders from vertical programs, projects, provincial health services, NGOs, and funding agencies. Identified priorities for system development are planning and budgeting, organizing services and supervision, financial management, and monitoring and evaluation.

17. **Design Financing Studies.** The fourth component will assist MOH to conduct an analysis and design three studies to test innovative strategies for health services financing. The studies will be implemented under the proposed PHC expansion project. The analysis will study the sources and expenditures of funds of health facilities and village health providers using available data and case studies. It will include current cost recovery and user fee practices, a preliminary analysis of affordability of services and willingness to pay, and options for providing subsidized services. The first study will be designed to rationalize and improve the efficiency of cost recovery in hospitals and health centers. A second study will be planned to improve and sustain revolving drug funds at the village level. The third study will explore risk pooling based on a provincial subscription system.

C. Cost Estimates and Financing Plan

18. The total cost of the TA is estimated at \$950,000 equivalent, of which \$800,000 equivalent will be financed by ADB, covering the entire foreign exchange cost of \$600,000 and \$200,000 equivalent of the local currency cost. The TA will be financed on a grant basis from the ADB funded TA program. ADB will finance consulting services, equipment, two vehicles, workshops, studies, and administrative and support services. The Government will contribute an estimated \$150,000 in kind for counterpart staff, office accommodation, office support, and workshops and meetings. The cost estimates and proposed financing plan are in Appendix 2.

D. Implementation Arrangements

19. MOH will be the Executing Agency for the TA. A steering committee chaired by the minister of health will provide overall policy guidance for the TA. A technical working group will be established for each component with membership from the Government, NGOs, aid agencies, and other representatives to provide technical advice. MOH will organize TA work and consultations, workshops, studies, and documentation for the consultants. The TA team will be located in the PHC Coordination and Rural Development Division of the Cabinet of MOH, and headed by the director of this division. Two fulltime counterpart staff will be assigned to work with the consultants. The office will have international telephone and Internet services.

20. The TA will require 26 person-months of international consulting services for a public health management and monitoring specialist (18 person-months), a strategic planning and budgeting specialist (3 person-months), and a health sector financing specialist (5 person-months). The consultants will be engaged as individual consultants, in accordance with ADB's *Guidelines on the Use of Consultants*. Outline terms of reference are in Appendix 3. Equipment including computers, software, printer, photocopier, and fax machine; and two utility vehicles will be procured for the TA in accordance with ADB's *Guidelines for Procurement under ADB Loans*, and will be provided to MOH on TA completion.

21. The director of the PHC Coordination and Rural Development Division will be responsible for organizing the participatory planning process for developing the provincial plans and budgets, building provincial capacity, developing management systems, and designing financial studies. The process for PHC development in general and specific management systems will be organized around a sequence of workshops at the provincial and national levels with representatives from MOH, provincial and district health services, communities and local aid agencies. Participants will work through a planning cycle involving (i) identification of needs, issues, constraints, and priorities; (ii) review of solutions and system design; and (iii) planning implementation and monitoring.

22. The TA will be implemented over 21 months and is expected to start in August 2000 and end in May 2002. The TA will be implemented in close consultation with a wide range of stakeholders, including provincial government staff, health institutions, NGOs, funding agencies, women's groups, private sector providers, and potential beneficiaries. The health management specialist will submit to ADB an inception report after one month, quarterly progress reports, a draft final report one month before the conclusion of the TA, and a final report within one month of completion of the work. The other two consultants will each submit an inception plan within two weeks of the start of their services, a midterm report, a draft final report two weeks before completion of services, and a final report within two weeks of completion of services. ADB staff will attend inception, midterm, and final tripartite meetings. All reports will be circulated to Government officials and stakeholders to encourage participation and obtain feedback to be incorporated in the reports. A final workshop with stakeholders will be organized at the time of the final tripartite meeting to plan for the next steps.

IV. THE PRESIDENT'S DECISION

23. The President, acting under the authority delegated by the Board, has approved the provision of the technical assistance, on a grant basis, to the Government of the Lao People's Democratic Republic in an amount not exceeding the equivalent of \$800,000, for the purpose of Capacity Building for Primary Health Care, and hereby reports such action to the Board.

TECHNICAL ASSISTANCE FRAMEWORK

Design Summary	Indicator/target	Monitoring Instrument	Risks/Assumptions
<p>A. Goal</p> <p>Improve the health status of the people in the Lao People's Democratic Republic (Lao PDR) based on equity, participation, and sustainability.</p> <p>B. Objectives</p> <p>Overall:</p> <p>Strengthen the capacity of the Ministry of Health (MOH) for primary health care (PHC) development, in particular, to improve services for the poor and ethnic minorities.</p> <p>Specific:</p> <p>1. Plan for PHC development.</p> <p>2. Build provincial capacity in PHC.</p>	<ul style="list-style-type: none"> - Infant, child, and maternal mortality rates, and crude birth rate are reduced by 10 percent overall and among the poor and ethnic minorities after five years. - Utilization of PHC increased by 40 percent, including for the poor, females, and ethnic minorities after five years. - Strategic plan, investment plan, and guidelines for implementation of PHC policy approved and disseminated within 12 months - PHC coordination units are proactive and effective. - Provincial health offices carry out annual planning, budgeting, and monitoring within 24 months. 	<p>Household survey</p> <p>Household survey</p> <p>Approval letter of MOH</p> <p>Provincial annual plans and quarterly reports</p>	<p>Natural disasters Economic crisis Policy change</p> <p>Project is approved Disaggregated data are available</p> <p>Acceptability to policy environment</p> <p>Provincial health services and programs support PHC coordination unit</p>

(Reference in text: page 1, para. 1)

Design Summary	Indicator/target	Monitoring Instrument	Risks/Assumptions
3. Design PHC management systems. 4. Design health sector financing studies.	<ul style="list-style-type: none"> - PHC management are standardized and operationalized within 12 months after start of work on a particular system. - PHC financing studies initiated within 12 months. 	Reports from programs, provinces, and funding agencies Project management office (PMO) report	Adequate capacity and funds available to implement guidelines Policy support for health sector financing reform
C. Outputs 1. For planning for PHC development including strategic plan, investment plan, and guidelines for PHC development 2. For building provincial capacity in PHC in planning and budgeting 3. For designing PHC management systems	<ul style="list-style-type: none"> - Stakeholders consulted - Strategic and investment plans and guidelines prepared within nine months - Provincial teams facilitated in planning, budgeting, management, and monitoring - 18 PHC coordination units established in six months - Five-year and annual plans prepared within 12 months - District training facilitated within 24 months - Existing practices reviewed within three months from start of work on a particular subsystem - Consensus reached in six months - Guidelines prepared in nine months - Implementation plans prepared within 12 months 	PMO report Field reports PMO report PMO report	Participation of MOH, nongovernment organizations (NGOs), and funding agencies to provide information and agree on strategic plan Suitable staff available with support from TA. Stakeholders reach consensus on guidelines.

Design Summary	Indicator/target	Monitoring Instrument	Risks/Assumptions
4. For designing health sector financing studies	<ul style="list-style-type: none"> - Financing analysis completed within three months from start of consulting services - Study designs completed within four months - Staff trained within five months 	PMO report	Feasible options to improve health sector financing for the poor can be identified.
Inputs			
1. For development of strategic plan	<ul style="list-style-type: none"> - International consultants:3+1 person-months - Workshops with programs by MOH - Literature review - Consultation with provinces 	PMO report	Domestic assistants are provided under the TA
2. For building provincial capacity in PHC planning and budgeting	<ul style="list-style-type: none"> - International consultants: 6+1 person-months - Provincial training - District training by provinces - Transport 	PMO report	Adequate education of staff to apply training
3. For developing PHC management systems	<ul style="list-style-type: none"> - International consultants: 8+1 person-months - Field visits and data collection - Consultation of programs with donors - Testing of instruments 	PMO report	Domestic assistants are provided under the TA
4. For designing health sector financing studies	<ul style="list-style-type: none"> - International consultants: 1+5 person-months - Field visits - Prepare domestic consultants - Prepare study instruments 	PMO report	Suitable international consultant is found.

COST ESTIMATES AND FINANCING PLAN
(\$'000)

Item	Foreign Exchange	Local Currency	Total Cost
A. Asian Development Bank Financing			
1. Consultants (International)			
a. Remuneration and Per Diem	405	0	405
b. Travel			
i. International	25	0	25
ii. Domestic	10	0	10
2. Equipment ^a	35	0	35
3. Vehicles	50	0	50
4. Workshops, Seminars, Studies	0	60	60
5. Miscellaneous Administration and Support Services			
a. Administrative Expenses	0	40	40
b. Domestic Assistants	0	50	50
c. Communications and Transport	0	20	20
6. Contingencies	75	30	105
Subtotal (A)	600	200	800
B. Government Financing			
1. Counterpart Staff and Allowances	0	70	70
2. Office Accommodation and Utilities	0	40	40
3. Secretarial and Office Support	0	20	20
4. Support for Field Studies	0	10	10
5. Workshops and Meetings	0	10	10
Subtotal (B)	0	150	150
Total	600	350	950

^a Includes audiovisual equipment, computers, software, printers, photocopier, and fax machine.
Source: Government and staff estimates.

OUTLINE TERMS OF REFERENCE

A. Health Management Specialist/Team Leader (18 person-months)

1. The consultant will be a public health management specialist with at least 10 years experience in developing management systems for the health sector, including for monitoring. The consultant will have regional experience and preferably speak Lao. The consultant will work in close coordination with Ministry of Health (MOH) staff, in particular the director of the Primary Health Care (PHC) Coordination and Rural Development Division, and have the following responsibilities:

- (i) plan, coordinate, and monitor the technical assistance (TA), and administrative and financial management of the TA inputs for the TA office;
- (ii) assist in the selection and guidance of the two short term consultants;
- (iii) plan PHC development, including strategic planning for PHC, the investment plan, and implementation guidelines for the PHC policy;
- (iv) design PHC coordination units and implement a training program for provincial capacity building in planning, budgeting, management, and monitoring; facilitate preparation of provincial annual and five-year plans and budgets for priority programs, projects, and services in the area;
- (v) analyze PHC management system designs; facilitate consensus building among stakeholders to select and improve the most suitable designs; adapt guidelines for the use of management systems; and prepare manuals for PHC management training for provincial, district, and services levels; and
- (vi) prepare written reports as specified in the TA paper.

B. Strategic Planning and Budgeting Specialist (3 person-months)

2. The strategic planning and budgeting specialist will have a management background with experience in strategic planning, budgeting, and developing institutional capacity for planning and budgeting, with at least 10 years experience in the health sector. The consultant will be responsible for

- (i) developing guidelines for the implementation of the national PHC policy, the preparation of a national strategic plan, and the investment plan for PHC;
- (ii) improving the design of the provincial planning and budget systems, and building provincial capacity for planning and budgeting;
- (iii) analyzing various management systems and building consensus among stakeholders to integrate management systems; and

- (iv) advising MOH on any other matter regarding PHC development as considered appropriate, in consultation with the Asian Development Bank (ADB); propose further TA work that could be undertaken; and prepare written reports as specified in the TA paper.

C. Health Sector Financing Specialist (5 person-months)

3. The consultant will be a health sector financing specialist or economist with at least 10 years experience in planning financing studies, and developing cost recovery and insurance systems, including in the region. The consultant will be responsible for the following:

- (i) Conduct a detailed analysis of sources and expenditures of funds of selective hospitals, health centers, and village health providers, to include allocative mechanisms, flow of funds, conditions, current cost recovery and user fee practices, and issues affecting affordability and willingness to pay.
- (ii) Provide advice and increasing understanding about possible benefits and risks of various health financing strategies, and facilitate study approval and support.
- (iii) Plan (i) a study to rationalize cost recovery in selective hospitals and health centers in one or two provinces, (ii) a study to improve the revolving drug fund at the village level in two provinces, and (iii) a study to test risk pooling based on a provincial subscription system. The three studies will include (i) a system and guidelines to set prices and adjust for inflation, (ii) arrangements to improve administrative efficiency and accountability, (iii) subsidy arrangements, (iv) training and institutional requirements, and (v) an evaluation plan to determine affordability and willingness to pay. The study designs will include instruments, methods, work plan, and analysis of data.
- (iv) Train central and provincial government staff to supervise and conduct the studies.
- (v) Make arrangements to supervise and monitor the studies and obtain feedback from MOH and ADB.
- (vi) Provide any other assistance and advice as may be reasonably expected within the scope of work, and prepare written reports as specified in the TA paper.