ADB

Technical Assistance

TAR: LAO 32313

Technical Assistance to the Lao People's Democratic Republic for Preparing the Health Sector Development Program (Financed by the Japan Special Fund)

July 2005

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 14 June 2005)

Currency Unit	–	kip (KN)
KN1.00	=	$0.0000936768
$1.00	=	KN10,675

ABBREVIATIONS

ADB	–	Asian Development Bank
BTC	–	Belgian Technical Cooperation
HIV/AIDS	–	human immunodeficiency virus/acquired immunodeficiency syndrome
HRD	–	human resource development
LAO PDR	–	Lao People's Democratic Republic
MDG	–	millennium development goal
MOH	–	Ministry of Health
NGPES	–	National Growth and Poverty Eradication Strategy
PHC	–	primary health care
TA	–	technical assistance

TECHNICAL ASSISTANCE CLASSIFICATION

Targeting Classification	–	Poverty intervention
Sector	–	Health, nutrition, and social protection
Subsector	–	Health systems
Theme	–	Gender and development
Subthemes	–	Gender equity in capabilities

NOTES

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

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I. INTRODUCTION

1. The Government of the Lao People's Democratic Republic (Lao PDR) gives high priority to the health sector, as reflected in the National Growth and Poverty Eradication Strategy (NGPES).[1] It is committed to make affordable, quality health care available so as to improve the health and nutrition status of its citizens and achieve the millennium development goals (MDGs) by 2015. The Ministry of Health (MOH) and the Asian Development Bank (ADB) have developed a strong relationship in the health sector. ADB has supported primary health care (PHC) development in eight northern provinces, and institutional strengthening and policy development for PHC nationwide.[2] It also supported MOH in community action for the prevention of HIV/AIDS,[3] and plans to provide further support for regional communicable diseases control.[4] With a better health infrastructure in place, the Government has requested ADB to help address structural and system issues in the health sector so as to improve the quality and affordability of PHC. As per ADB's Country Strategy and Program, a Health Sector Development Program (the Program) is scheduled for 2007, with program preparatory technical assistance (TA) in 2005.[5]

2. The TA Fact-Finding Mission visited the Lao PDR in January 2005 and met with representatives of the ministries of health, education, labor, and finance; and several aid agencies. The minister of health and the Mission signed a memorandum of understanding regarding the proposed TA on 21 January 2005. The design and monitoring framework is in Appendix 1.

II. ISSUES

3. The Lao PDR is one of the least developed countries in the region with an estimated per capita income of $340 in 2004, and three quarters of its population living on less than $2 per day. Under the New Economic Mechanism introduced in 1986, the Government initiated the transition from a centrally planned to a market-oriented economy. The gross domestic product increased by 6.0% in 2004. Poverty declined from 46% to 33% between 1992/93 and 2002/03, although poverty in the uplands is still high at 43% compared with 28% in the lowlands. Income and urban-rural disparities have been widening since the economic reforms.

4. The Government is committed to achieving macroeconomic stability and sustainable growth with equity by improving governance.[6] The NGPES provides the overarching policy framework for poverty reduction and economic growth.[7] It singles out four priority sectors including health.[8] The public expenditure management strengthening program provides the framework for improving financial management. The Government is preparing a new economic reform program and aid coordination mechanism. National working groups with broad representation are working on sector development priorities and a wide range of studies.

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1 Government of Lao PDR. 2004. *National Growth and Poverty Eradication Strategy.* Vientiane.

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

3 ADB. 2001. *Grant Assistance to the Kingdom of Cambodia, Lao People's Democratic Republic, and Socialist Republic of Viet Nam for Community Action for the Prevention of HIV/AIDS*. ($1.6 million for Lao PDR). Manila.

4 ADB. 2004. *Regional Technical Assistance to the Governments of Cambodia, Lao PDR, and the Socialist Republic of Viet Nam for the Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila.

5 The TA first appeared in *ADB Business Opportunities* (Internet addition) on 24 January 2005.

6 Government of Lao PDR. 2003. *Priority Areas for Governance Reform: A Policy Paper of the Government of Lao PDR on Governance Issues.* Vientiane.

7 The Nam Theun 2 Hydropower Development Phase II Project provides an example of making economic growth pro-poor.

8 World Bank. 2005. *First Poverty Reduction Operation*. Washington, DC: World Bank. This is a 3-year policy reform program. The first tranche aims at ensuring efficient management of public sector resources. The second tranche will also support alignment of public social sector expenditures, while the third tranche will support enhancing the environment for growth and revenue generation.

5. MOH has developed a poverty-focused health development plan for 2005–2010 within the general framework of the NGPES, Health Sector Strategy 2020, and the Health Sector Master Plan prepared with the assistance of the Government of Japan. MOH, as per PHC policy, aims to achieve health for all by providing all citizens access to PHC.

6. MDGs for the health sector show a positive trend, but at a slower pace than projected.[9] Child mortality rate declined dramatically from 170 to 100 per 1,000 live births between 1990 and 2005, compared with the target of 55 per 1,000 live births by 2015; the proportion of underweight children below the age of five, estimated at 40% in 1990, is still above 30% in 2005 compared with the target of 20% by 2015;[10] and maternal mortality ratio dropped from 750 to about 500 per 100,000 live births between 1990 and 2005, compared with the target of 175 per 100,000 live births. The Lao PDR is surrounded by countries with generalized HIV/AIDS epidemics. Social changes and increased connectivity are accelerating the spread of HIV/AIDS in high-risk groups.

7. Current utilization of the public health system is low due to both demand and supply problems. Nationwide, only about 40% of children are immunized in time, and less than one third of couples use modern contraceptives. Use of basic curative care has doubled to 80% in 10 years, but preventive and reproductive health services have stalled.

8. Achieving health MDGs will, to a large extent, depend on providing the poor access to quality PHC. In the Lao PDR, this will require targeting women and children, ethnic minorities, and very poor communities; and addressing community, services, and institutional factors causing poor supply and demand. Reproductive health and nutrition interventions are underdeveloped in the Lao PDR.[11] Rural conditions and beliefs and customs pose major challenges for service delivery and malnutrition.

9. Although public health spending accounts for 8.7% of the public sector budget, it is small due to low government revenue. The central and provincial governments and social security institutions finance about 20% of public health services, aid agencies 30%, and users 50%. The health sector, including the private sector accounts for 3.1% of the gross domestic product, compared with 5.1% in Viet Nam, 11.8% in Cambodia, and around 7% globally. Per capita spending on health care is about $11 per person per year, and for the poor it is about $5 per person per year compared with the global minimum standard of $34 per person per year.

10. The PHC Expansion Project helped develop a network of PHC services from village to hospital (footnote 2). Although physical access is still below international standards, staff and recurrent budget constraints make it difficult to expand the network further and improve its quality. Equally important to achieving MDGs will be the integration of vertical programs and provincial services. Improving health services will also require addressing affordability and quality of services, and related management and financing problems. MOH has identified five priority areas for further analysis and support: (i) human resource development (HRD); (ii) health financing; (iii) planning and budgeting; (iv) PHC management, monitoring, and service delivery; and (v) community-based health and nutrition promotion.

11. MOH gives high priority to HRD to improve the quality and impact of health services. One third of district hospitals lack a doctor, and only 6% of medical students are from ethnic minorities. There is a general shortage of paramedics in rural health facilities. Training of ethnic

[9] MDGs are standard global targets and are ambitious for the Lao PDR, with its difficult terrain, high level of poverty, and large ethnic minority population. Achieving projections based on current trends would require intensification of efforts, as further improvement of indicators will become relatively more difficult.
[10] Contributing factors are low birth weight, low calorie intake, poor diet, illnesses, and inappropriate child care.
[11] The total fertility rate was reduced from 5.6 to 4.0 children per woman of reproductive age from 1990 to 2005.

minority students helped provide staff for rural areas; and training of volunteers with drug revolving funds helped bring basic care to remote villages.[12] MOH is preparing a comprehensive HRD plan including medical curriculum reforms, a postgraduate program for district hospital doctors, new paramedic cadres, and upgrading of volunteer village health workers.

12. The Government is exploring ways of improving health financing, while at the same time making it more affordable to the poor. Decree 52 introduced formal cost recovery for the purchase of medicines and services in 1995. However, the very poor can ill afford the services. Exemption systems for the poor don't work very well. MOH is considering a range of options such as abolishing the 20% tax on patients' fees.[13]

13. Planning and budgeting practices have improved in the past decade. Investment spending has declined from 60% to 35% and recurrent expenditures, though still low, have improved. However, planning and budgeting remain fragmented, and there is a general paucity of information. Provincial autonomy needs to be balanced better with national policies. Inefficiencies in cash management cause late payment of salaries and delays in procurement. Low pay and lack of incentives are constraints to attracting personnel. The Government is preparing a medium-term expenditure framework to redirect resources toward a more balanced expenditure pattern based on government goals and policies.

14. The Government gives high priority to health and nutrition promotion. It has successfully promoted a range of public priorities, and wants to expand further. However, current health education activities in MOH are fragmented. The central technical unit supported by the Government of Japan has good products and also works for the private sector. With ADB support, MOH started a large-scale peer education program in the northern provinces and has expanded HIV/AIDS education (footnote 3). There is a need for a long-term strategy and plan to guide expansion.

15. Aid coordination is satisfactory. The Japan International Cooperation Agency provides support for aid coordination, HRD, and child care. The Belgian Technical Cooperation (BTC) supports the development of a district health system. The World Bank is planning support for structural reforms, while its Health Services Improvement Project will be targeting the southern provinces.

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

16. The overall goal of the ensuing Program is to contribute to improving the health of the poor to achieve the MDGs of reducing maternal and child mortality, and malnutrition. The Project aims to improve health sector performance by making quality PHC available, in particular for the poor, women, children, and ethnic minorities in rural areas. Three types of support are envisaged in close collaboration with other agencies: (i) structural and policy reforms to improve the functioning of the health sector, in particular for pro-poor PHC; (ii) directly strengthening PHC in eight northern provinces, in particular in HRD, health and nutrition

[12] Under the current PHC Expansion Project, ethnic minority students are provided with general and vocational education to work in rural health centers near their home. PHC access may be further improved through village volunteers, currently the second most frequently used source of health care.

[13] In 1999, the Ministry of Labor introduced social security for companies with at least 10 employees. The Government, with the assistance of the International Labour Organization, is reviewing the health insurance scheme for civil servants, which is currently based on co-payment. The Belgian Technical Cooperation is assisting the Social Security Organization in strengthening its management of the health insurance scheme. The Government and the World Health Organization (WHO) have explored a community-based health insurance system. Under the PHC Expansion Project, various financing studies have been undertaken.

education, and PHC planning, budgeting, and delivery; and (iii) capacity building of MOH. The Program could be in the form of a 5-year sector development program (SDP) including program and project financing. The initial poverty and social analysis is in Appendix 2.

17. The TA will help (i) assess issues and opportunities for health system development; (ii) conduct a participatory planning process to set priorities in policy reform, capacity building and investment; and (iii) prepare a program proposal and implementation memorandum for possible ADB assistance. Following the existing policy framework and programs, the TA will focus on five areas: HRD, health financing, planning and budgeting, PHC service delivery, and health and nutrition promotion.

B. Methodology and Key Activities

18. MOH will establish three task forces to carry out a review of policy reforms, capacity building, and investment needs in the five priority areas. The TA will support these task forces for a 6-month period. Each task force will consist of central and provincial government staff, consultants, and representatives of aid agencies. The task forces will consult public and private stakeholders using existing working groups, workshops, and study tours in the region.

19. The first task force on HRD will be established in the Department of Human Resources and work with the Cabinet and the Curative Department, HRD institutions, and aid agencies. The task force will review health staff performance using focus group discussion and studies, identify key issues affecting the quality and range of care, and propose options for addressing these. It will model future staff requirements using software, examine technical and financial capacity constraints, and help develop the long-term strategic plan for HRD and a medium-term implementation plan for HRD including capacity building for MOH.

20. The second task force will be established in the Department of Planning and Finance. The task force will examine health financing; affordability of services; and provincial planning, budgeting, and financial management. It will review sources and uses of funds in the sector, identify affordability problems based on local and international studies and consultations, and propose options to improve health financing. In particular, it will examine options for expanding insurance systems and free health care coverage for the very poor. It will work closely with the Social Security Organization and the Budget Department of the Ministry of Labor, the Health Committee in the Social Security Organization, the Budget Department of the Ministry of Finance, and aid agencies. A financial management assessment will be done based on the public expenditure management strengthening program, ADB's *Guidelines for the Financial Governance and Management of Investment Projects*, and related tools.

21. The third task force covering PHC service delivery and health and nutrition education will be established in the Cabinet, and work with the curative and hygiene and prevention departments and aid agencies. It will examine roles and responsibilities in the provincial health system, integration of provincial services and vertical programs, and management of provincial health services so as to improve the use and quality of services and strengthen community-services interactions. It will also examine ways of strengthening community participation and promotion of health and nutrition, working closely with citizens' organizations.

22. The task forces will submit successive reports to the MOH steering committee and partners, including workplans, subsector updates, stakeholder consultation reports, strategic plans, and implementation plans.

C. Cost and Financing

23. The total cost of the TA is estimated at $875,000 equivalent including $555,000 in foreign exchange and $320,000 equivalent in local currency. ADB will finance $700,000 including the entire foreign exchange and $145,000 equivalent in local currency. The TA will be financed on a grant basis by the Japan Special Fund, funded by the Government of Japan. The Government of the Lao PDR will provide $175,000 equivalent through in-kind contributions for counterpart staff, workshops, and office facilities. The cost and financing plan are in Appendix 3. The Government was informed that TA approval does not commit ADB to finance any ensuing Program.

D. Implementation Arrangements

24. MOH will be the Executing Agency for the TA. The MOH steering committee, chaired by the minister of health, will review progress and direct the task forces at least once a month. MOH directors (HRD, Cabinet, Hygiene and Prevention, and Planning and Finance) will guide the task forces on a weekly basis. The Director of the Planning and Finance Department will arrange monthly meetings among task forces to share progress and coordinate activities. Representatives of other departments and aid agencies will be invited. The project management office of the PHC Expansion Project will serve as the TA implementation office. MOH will appoint a part-time project director and a full-time deputy director for the TA. Each concerned department will nominate a focal person to coordinate with the office. A participatory planning process will be followed for planning the program scope and implementation arrangements.

25. ADB will support 24 person-months of international consulting services (person-months are in parentheses), including a team leader/health policy expert (6), a HRD expert (5), a health financing expert (3), a health economist (3), a health system expert (5), and a health education expert (2). ADB will also support 28 person-months of domestic consulting services, including a project manager/financial management expert (6), a HRD expert (5), a financing expert (5), a public health expert (5), a health education expert (3), and a sociologist (4). ADB will engage the consultants as a firm using the simplified technical proposal procedure in accordance with its *Guidelines on the Use of Consultants*, and other arrangements satisfactory to ADB for engaging domestic consultants. The quality- and cost-based selection method will be used. International and domestic consultants will work together with counterparts to perform the services. The outline terms of reference for consultants are in Appendix 4. Under the TA, MOH will procure equipment and a vehicle in accordance with ADB's *Guidelines for Procurement*, and will be retained by them on completion of the TA.

26. The consulting firm will submit an inception report after 1 month of TA work, including progress in establishing the task forces. Sector analysis, based on sector updates of the task forces, will be submitted at midterm, along with a program concept. The draft final report will be submitted after 5 months, and a final report and implementation memorandum on completion of the TA. The TA will begin in September 2005 and be completed by March 2006.

IV. THE PRESIDENT'S DECISION

27. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of $700,000 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/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
Impacts			**Risks**
Reduce child mortality, in particular among the poor and ethnic minorities in the northern provinces	From 100 to 75 per 1,000 live births overall, and 120 to 90 per 1,000 live births for poor ethnic minorities in 5 years	Household survey	• Major epidemics • Crop failure
Reduce maternal mortality ratio in the northern provinces	From 500 to 350 per 100,000 live births in 5 years		
Reduce the proportion of underweight children below 5 years of age	From 30% to 25% of children below 5 years of age in 5 years		
Outcomes			**Assumptions**
1. Improved use of health services, in particular by women, the poor, and ethnic minorities	Use of health services doubled for poor women and children, and ethnic minorities groups	Household survey	• Social barriers of health services, in particular for ethnic minorities, can be overcome.
2. Improved coverage of essential interventions such as immunization and use of reproductive health services	Use of immunization services increased from 55% to 85%, use of modern contraceptives increased from 30% to 40%		• People accept preventive measures.
3. Improved personal practices to prevent and care for common infections and malnutrition	Use of oral rehydration fluids, and timely referral in case of diarrhea improved by 20% in targeted communities		• People can be reached and can afford preventive measures.
4. Reduced expenses for health services by the poor	Payment for basic health care by the poor reduced by 20%		• Subsidies reach the poor.
Outputs			**Assumptions**
1. Access to paramedics and volunteer workers, in particular female staff and persons from ethnic minorities	Number of paramedics and volunteer workers available in rural areas, including female staff and persons from ethnic minorities	Health services survey	• The Government can afford employing more paramedics and subsidizing the poor.
2. Affordable public health services for the poor	Adherence to approved fee structure for cost recovery with equity fund for the poor	Health services survey	• Sufficient ethnic minority candidates can be identified.
3. Better quality of primary health care	Staff skills, use of drugs, quality of management	Health services survey and management study	• Adequate recurrent budget is available.
4. Improved integration of PHC and programs	Provision of services of vertical program in health centers	Health services survey	• There is political will to integrate PHC and vertical programs.
5. Intensified health and nutrition promotion in ethnic minority groups	Range, quality, and reach of promotion activities	Health promotion study	• Behavioral change communication is effective.

TA Activities with Milestones	Inputs
1. Based on the existing policy framework and programs, MOH establishes three task forces to assess issues and opportunities for health system development before TA signing: 1.1 Task force 1: HRD, in particular for women, ethnic minorities, paramedics and volunteers 1.2 Task force 2: Health financing, planning and budgeting to make basic services available and more affordable to the poor 1.3 Task force 3: Integrating and strengthening PHC service delivery and promoting health and nutrition, in particular for women, children, ethnic minorities, and the poor in general. 2. Task forces, supported by consultants and counterparts, prepare a detailed inception report, submitted in the first month of the TA. 3. Task forces review and analyze subsectors to update progress, and identify issues and opportunities. A situation analysis will be submitted in the second month of the TA. 4. Task forces conduct workshops, field visits, and other activities to identify priorities for policy reform, capacity building, and services development in the northern provinces in the third month of the TA. 5. Task forces update strategic plans for the sector, including policy reforms, capacity building, and PHC service delivery in the northern provinces in the fourth month of the TA. 6. Task forces prepare a program outline for policy reform, capacity building, PHC service delivery, aid coordination, and program management in the fourth month of the TA. 7. Task forces confirm the proposed program scope and implementation arrangements, carry out more detailed planning for the program implementation memorandum, and complete the draft project proposal in the fifth month of the TA. 8. The team leader, financial management expert, and counterpart staff incorporate comments and finalize the program proposal and program implementation memorandum in the sixth month of the TA.	• ADB funding: $700,000 • Government funding: $175,000

ADB = Asian Development Bank, HRD = human resources development, Lao PDR = Lao People's Democratic Republic, MOH = Ministry of Health, PHC = primary health care, TA = technical assistance.

INITIAL POVERTY AND SOCIAL ANALYSIS

A. Linkages to the Country Poverty Analysis

Is the sector identified as a national priority in country poverty analysis? ☒ Yes ☐ No	**Is the sector identified as a national priority in country poverty partnership agreement?** ☒ Yes ☐ No

Contribution of the sector or subsector to reduce poverty in the Lao People's Democratic Republic: The health sector plays a major role in poverty reduction due to the high burden of diseases, major impact on productivity, high level of poverty requiring government intervention to make services available and affordable, and income erosion due to poor quality of care.

B. Poverty Analysis

Targeting Classification: Poverty Intervention

What type of poverty analysis is needed? The Program will aim to direct the health system toward improving benefits for the poor and vulnerable, including women, ethnic minorities, and other groups. The technical assistance (TA) will analyze human resources development, health financing, planning and budgeting, primary health care system development, and health and nutrition education; and propose policy reforms, capacity building, and investments. The purpose is to provide pro-poor health services that are more accessible, affordable, and acceptable; of adequate quality; and more sustainable. The analysis will include an assessment of physical, social, and financial access to health services, whether health services management is pro-poor and pro-gender, opportunities for women and ethnic minorities, and specific issues for vulnerable groups. The analysis will also look at the effects of the high cost of health care on the poor, and assess the potential benefits and constraints of the Program for the poor.

C. Participation Process

Is there a stakeholder analysis? ☒ Yes ☐ No

Is there a participation strategy? ☒ Yes ☐ No

The TA will help establish three task forces in the Ministry of Health to ensure ownership of MOH and co-opt other aid agencies in the planning process toward a sector-wide approach. Workshops and field visits will facilitate consultations between service providers and potential beneficiaries.

D. Gender Development

Strategy to maximize impacts on women: The TA will develop a gender strategy and plan to emphasize the needs of women, particularly as regards reproductive health and access to health services. The TA will also examine ways to provide women with employment opportunities and social protection. The strategy will incorporate the views of beneficiaries, including women from ethnic minorities.

Has an output been prepared? ☐ Yes ☒ No

E. Social Safeguards and Other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
Resettlement	☐ Significant ☐ Not significant ☒ None	The Program will use existing health facilities. Civil works will be for upgrading existing services and schools.	☐ Full ☐ Short ☒ None

Affordability	☐ Significant ☐ Not significant ☒ None	One of the aims of the Program is to make health services more affordable to the poor.	☐ Yes ☒ No
Labor	☐ Significant ☐ Not significant ☒ None	The Program aims to create opportunities for employment of paramedics, and train volunteers to increase their income through a small markup on the sale of drugs.	☐ Yes ☒ No
Indigenous Peoples	☒ Significant ☐ Not significant ☐ None	The Program is targeting ethnic minorities with the purpose of increasing their benefits.	☒ Yes ☐ No
Other Risks and/or Vulnerabilities	☐ Significant ☐ Not significant ☒ None	The TA will examine if there is any other major risk or vulnerability that may need to be addressed in the program design.	☐ Yes ☒ No

COST ESTIMATES AND FINANCING PLAN
($'000)

Item	Foreign Exchange	Local Currency	Total Cost
A. Asian Development Bank Financing[a]			
1. Consultants			
a. Remuneration and Per Diem			
i. International Consultants	400.00	0.00	400.00
ii. Domestic Consultants	0.00	50.00	50.00
b. International and Local Travel	35.00	10.00	45.00
c. Reports and Communications	10.00	10.00	20.00
2. Equipment and Furniture[b]	10.00	10.00	20.00
3. Vehicle	35.00	0.00	35.00
4. Workshops, Surveys, and Studies	0.00	30.00	30.00
5. Miscellaneous Administration and Support Costs	0.00	20.00	20.00
6. Representatives for Contract Negotiations	5.00	0.00	5.00
7. Contingencies	60.00	15.00	75.00
Subtotal (A)	**555.00**	**145.00**	**700.00**
B. Government Financing			
1. Office Accommodation and Transport[c]	0.00	75.00	75.00
2. Remuneration and Per Diem of Counterpart Staff and Support Staff	0.00	50.00	50.00
3. Others such as Workshop Facilities	0.00	50.00	50.00
Subtotal (B)	**0.00**	**175.00**	**175.00**
Total	**555.00**	**320.00**	**875.00**

[a] Financed by the Japan Special Fund, funded by the Government of Japan.
[b] Includes computers, printer, photocopy machine, and telecommunications equipment.
[c] One additional vehicle will be provided by the Ministry of Health for transport in Vientiane, and the provincial health offices will provide transport in the provinces.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. International Consultants

1. Team Leader/Health Policy Expert (6 person-months)

1. The team leader and health policy expert will be the principal liaison with development partners, provide overall conceptual guidance, manage the consultants, and administer the technical assistance (TA). The expert will report to the project director of the Ministry of Health (MOH) and the mission leader of the Asian Development Bank (ADB). The expert will have at least 15 years experience, including in health sector reforms in the region, and as team leader of projects. The expert will

(i) jointly with the deputy project director, manage the TA and provide liaison with MOH, other ministries, and development partners;
(ii) coordinate a participatory planning process to obtain the necessary inputs for program design and ensure government ownership of the Program;
(iii) guide the consultants and be responsible for the collective work of the team;
(iv) ensure that the TA is implemented according to the terms of reference of the consultants and any subsequent instructions or guidance from MOH and ADB;
(v) prepare a detailed inception report including TA implementation arrangements;
(vi) as a member of the task forces, review policy development and dissemination processes, strategic planning and budgeting processes;
(vii) identify policy reform, capacity building and investment priorities based on guidance from the MOH steering committee and the work of the task forces;
(viii) examine the suitability of a sector development program (the Program) for ADB assistance, identify planning requirements, and instruct experts accordingly;
(ix) develop the program policy matrix with the stakeholders and provide guidance on the economic and financial analyses for the Program;
(x) ensure timely submission of formal written reports, including the inception report after 4 weeks, sector analysis at midterm, a program outline in month 4, a draft final report in month 5, and a final report on completion of the TA; and
(xi) with the deputy project director, take overall responsibility for preparing the situation analysis and program proposal for submission to MOH and ADB.

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

2. The human resources development (HRD) expert will be responsible for planning the HRD components and have at least 10 years experience in this field. The consultant will

(i) report to the team leader and work as a member of the task force for HRD;
(ii) review HRD for the health sector in MOH and Ministry of Education;
(iii) present lessons learned from international experience to the steering committee;
(iv) analyze major HRD issues in policies, structures, planning and financing, physical facilities, curriculum and training, recruitment and remuneration, staff distribution and vacancies, and staff performance and adjustment measures;
(v) help develop the long-term HRD vision, and strengthen the medium-term HRD implementation plan including capacity building for MOH; and
(vi) identify HRD policy reforms, capacity building, and investments that could be supported under the Program; and prepare a detailed proposal.

3. Health Financing Expert (3 person-months)

3. The health financing expert will be responsible for planning health financing reforms, with a focus on risk pooling, and have at least 10 years experience in this field. The expert will

(i) report to the team leader; and work as a member of the task force for health financing, planning, and budgeting;
(ii) provide knowledge inputs on health financing and health insurance for the steering committee, task force, and workshop participants;
(iii) examine sources and uses of funds in the sector based on existing documentation;
(iv) review and assess existing arrangements (legislation, programs, and plans) for health care financing by various government and nongovernment actors, focusing on cost-sharing mechanisms;
(v) prepare a broad but comprehensive health financing report, identifying successes, issues, priorities, and options. In the report, propose alternative provider payment mechanisms and administrative;
(vi) assist the steering committee in developing a draft master plan on health financing with specified milestones. Include in the plan the roles of the concerned ministries with respect to financing and implementation, and explore potential co-financing and involvement of multilateral and bilateral aid agencies, nongovernment organizations, and the private sector in program activities; and
(vii) prepare a proposal for the Program, identifying policy, capacity building, and investment requirements including cost estimates and potential cofinancing.

4. Health Economist (3 person-months)

4. The health economist will be responsible for economic analysis to support a program loan, project economic analysis, and cost estimates and financial sustainability. The consultant will

(i) report to the team leader and work as a member of the task force for health financing, planning, and budgeting;
(ii) review the macroeconomic settings and sector financing based on available documentation, and assess the adjustment cost of the proposed policy reforms;
(iii) guide the domestic consultant in estimating costs, planning counterpart fund requirements, examining financial sustainability, and analyzing the costs of the Program; and
(iv) using ADB's *Guidelines for the Economic Analysis of Projects*, conduct economic and financial analyses of the project component, including an economic justification and an estimate of the overall rate of return of the project component.

5. Health System Expert (5 person-months)

5. The health system expert will be responsible for strengthening primary health care (PHC) systems, with a focus on planning, coordination, and monitoring of services; and improving the quality of care. The expert will have worked at field level in Southeast Asia, and have at least 10 years of experience in implementing PHC. The expert will

(i) report to the team leader and work as member of the task force for PHC delivery and health and nutrition promotion;

(ii) review PHC and nutrition policies, plans, programs, capacity and activities in the health sector;
(iii) analyze major issues in PHC service delivery; and community, health center and district hospital levels;
(iv) prepare a broad plan for overall improvement of PHC service delivery, based on identified priorities and in coordination with aid agencies;
(v) identify PHC policy reforms, capacity building, and investment that could be supported under the Program and prepare a detailed proposal; and
(vi) review medical waste and other environmental issues and prepare a plan to address them.

6. Health Education Expert (2 person-months)

6. The health education expert will be responsible for planning better health and nutrition promotion in the PHC system to improve household and community care, and promote the rational use of services and medicines. The expert must have at least 5 years experience in behavioral change communication, including with ethnic minorities in Southeast Asia. The expert will

(i) report to the team leader; and work as a member of the task force for PHC delivery and health and nutrition promotion;
(ii) review health and nutrition promotion policies, plans, programs, capacity, and activities;
(iii) analyze major issues in health and nutrition promotion at community and health center levels;
(iv) prepare a broad health and nutrition promotion plan for PHC improvement, based on identified priorities and in coordination with aid agencies;
(v) identify health education policy reforms, capacity building, and investment that could be supported under the Program and prepare a detailed proposal; and
(vi) include good hygiene practices as part of preventive health care to improve living and environmental conditions and reduce health risks from contamination.

B. Domestic Consultants

1. Project Manager/Financial Management Expert (6 person-months)

7. The project manager/financial management expert will be responsible for TA management under the guidance of the team leader, and assessment of MOH financial management. The expert will be a certified accountant or have a comparable educational background, and have experience in preparing program cost estimates. The consultant will

(i) work as a member of the task force for health financing, planning and budgeting;
(ii) be responsible for project and financial management;
(iii) carry out a financial management assessment in accordance with the *Guidelines for the Financial Governance and Management of Investment Projects Financed by the Asian Development Bank*, also applying new ADB project tools;
(iv) propose ways of strengthening financial management in the sector and the Program; and
(v) assist the team leader with project management, including supervision of accounting, procurement, logistics, personnel management, and reporting.

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

8. The HRD expert will be responsible for planning HRD, including fostering a participatory approach to help develop the vision for HRD and the medium-term HRD. The expert will have worked at a provincial level. The expert will

(i) report to the team leader; and work with other members of the task force for HRD;
(ii) hold focus group discussions at all levels to identify HRD issues, priorities, and options;
(iii) review skills requirements for PHC and staff performance at all levels;
(iv) review training institutions including profile and level of students; quality of curricula, instruction, materials, and facilities;
(v) help prepare an HRD plan to make adjustments to improve the quality of PHC; and
(vi) identify policy reforms, capacity building, and investment that could be supported under the Program and prepare a detailed proposal.

3. Financing Expert (5 person-months)

9. The financing expert will be responsible for financial analysis and have experience in insurance systems and financial analysis of health services. The expert will

(i) report to the team leader; and work as a member of the task force for health financing, planning, and budgeting;
(ii) assist the international health financing expert with reviewing and analyzing health financing;
(iii) in collaboration with aid agencies, help organize a participatory planning process through the task force to identify priorities and next steps in improving health financing; and
(iv) assist the program manager with preparing cost estimates, and the economist with the economic analysis of the Program.

4. Public Health Expert (5 person-months)

10. The public health expert will be responsible for planning to improve the quality of care. The expert will have a degree in Master of Public Health or similar educational background, and experience in PHC system development as a provincial health director in a comparable function. The expert will

(i) report to the team leader; and work as a member of the task force for PHC delivery and health and nutrition promotion, including staff and consultants of the current project and of other aid agencies;
(ii) help analyze major issues in PHC service delivery at community, health center, and district hospital levels;
(iii) in coordination with aid agencies, assist with preparing a broad, but comprehensive plan for MOH to improve the overall performance of the PHC services; and
(iv) identify any environmental issues in the program design that will need to be planned, and inform ADB and MOH accordingly.

5. Health Education Expert (3 person-months)

11. The health education expert will be responsible for planning to improve health promotion along with the international consultant. The expert will have experience in behavioral change communication programs in remote, poor communities particularly those with ethnic minorities. The expert will

(i) report to the team leader; and work with members of the task force for PHC delivery and health and nutrition promotion;
(ii) review health promotion policies, plans, programs, capacity and activities in the health sector;
(iii) analyze major issues in health promotion at community and health center levels;
(iv) help prepare a broad health promotion plan as part of the overall plan for PHC improvement, based on identified priorities and in coordination with aid agencies; and
(v) identify policy reforms, capacity building, and investment that could be supported under the Program, and help prepare a detailed proposal.

6. Sociologist (4 person-months)

12. The sociologist will be responsible for social analysis of the Program (poverty, gender, and ethnic minorities), and will have substantial experience in project planning and evaluation. The expert will

(i) report to the team leader; and work as a member of the task force for PHC delivery and health and nutrition promotion;
(ii) review and assess PHC delivery and demand in the Lao People's Democratic Republic (Lao PDR), with regard to poverty, gender, ethnic minorities, and other dimensions of vulnerability, including particular services like immunization and family planning;
(iii) based on the country gender strategy for the Lao PDR, and ADB's *Guidelines for the Social Analysis of Projects*, prepare a social analysis including a gender and development plan and an ethnic minority plan, proposing a practical, integrated approach to strengthening the social aspects of PHC service delivery;
(iv) help prepare a broad but comprehensive plan to improve PHC service delivery, based on identified priorities and in coordination with aid agencies; and
(v) screen sites of facilities targeted for upgrading for possible involuntary resettlement impacts, including impacts on people with no land titles—e.g., loss of legal structures and incomes—and prepare a resettlement plan, as required.