SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY: LAO PEOPLE’S DEMOCRATIC REPUBLIC

Country: Lao People’s Democratic Republic (Lao PDR)  
Project Title: Greater Mekong Subregion Health Security Project  
Lending/Financing Modality:  
Project Department/Division: Southeast Asia Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy
The National Growth and Poverty Eradication Strategy of the Government of the Lao PDR was approved in 2003 as the framework to develop and implement initiatives to end poverty and sustain national growth. Since then, the country has been moving towards a market-oriented economy and is one of the fastest growing economies in the GMS. The Lao PDR has achieved remarkable economic growth of about 7% of GDP annually since 2006 and an income per capita of about $1,600 by 2014. It has set a target of 7.5% growth up to 2020 to graduate from least developed country status. The Lao PDR’s growth helped lower the number of poor people to an estimated 23.2% of the population in 2012–2013, down from 33.5% in 2006. However, this rapid growth has been inequitable and has been accompanied by (i) relatively small reductions in poverty compared to other countries in the region because development has largely been urban-based and driven by foreign investment in small industries, and (ii) major migration. Based on the upcoming 8th National Socio-Economic Development Plan, 2016–2020, the government has set a modest target of reducing the poverty rate to 15% by 2020. ADB’s country partnership strategy, 2012–2016 for the Lao PDR is aligned with the government’s 7th National Socio-Economic Development Plan, 2011–2015, which aimed to (i) support sustainable economic growth and reduce poverty and inequality; and (ii) promote inclusion of women, ethnic groups, those living in remote areas, the private sector, nongovernment organizations, and development partners. The national strategies and ADB’s country partnership strategy align closely to project activities, as the project outputs aim to (i) improve regional cooperation and communicable disease control in border areas, (ii) strengthen national disease surveillance and outbreak response systems, and (iii) improve laboratory services and hospital infection prevention and control. These outputs especially target mobile populations, ethnic minorities, and other vulnerable groups as well as the poor.

B. Results from the Poverty and Social Analysis during PPTA or Due Diligence

1. Key poverty and social issues. About 70% of the population of the Lao PDR lives in rural areas and depends on agriculture and natural resources for survival. Farming is largely at the subsistence level, and productive conditions are generally poor. Poverty and extreme poverty are most common in mountain villages, where the majority of the country’s ethnic minority people live, particularly in the eastern districts bordering Viet Nam. In upland areas, the poverty rate is as high as 43%. Rural people especially suffer from communicable diseases that are easily treated or prevented, but even where services are available, many people do not use them because of the relatively high user fees. The project includes 12 border provinces out of a total of 18 provinces.

2. Beneficiaries. Most project beneficiaries are likely to be low-income agricultural and forest workers, migrants, and ethnic groups more vulnerable to the targeted communicable diseases, although the poorest groups are not explicitly targeted. The project will benefit the general public, as most project resources will be allocated to strengthening disease control and hospital services. A small part of the project targets high-risk groups, often but not always poor, with communicable disease control. Due to the high prices and perceived poor quality of public health services, these high-risk groups often resort to traditional medicine and self-medication. The project will specifically help improve coverage of migrants and MEVs, who (i) are more likely to be exposed to, and spread, different types of diseases and drug resistance, depending on their location and occupations; and (ii) generally have less access to health services.

3. Impact channels. The majority of project resources will be allocated to (i) timely disease outbreak reporting and response, which will contain the spread of outbreaks of infectious diseases and thus reduce disease impact on the poor; and (ii) strengthening health care in border areas, which will improve prevention and access to services for the poor and MEVs. Poor and vulnerable groups will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

4. Other social and poverty issues. Use of health services often results in financial hardships for patients and their relatives. A 2004 household survey found that 34% of the poorest quintile had sold assets, while 29% had borrowed cash from relatives, to pay for hospital bills.

5. Design features. The linkages between burden of disease and poverty and development are well known. The project addresses key poverty and social issues by (i) strengthening surveillance and outbreak response up to the village level, (ii) strengthening regional control strategies, (iii) increasing prevention and care for MEVs, and (iv) improving laboratory diagnostics and hospital infection control. Performance indicators will be monitored through evaluations of the regional disease control strategy, national surveillance and response monitoring system, laboratory and hospital quality control systems, and provincial health services and outreach statistics in targeted provinces.
II. PARTICIPATION AND EMPOWERING THE POOR

1. Participatory approaches and project activities. The project will assist the poor in the Lao PDR by better preparing doctors to treat illnesses of the poor. The doctors will be more capable to respond to the health concerns of the poor and vulnerable, particularly ethnic minority populations. Ensuring good health is a fundamental step in empowering the poor.

2. Civil society is required to report outbreaks. Civil society representatives in this project, who will usually be village health volunteers, will be engaged in community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, and refer patients for health services, and use mobile phones for reporting.

3. Civil society organizations. At the national level, ADB will support the country’s health needs in coordination with the government and other development partners, which may include international nongovernment organizations. ADB will share experiences and data on health issues with other stakeholders, as necessary, to enhance the health of the target population.

4. The following forms of civil society organization participation are envisaged during project implementation, rated as high (H), medium (M), low (L), or not applicable (NA): ☒ H Information gathering and sharing ☐ Consultation ☐ Collaboration ☐ Partnership

5. Participation plan. ☐ Yes. ☒ No. No participation plan will be prepared for the project because the project design (i) is based on extensive evidence of the health needs of the poor in the region, and (ii) addresses these needs through the training of doctors to respond to these issues.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: effective gender mainstreaming

A. Key issues. The project has been categorized as effective gender mainstreaming as it will directly improve access of women to health services. The patterns of infectious diseases differ substantially between women and men, because of differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and childcare. Multiple factors contribute to women’s access to and affordability of health services, including cultural perceptions, travel distance, potential safety risk, workload, and financial resources. Women are usually primary caregivers and responsible for the prevention, detection, and care of infectious diseases amongst family members. The Country Gender Assessment for Lao PDR notes that increased economic links with neighboring countries present a number of opportunities and risks. Reports indicate that young women and girls who are trafficked often end up in forced prostitution and domestic labor. The proportion of female staff working in the health sector is relatively high, but female health workers tend to be concentrated in the lower levels of the system and there is a shortage of female health staff in remote areas. Sufficient gender legislation is in place. The MOH has a central focal point for gender, but not at the provincial level. Implementation of gender action plans in previous health projects tended to be less than satisfactory as gender is not perceived as a major issue by the MOH. However, substantial capacity for gender-related support is available in mass organizations at the community level.

B. Key actions. Gender dimensions have been incorporated in the project documentation, including the scope and due diligence of the report and recommendation of the President, the design and monitoring framework, loan covenants, and the gender action plan. The project, based on general good practice for gender endorsed by the MOH, will enhance participation of women in all its activities: (i) project implementation plans and annual operational plans will address gender dimensions; (ii) the project will collect, analyze, and report gender-disaggregated data; and (iii) participation of female and male staff in training programs and scholarships will be equitable.

☒ Gender action plan ☐ Other actions or measures ☐ No action or measure

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement

1. Key impacts. No resettlement is involved in this project. Screening during the selection of health facilities to be refurbished will rule out proposed sites with land acquisition and resettlement impacts.

2. Strategy to address the impacts. No strategy required.

3. Plan or other Actions.

☒ Resettlement plan ☐ Resettlement framework ☐ Environmental and social management system arrangement ☐ No action

☒ Combined resettlement and indigenous peoples plan ☐ Combined resettlement framework and indigenous peoples planning framework ☒ Social impact matrix

B. Indigenous Peoples

Safeguard Category: ☒ A ☐ B ☐ C ☐ FI
1. **Key impacts.** The project is expected to have a positive impact and no negative impact on ethnic minorities in the proposed project areas given the type of project activities, including identifying disease outbreaks and major infections in ethnic minority communities, and linking them with better diagnostic health services. An ethnic group development plan has been prepared to help realize benefits for ethnic groups. Proposed interventions are not considered sensitive for ethnic minority groups. Ethnic groups will be able to access project benefits from the beginning, as they will be included in the planning process and jointly conduct activities with implementing agencies. Further, the project will be carried out in areas where many ethnic groups are located, allowing them to take advantage of interventions directly. Is broad community support triggered? Yes  No

2. **Strategy to address the impacts.** None.

3. **Plan or other actions.**

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<thead>
<tr>
<th>Plan or Other Actions</th>
<th>None</th>
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<tbody>
<tr>
<td>Indigenous peoples plan</td>
<td>Combined resettlement plan and indigenous peoples plan</td>
</tr>
<tr>
<td>Environmental and social management system arrangement</td>
<td>Combined resettlement framework and indigenous peoples planning framework</td>
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<tr>
<td>Social impact matrix</td>
<td>Indigenous peoples plan elements integrated in project with a summary</td>
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<td>No action</td>
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V. **ADDRESSING OTHER SOCIAL RISKS**

A. **Risks in the Labor Market**

1. Relevance of the project for the country’s or region’s or sector’s labor market, indicated as high (H), medium (M), and low or not significant (L).

<table>
<thead>
<tr>
<th>Risk</th>
<th>None</th>
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<tbody>
<tr>
<td>Unemployment</td>
<td>Underemployment</td>
</tr>
<tr>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>Retrenchment</td>
<td>L</td>
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<tr>
<td>Core labor standards</td>
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2. **Labor market impact.** There will be no substantial impact on the local labor market. There will be short-term employment benefits from avoiding and containing epidemics, such as in factories and schools, and in the tourism industry. There will be long-term health and labor standards benefits from improving education and health care of migrants.

B. **Affordability.** The project will not increase the price of health services, but increased availability of services may increase health spending by the poor. However, health interventions provided under current arrangements are usually free for public goods, and subsidized for the poor through the health equity funds. No payments are required for diagnosis and treatment associated with major communicable diseases. Increasing diagnostic facilities will also reduce travel time and costs. Subsidizing supplies will further reduce out-of-pocket spending. Selecting the most cost-effective diagnosis and treatment strategies will help promote financial sustainability.

C. **Communicable Diseases and Other Social Risks**

1. The impact of the following risks are rated as high (H), medium (M), low (L), or not applicable (NA): Communicable diseases, Human trafficking, Others (please specify)

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Rating</th>
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<tbody>
<tr>
<td>Communicable diseases</td>
<td>NA</td>
</tr>
<tr>
<td>Human trafficking</td>
<td>NA</td>
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<tr>
<td>Others</td>
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2. Risks to people in project area. Not applicable.

VI. **MONITORING AND EVALUATION**

1. **Targets and indicators.** Poverty and social targets and indicators overlap with overall targets and indicators, as described in the DMF. Baselines and targets will vary considerably by province and are yet to be established through the provincial planning process. The following gender and social development areas will be monitored: (i) surveillance and response for communicable diseases; (ii) laboratory quality and biosafety standards, monitored through annual assessments; and (iii) female and male participation in workshops, trainings, and other events, monitored through event reports. Targets and/or indicators for ethnic groups include sufficient ethnic group representation, mainstreaming of ethnic group issues, and training of ethnic group staff.

2. **Required human resources.** Village health group, hospital and health center staff; MOH and provincial health staff; gender and social safeguards experts; laboratory and biosafety experts; will monitor the poverty and social impact of the project. A consulting firm will be hired to carry out project baseline, mid-term and end-line surveys.

3. **Information in the project administration manual.** The project administration manual describes the project performance management system, including the DMF, quarterly and annual reports, midterm review, project completion report, and independent evaluation and audit.

4. **Monitoring tools.** The monitoring tools will include health service statistics, project reports, DMF indicators reports, and GAP monitoring report.

ADB = Asian Development Bank; DMF = design and monitoring framework; GDP = gross domestic product; Lao PDR = Lao People’s Democratic Republic; MDG = Millennium Development Goal; MEVs = mobile populations, ethnic minorities, and other vulnerable groups; MOH = Ministry of Health; PPTA = project preparatory technical assistance.

Sources: