Initial Poverty and Social Analysis

Project Number: 56095-001
November 2022

Thailand: Medical Excellence Centers Project

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 1 September 2022)

Currency unit	–	baht (B)
B1.00	=	$0.02734
$1.00	=	B36.5740

ABBREVIATIONS

ADB	–	Asian Development Bank
CSO	–	civil society organization
MEC	–	medical excellence center
MMR	–	Maternal mortality rate
MOPH	–	Ministry of Public Health
NA	–	not applicable
NHSO	–	National Health Security Office
OOP	–	out-of-pocket payment
TA	–	technical assistance
UCS	–	Universal Coverage Scheme
VHV	–	village health volunteers

NOTES

In this report, "$" refers to United States dollars.

INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	Kingdom of Thailand	Project Title:	Medical Excellence Centers Project
Lending/Financing Modality:	Project	Department/ Division	Southeast Asia Department, Human and Social Development Division

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

A. Links to the National Poverty Reduction Strategy and Country Partnership Strategy

The project will contribute to sustaining the reduction in the share of OOP to total health expenditure from 34.90% in 2000, 14.50% in 2010, to 8.67% in 2019, which has been made possible by the UCS and its contracting of government hospitals. This reduction of the share of OOP has decreased impoverishing heath expenditures in Thailand, with the proportion of population spending more than 10% of household consumption or income on OOP health care expenditure down to 2% in 2019, and those spending more than 25% of household consumption or income for OOP at less than 1%. It will help prevent people getting into poverty due to health care costs. It will also help poor and vulnerable population groups access hospital services of limited availability such as cancer and cardiac care. It is aligned with objective 1 of ADB's country partnership strategy with Thailand by helping men and women access innovative health services, and partly with objective 2 by helping expand hospital services to both Thai and non-Thai population in the catchment provinces of the five hospitals. It is also aligned with the objective of the government's National Strategy for 2018–2037 and the draft 13th National Economic and Social Development Plan (Plan 13) of a modern public health system which will help sustain universal health coverage in Thailand.

B. Poverty Targeting

☒General Intervention ☐Individual or Household (TI-H) ☐Geographic (TI-G) ☐Non-Income MDGs (TI-M1, M2, etc.)

The project will finance enhancing the capacity of five UCS-contracted government hospitals provide cancer, cardiac, surgical, and other hospital services through the establishment of MECs. With coverage of the poor and other informal population in the UCS fully financed by the government, these new MECs will expand access by the poor to hospital services which are usually of limited availability.

C. Poverty and Social Analysis

1. **Key issues and potential beneficiaries**. The expected beneficiaries are primarily the UCS members in the zones and provinces of the five hospitals, and the UCS members in the other provinces. The UCS covers about 76% of the population with all low-income groups and workers in the informal sector covered. The UCS members are eligible to access private and public ambulatory services, inpatient care, maternity benefits, annual physical check-ups, and disease prevention in UCS-contracted hospitals.
2. **Impact channels and expected systemic changes**. The project will improve geographic access to cancer, cardiac, surgical, and other health services to poor and vulnerable populations living in the provinces and health zones where the five hospitals are located.
3. **Focus of (and resources allocated in) the transaction TA or due diligence**. The due diligence will identify potential barriers that constrain access of the poor to MECs services that the project will finance.

II. GENDER AND DEVELOPMENT

1. What are the key gender issues in the sector and/or subsector that are likely to be relevant to this project or program?
Health status. Breast and cervical cancers are among the top five cancers in the country. More women than men are obese and physical activity is lower among girls, both presenting a higher risk for noncommunicable diseases. While overall MMR is low at 37 per 100 livebirths, MMR remains high at 59.4 in the southern provinces of Thai Muslims.[a] Non-Thai speaking households (Thai minorities and migrant peoples, 43% of whom are women)[b] have 94% higher probability of having an unmet need for family planning than a household with a Thai-speaking head. A mother's educational level impacts on her access to family planning, antenatal care, and freedom from domestic violence; and her children's access to vaccination, and risk of stunting, underweight, and wasting. Thailand has the highest suicide rate in Southeast Asia, with 59% of those found suffering are women, and 22% depressed adolescents at risk of committing suicide. About 1 in 4 women experience intimate partner violence, with higher proportion occurring in the North and Central regions.[c] Thailand, the second most aged nation in Southeast Asia has 10.7 million older persons as of 2015, comprising 16% of the population, 55% of whom are women. Homebound and bedridden elderly are increasing while family support, income, and access to quality long-term care services and facilities are decreasing.
Sex-job stereotyping. Women comprise fewer than half of all doctors and over 9 in every 10 nurses, less than third of managers, and spend two times more than men in unpaid household and care work. Village health volunteers (75% women) who are mostly retired or elderly, are recognized as the unsung heroes of the pandemic, but are considered essentially unpaid workers, with a very minimal pay of B1,000–B1,500 a month despite the multiple roles they play in

delivering various primary health services, engaging in social work and providing health trainings, physical and psychological consultations, routine disease monitoring and screening.

Hospital infrastructure. The inability to access health facilities negatively impacts one's health status. Poor access to health services stems usually from remoteness of health facilities and lack of safe and inclusive environment to meet the patients' needs in the facilities, such as lack of privacy, hygiene, and safety for women,[d] especially women with disabilities, elderly, transgender, and minority and migrant women.

Gender mainstreaming. Gender budgeting, collection of sex-disaggregated data, and the designation of Chief Gender Equality Officer and Gender Focal Points across ministries to promote gender equality is institutionalized in the laws. However, these mechanisms are not fully utilized due to a limited understanding on how these should be implemented and used for policy and program development.[e]

2. Does the proposed project or program have the potential to contribute to the promotion of gender equity and/or empowerment of women by providing women access to and use of opportunities, services, resources, assets, and participation in decision-making? ☒ Yes ☐ No

The project contributes directly to addressing gender and social inclusion gaps in the health sector including through the following key measures: (i) diseases which especially affect women (such as breast and cervical cancer) and health issues that are heavily influenced by gender, such as mental health, reproductive and sexual health, gender-based violence, and elderly care, are targeted for support, taking into account intersecting factors that increase vulnerability to these health issues; (ii) capacity-building to address gender-job stereotyping and increased women's participation in the health sector will also be done, such as training female medical staff to enhance their career opportunities and capacity building requirements for the new MECs and digitalization; (iii) hospital infrastructure design will take into account the distinct needs of elderly, disabled, transgender, minority and migrant women and girls. These physical design features include separate spaces to ensure privacy, hygiene, and safety of patients, visitors, and hospital staff; (iv) capacity-building of project stakeholders will also be done to strengthen gender mainstreaming in the sector, including the effective use of the gender budget, and collection and analysis of sex-disaggregated and gender data to inform design, planning, implementation and evaluation of health projects; and (v) other innovative measures to address the identified gender issues will be explored and applied where relevant in the project.

3. Could the proposed project have an adverse impact on women and/or girls or widen gender inequality?
☐ Yes ☒ No

4. Indicate the intended gender mainstreaming category:
☐ GEN (gender equity) ☒ EGM (effective gender mainstreaming)
☐ SGE (some gender elements) ☐ NGE (no gender elements)

III. PARTICIPATION AND EMPOWERING THE POOR

1. Who are the main stakeholders of the project, including beneficiaries and affected people?

Stakeholders include the MOPH and the provincial government who jointly oversee the hospitals. At the hospital level, the hospital director has decision-making capacity and responsibility to carry out the hospital operations within the perimeter of the laws applicable to public institutions such as the fiscal budget management regulations, procurement regulations, or civil service regulations. The MOPH and hospital directors are part of the working group organized to finalize the project design. The NHSO who manages the UCS ensures that its member particularly the poor are appropriately provided with UCS-covered health services will be consulted to ensure UCS financing coverage of the services. The MOPH will be advised to document consultations with local citizens particularly the VHV on their views on the project.

2. Who are the key, active, and relevant CSOs in the project area?

Patients' groups, health worker associations, disability associations, and VHVs will be the relevant CSOs.

3. Are there issues during project design for which participation of the poor and vulnerable is important?

☒ Yes ☐ No If yes, what are these issues? Ensuring that the design of the MECs will be consistent with the established referral system in the province and district, and that access by UCS members to these new MECs services are assured.

4. How will the project ensure the participation of beneficiaries and affected people, particularly the poor and vulnerable and/or CSOs, during project design to address these issues?

Consultations with the NHSO, hospital workers and their respective associations, VHVs, patients' groups, and organizations of people living with disabilities will be conducted. Social development resource persons will be contracted to support the consultations that will be conducted in the five provinces.

5. What level of CSO participation is planned during the project design?

M Information generation and sharing M Consultation NA Collaboration NA Partnership

Patients groups and VHVs will be contacted during project design. Other CSOs particularly those involved in women's health, migrant health, and climate change, and health will be consulted as well.

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C ☐ FI

1. Does the project have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☐ Yes ☒ No
2. What action plan is required to address involuntary resettlement as part of the transaction TA or due diligence process?

☐ Resettlement plan ☐ Resettlement framework ☐ Social impact matrix
☐ Environmental and social management system arrangement ☒ None

B. Indigenous Peoples Category ☐ A ☒ B ☐ C ☐ FI

1. Does the proposed project have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☐ Yes ☒ No
2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No

Indigenous peoples are likely to live in remote and rural areas, where the project intends to upgrade and construct MECs. There are no expected negative impacts on indigenous people; rather, they will be able to access health care services more easily with the construction of MECs.

3. Will the project require broad community support of affected indigenous communities? ☐ Yes ☒ No MECs may be located in rural areas and as such, broad community support will be sought during due diligence, possibly through CSO consultations.
4. What action plan is required to address risks to indigenous peoples as part of the transaction TA or due diligence process?

☒ Indigenous peoples plan ☐ Indigenous peoples planning framework ☐ Social impact matrix
☐ Environmental and social management system arrangement ☐ None

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the project design?

☒ Creating decent jobs and employment NA Adhering to core labor standards NA Labor retrenchment
☒ Spread of communicable diseases, including HIV/AIDS NA Increase in human trafficking ☒ Affordability
NA Increase in unplanned migration NA Increase in vulnerability to natural disasters NA Creating political instability
NA Creating internal social conflicts ☐ Others, please specify _____

The project will have positive impacts to decrease spread of communicable diseases, decreasing vulnerability to natural disasters, improved access to affordable hospital services, and creating decent hospital jobs and employment.

2. How are these additional social issues and risks going to be addressed in the project design? The positive impacts will be maximized during project design

VI. TRANSACTION TA OR DUE DILIGENCE RESOURCE REQUIREMENT

1. Do the terms of reference for the transaction TA (or other due diligence) contain key information needed to be gathered during transaction TA or due diligence process to better analyze (i) poverty and social impact, (ii) gender impact, (iii) participation dimensions, (iv) social safeguards, and (v) other social risks? Are the relevant specialists identified?

☒ Yes ☐ No

2. What resources (e.g., consultants, survey budget, and workshop) are allocated for conducting poverty, social, and/or gender analysis; and the participation plan during the transaction TA or due diligence? Consultants

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[a] M. Adulyarat et al. 2016. Culturally-sensitive Maternity Care Needs of Muslim Mothers in a Rural Community of the Southernmost Province in Thailand. *Pacific Rim International Journal of Nursing Research*. 20 (4). pp. 350–363.
[b] UN Women Asia and the Pacific. Thailand.
[c] Green Climate Fund. 2021. *Country Gender Assessment*. Seoul.
[d] United Nations Office for Project Services. 2020. *Infrastructure for Gender Equality and the Empowerment of Women*. Copenhagen.
[e] Organisation for Economic Co-operation and Development. 2021. *Thailand: Gender Budgeting Action Plan*.
Source: Asian Development Bank.