Lao People's Democratic Republic

Peace Independence Democracy Unity Prosperity

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Ministry of Health

Health and Nutrition Service Access Project (P166165)

Ethnic Group Development Framework

October 29, 2019

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I. Overview of the project

The Health and Nutrition Services Access Project (HANSA) builds upon and aims to sustain the gains achieved under the Health Governance and Nutrition Development Project (HGNDP). The project has a particular focus on the four northern provinces in Lao PDR, which have been chosen for multiple, simultaneous and mutually reinforcing investments by the Government of Lao PDR and the World Bank, as these provinces represent the most ethnically diverse, remote and disadvantaged geographical locations in Lao PDR. Several nutrition-centric interventions under HANSA, such as DLIs for SBCC, integration outreach and for growth monitoring and growth promotion, are concentrated in these four provinces. Other interventions, which will eventually roll out nationwide over the lifetime of HANSA, such as the quality performance scorecard (QPS), the public finance management (PFM) capacity building of Health Centers (HC), and the direct data entry under district health information system version 2.0 (DHIS2), also commence in these four provinces first, and therefore will see the longest duration of investment effort in these provinces.

II. Project Development Objective and Components

The project development objective is to improve access to quality health and nutrition services in targeted areas of Lao PDR.

The 4 main project components are including:

* **Component 1: Integrating Service Delivery Performance with National Health Insurance Payments:** This component will finance Quality and Performance linked payments to health centers, using the existing channel that provides fixed capitation payments from the national health insurance system. Through an objective assessment of the health center performance across key dimensions of quality of service delivery, verified by an independent institution, this top-up payment will create performance linkages to the capitation payments and providing additional resources to the primary healthcare level.

* **Component 2: Service Delivery and Nutrition Convergence:** This component will use a combination of disbursement linked indicators (DLIs) prioritized toward the four convergence provinces in northern Lao PDR, and other DLIs with a nationwide footprint. It will continue the legacy of results-based instruments focused on service delivery improvements from the predecessor HGNDP, adapted to the nutrition convergence approach and to the changing health system configuration in the Lao PDR. DLIs will also be instrumental in the delivery of the HANSA design, to organize and implement the quality assessment system, for public financial management improvements directed at the health facility level, and to strengthen the integration and sustainability of priority public health programs.

* **Component 3: Adaptive Learning and Project Management:** This component will finance capacity building, research, monitoring and evaluation, regulatory strengthening, strengthening of waste management guideline and practice, investment in information systems and overall project coordination and management.

* **Component 4: Contingency Emergency Response Component:** The objective of the contingency emergency response component, with a provisional zero allocation, is to allow for the reallocation of financing in accordance with the International Development Association (IDA) Immediate Response Mechanism in order to provide an immediate response to an eligible crisis or emergency, as needed. This component will finance expenditures on a positive list* of goods and/or specific works, goods, services and emergency operation costs required for emergency recovery. An Operational Manual for this component will detail the eligible situation when the CERC can be triggered, financial management, procurement, safeguard and any other necessary implementation arrangements, to be submitted to and accepted by the World Bank Group (WBG) prior to the disbursement for this component of IDA funds

III. Project Location

For component 1 of project: the initial roll out of this performance-based payment to health centers will take place in the four northern priority provinces: Oudomxay, Phongsaly, Huaphan and Xiengkhuang. After then, the expectation is for this mechanism to be rolled out in other provinces with a perspective to cover nationwide, adding 4 provinces in each six monthly cycle. An operational manual of this performance-based mechanism will be developed within one month after project effectiveness. It is expected that for the first roll out of the performance score cards, around 220 health centers in these four provinces will be assessed.

For component 2, the coverage of DLIs will depend on the nature of DLI content as detailed below:

- Two DLIs (G and H) related to nutrition specific service will be focused on the 4 nutrition priority provinces.
- Other two DLIs (J and K) related to Global Fund (GF) funded will depend on discussion between CHAS and GF which will be finalized during project appraisal in January 2020.
- For DLI A which directly linked to Project Component 1 on QPS will initial at 4 convergence provinces in year 1 and then will add more 4 provinces each year so that by year 4 will cover nationwide in which 90% of health center in the country will receive timely quality assessment and verification visits

- For DLI B on timely receipt of National Health Insurance Bureau (NHIB) payment at health center level and increase in the number of health centers received free maternal and child health (MCH) services will cover all provinces except Vientiane Capital
- For DLI C on availability of essential drugs and supplies at health center level improved the scope is similar to DLI A
- For DLI D on number of provinces in which the number of health centers without a clinical health worker has been reduced the scope is similar to DLI A and C
- For DLI E on financial management capacity at health center level improved the scope is similar to DLI A, C and D
- For DLI F on increase coverage and correctness of event capture report the scope is similar to DLI A, C, D, and E
- For DLI I on EPI the scope is focus on 50 priority districts of all provinces based on DHIS2 system to generate Penta 3 and SBA
- For DLI L on increase national readiness for health security in responding to pandemics and health emergency at international boundaries (airports and ground crossings) the scope is similar to DLI A, C, D, E and F

For Component 3, the scope of project is nationwide from effectiveness to closure of the project For Component 4, the project will cover the areas where the CERC is triggered. The most likely situation to be triggered for emergency response would be the natural disaster e.g. flood and landslide or pandemic. The project is highly likely exposed to flooding in the four project provinces in the south and flashing flood or landslide in the four project provinces in the north in very near future. Extreme flooding may lead to damage of health facility, water supply system, and road which will directly impact the access of health and nutrition of the target beneficiaries. In addition, some kinds of pandemic of human influenza or zoonosis disease could spread through in the national disaster areas or cross border. The potential impact on component 2 is highly likely. The right kind of capacity building measures could increase preparedness and longer-term resilience to unexpected natural disaster risks. Understanding the climate and geophysical risks need to be explored.

IV. Institutional and Implementation Arrangements

The Project will be implemented by the MoH through the Department of Planning and Cooperation (DPC), MOH technical departments and the provincial health offices (PHOs) and district health offices (DHOs). The DPC is expected to remain the main coordination body building upon the mechanism already in place under Health Governance and Nutrition Development Project (HGNDP). For sustainability and greater use of government systems, the preparation will explore the possibility of Department of Finance (DOF) in a larger fiduciary role, potentially taking

on some of the procurement and financial management responsibilities that are currently carried out by National Project Coordination Office (NPCO).

1. At the national level, the existing NPCO in the DPC will be responsible for overall project management and administration, implementation of project activities and achievement of DLIs in close coordination with MOH technical departments and those PHOs and DHOs participating in the project and M&E. The National Health Insurance Bereau (NHIB) and the Department of Health Care and Rehabilitation (DHR) will play a central role in the design and implementation of the component 1, in close coordination with other technical departments including Department of Foods and Drugs (DFD), Department of Communicable Diseases Control (DCDC), DPC and Department of Hygiene and Health Promotion (DHHP), as well, as centers under these departments who will likewise play a critical role in the implementation of activities in their respective key areas. Department of Finance will play an increasingly larger role both taking on more fiduciary management (FM) responsibilities, but also coordinating and taking on the oversight role for building FM capacity at subnational levels, including at health center level. In addition the DOF will monitor the Eligible Expenditure Program for DLIs under the project and ensure that these are reported to the WB at the time of submitting the DLI payment request, and for the audit thereof. Each department and centre will nominate a focal point supported by a core group from DPC for the preparation and implementation of the project.

2. At subnational level, the PHOs and DHOs will continue to assume the roles for monitoring and supervision, especially in the implementation of DLIs and quality supervisory checklists. Enhanced coordination between provincial levels and district levels is critical. PHOs will be responsible for: (a) the implementation of Project activities and achievement of DLIs at the provincial level; (b) the monitoring and reporting to the MOH of Project activities and achievement of DLIs at the provincial level; and (c) the provision of technical support to DHOs in the implementation of Project activities at the district level and village level. The DHOs will be responsible for: (a) the implementation of Project activities including the six monthly quality assessments at the district and village level and reporting to the PHO on said activities; and (b) the supervision and provision of technical support to health facilities in their delivery of reproductive, maternal and child health, and nutrition services.

V. Background Information

5.1 Legal and Institutional Framework on Ethnic Groups in Lao PDR

According to the 1991 Constitution, Lao PDR is defined as a multi-ethnic state, with “equality among all ethnic groups.” Article 8 of the Constitution reads:

> "The State pursues the policy of promoting unity and equality among all ethnic groups. All ethnic groups have the rights to protect, preserve and promote the fine customs and cultures of their own tribes and of the nation. All acts of creating division and discrimination among ethnic groups are forbidden. The State implements every measure to gradually develop and upgrade the economic and social level of all ethnic groups".

The intention of the Constitution is to grant equal status to all ethnic groups, and to this end no reference is made to distinctions between highlanders (Lao Soung) and lowlanders (Lao Loum) and midlanders (Lao Theung). The official terminology, for describing the diverse population of the Lao PDR is 'ethnic group' and was introduced in the 1991 Constitution. The term "indigenous people" is not used in Lao PDR. Article 75 of the Constitution specifically indicates that the Lao language and script are the official national language and script. The lead government agency in relation to ethnic minorities is the Lao Front for National Development (LFND), Department of Ethnic Affairs. Therefore the Social Assessment and the Ethnic Group Development Framework (EGDF) will use the official terminology of the Government of Lao PDR.

The 1992 ethnic minority policy, Resolution of the Party Central Organization Concerning Ethnic Minority Affairs in the New Era, focused on gradually improving the lives of ethnic minorities, while promoting their ethnic identity and cultural heritage. It is the cornerstone of current national ethnic minority policy. The general policy of the Party concerning ethnic minorities can be summarized as follows (Pholsena 2005):

a. Build national sentiment (national identity).
b. Realize equality between ethnic minorities.
c. Increase the level of solidarity among ethnic minorities as members of the greater Lao family.
d. Resolve problems of inflexible and vengeful thinking, as well as economic and cultural inequality.
e. Improve the living conditions of the ethnic minorities step by step.
f. Expand, to the greatest extent possible, the good and beautiful heritage and ethnic identity of each group as well as their capacity to participate in the affairs of the nation.

The implementation of the Party's policy on ethnic minorities is tasked to the LFND (known colloquially as Neo Hom).

In relation to health care, the policy calls for protection against and eradication of dangerous diseases and to allow ethnic groups to enjoy good health and long life. The Government, it states, should provide appropriate investments to enlarge the health care network by integrating modern and traditional medicine.

The LFND launched a new national guideline on Ethnic Group Consultation (2012) which was totally in line with the World Bank policy on Indigenous People (OP/BP 4.10). The guideline aims to (1) “ensure that all ethnic groups who benefit from or are adversely affected by a development project, without regard to the source of funding, are fully engaged in a meaningful consultation process at all stages from preparation into implementation”; and (2) “ensure that the potentially affected ethnic groups are fully informed of project objectives, as well as their potential positive and adverse impacts on their livelihood and their environment, and provided with opportunities to articulate their concerns.”

Policy relating to the non-Lao Tai remains relatively unchanged from that announced by Party Central in 1992, which identifies three essential tasks for their development: (a) strengthening political foundations; (b) increased production and opening of channels of distribution in order to convert subsistence based economics towards market-based economics; and (c) a focus on the expansion of education, health and other social benefits.

Despite the fact that the number of ethnic groups have changed over time, specialist agree on the ethno-linguistic classification of ethnic groups produced by the LFNDwhich contains 49 categories and over 160 subgroups.

According to the official categorization of the LFND, ethnic groups in Lao PDR can be categorized into four ethno-linguistic categories:

a. The Lao-Tai (also referred to as ‘Tai-Kadai’) which includes the ‘ethnic Lao’ group and lowland Tai/ Thay speaking groups;
b. Mon-Khmer ethnic groups, which includes the Khumic, Palaungic, Kautic, Bhahnaric Khmer and Vietic speaking groups;
c. Hmong-Mien, including the Hmong and the Mien speaking groups.
d. Sino-Tibetan (also referred to as Chinese-Tibet), which includes Chinese Ho and Tibeto-Burman speaking groups.

Please see table I for the ethnic composition in each province.

Table 1: Provinces and their Ethnic Composition

Province	Total Pop	% EMG	2014 EMG Popn	% and No. of Lao-Tai		% and No. of Mon-Khmer		% and No. of Tibeto-Burma		% and No.of Hmong-Lewmien		% and No. Other	
Oudomxai	329,110	78.5%	253,177	20.6%	54,281	60.5%	150,584	5.7%	10,466	12.3%	35,340	0.0%	156
Phongsali	180,996	80.4%	145,203	18.9%	25,198	20.7%	31,240	53.6%	78,921	6.1%	8,811	0.0%	0
Luang Namtha	181,000	72.2%	123,975	26.9%	34,632	34.3%	35,892	31.2%	43,209	6.8%	9,175	0.0%	0
Bokeo	182,198	62.4%	111,294	37.1%	39,137	28.4%	43,266	18.2%	11,202	15.1%	16,074	0.1%	268
Xiengkhouang	263,465	51.3%	129,540	48.0%	55,326	10.0%	15,037	0.1%	120	41.2%	58,115	0.0%	0
Luang Prabang	472,618	70.7%	302,364	30.0%	79,866	51.4%	151,169	0.2%	419	17.6%	52,343	0.1%	313
Houaphan	340,828	44.4%	150,345	55.7%	66,283	20.3%	28,812	0.0%	38	23.1%	34,628	0.0%	13
Sayabouly	403,504	27.2%	106,955	73.6%	58,727	15.8%	27,685	0.1%	206	9.9%	13,397	0.0%	115
Xaysomboun	81,801	67.1%	54,824	32.0%	13,876	19.3%	8,198	0.1%	67	47.7%	32,202	0.3%	158
Vientiane Prov	446,270	30.8%	143,469	70.7%	69,680	16.6%	31,956	0.1%	91	11.5%	19,657	0.0%	22
Bolikhamxai	294,707	29.7%	76,420	74.6%	42,182	8.8%	9,067	0.1%	68	14.5%	16,252	0.7%	1,007
Khammouane	434,199	19.5%	64,896	76.4%	41,230	21.5%	21,600	0.1%	176	0.0%	12	0.7%	870
Savannakhet	1,004,646	29.2%	222,757	69.9%	114,959	29.2%	105,742	0.0%	0	0.0%	0	0.2%	348
Champasak	727,821	13.4%	100,654	85.1%	57,208	13.4%	41,925	0.0%	0	0.0%	0	0.2%	401
Saravan	403,575	48.9%	151,431	49.8%	47,751	48.9%	101,195	0.0%	0	0.0%	0	0.6%	1,529
Sekong	115,165	89.3%	98,765	10.0%	11,958	89.3%	86,082	0.0%	0	0.0%	0	0.1%	80
Attapue	143,934	69.3%	87,857	29.2%	25,180	69.6%	61,550	0.0%	0	0.0%	0	0.1%	77
Vientiane Capital	903,747	3.7%	40,090	95.0%	36,731	1.4%	601	0.2%	72	2.3%	2,320	0.1%	38
Total	**6,909,583**	**34.2%**	**2,364,017**	**54.1%**	**874,208**	**28.3%**	**951,603**	**4.6%**	**145,055**	**11.9%**	**298,326**	**0.2%**	**5,395**

Sources: The 4th Population and Housing Census (PHC) 2015

Under component II, HANSA project will build on the progress of the existing HGNDP project, and continue supporting in the same four provinces, which are considered the poorest, and have diverse ethnic groups, including three main groups of Hmong, Khmu and Lao Lum. The key project beneficiaries are especially the vulnerable, poor and women-headed household groups, including but not limited to ethnic groups in all the project target areas.

The population and ethnic origin group in the 12 nutrition districts of 4 project provinces of Xiengkhuang, Huaphanh, Oudomxay and Phongsaly are retrieved from the Population Housing Census (2015), as are indicated in the table 2 below.

Table 2: Population Housing Census 2015

Provinces	**Districts**	**Total**			**Ethnic Origin group**				
		Population	**Males**	**Females**	**Lao-Tai**	**Mon-Khmer**	**Hmong-Iewmien**	**Tibeto-Burma**	**Others**
Xiengkhuang	Kham	47,512	23,938	23,574	5,034	10,102	11,844	3	0
	Nonghet	37,613	18,974	18,613	6,248	8,111	22,972	7	3
Huaphanh	Houameuang	32,680	16,620	16,060	5,407	19,936	7,041	14	0
	Xamtai	36,860	18,624	18,236	17,620	619	18,267	5	0
	Kuan	24,603	12,558	12,045	8,197	2,762	13,373	8	8
	Xone	15,932	7,995	7,937	5,933	2,961	6,927	7	0
Oudomxay	Lar	17,173	8,637	8,536	1,913	9,506	539	5,068	0
	Namor	38,826	19,399	19,427	6,106	20,763	7,403	4,170	3
Phongsaly	Khua	26,164	13,014	13,150	3,387	14,313	58	8,090	1
	Mai	26,361	13,161	13,200	7,988	7,623	1.330	9,228	23
	Samphan	24,420	12,521	11,899	1,391	7,415	2,878	12,414	3
	Bountai	24,277	12,277	12,000	3,818	3,314	1,175	15,655	5
4 Provinces	**12 Districts**	**352,421**	**177,718**	**174,677**	**73,042**	**107,425**	**92,478**	**54,669**	**46**

It has been established that these groups meet the Bank's definition of 'indigenous people', that is, they possess the following characteristics:

a. Self-identification as members of a distinct indigenous cultural group and recognition of this identity by others;
b. Collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories;
c. Customary, cultural, economic, social, or political institutions that separate them from those of the dominant society and culture; and
d. An indigenous language, often different from the official language of the country.

VI. Key findings of Social Assessment (SA)

The Ministry of Health conducted the social assessment in order to: i) assess potential risks and social impacts of the proposed project activities as per the World Bank's operational policy on environmental assessment (OP 4.01); ii) identify vulnerable and under-served population groups, to identify social and cultural issues relevant for the proposed project; iii) inform the design of the project and EGDF to enhance project outcomes and ensure equitable benefits for vulnerable social groups such as the poor, women, and ethnic minorities; and iv) identify and assess particular issues and risks concerning ethnic minorities following the requirements of the World Bank's operational policy on indifenous peoples (OP4.10) that aims to ensure that the project provides culturally appropriate benefits and do not have adverse social impacts on ethnic minorities.

The social assessment reviewed key literatures on accessibility, inclusion, risks and impacts of the National Health Insurance (NHI), the Maternal, Neonatal and Child Health (MNCH) and nutrition services. The main literatures include the NHI Assessment Report of 2018, the Decree on NHI Scheme (2012), the social assessment of the Ethnic Group Development Plan (EGDP) of the HGNDP, the Population and Household Census (PHC of 2015), and the Lao Social Indicator Survey (LSIS of 2017) .

The SA have identified the key findings and constrains and recommendations on issues related to the project component 1 and 2.

A. Summary of key findings, constrains and recommendations related to the implementation of the Project activities under Component 1.

Background: Decree on NHI - According to the Government Decree on National Health Insurance No 470/ GO dated 17/10/2012, the Central National Health Insurance Bureau is managing under the MoH, and is equivalent to the Department. Currently, the NHI scheme gradually integrate other existing schemes such as free MNCH, health equity funds, and schemes covering the formal sector. NHI scheme has been implementing in all 17 provinces since the end of 2017. The NHI scheme aims to ensure Lao population, including women, children, poor, vulnerable, and all ethnic groups, are able to access to health care services (including promotion, prevention, treatment and rehabilitation), and get maximize the health benefits thoroughly and equitably.

NHI assessment report 2018 - After the NHI scheme has been introduced for a year, the NHI assessment was conducted (Apr – Jun 2018) in the five selected provinces of Luangnamtha, Bolikhamxay, Salavanh, Sekong, and Attapeu. The objectives were to review the implementation and effectiveness of NHI to cover the informal sector population; to assess the effects of NHI on financial management of health facilities; and to review the transition of Social Health Protection mechanism. Qualitative and quantitative methods were used for reviewing of each objective. The NHI assessment had done by (1) using exist patient survey questionnaire interviewed with 1.870 respondents, who are poor and non-poor patients/ caregivers from inpatients and outpatients from ethnic groups (not specified); and (2) using depth interview questionnaire interviewed with 91 key informants from provincial and district health insurance committee, provincial and district health insurance staff, health center staff, and health providers; and (3) using facility assessment checklist.

According to the NHI assessment (2018), many key constrains are identified from both demand and supply sides as highlighted below:

1. At the demand side, the key major constrains are that (1) patients don't understand about NHI scheme and they don't bring the NHI eligible document. So, they have to pay for health services instead of receiving a free of charge health services. (2) Patients don't understand about the rational drug use or rational treatment, and they also keep complaining about wasting time waiting to be served in a long queue. Thus, many patients reported that they prefer to pay for health services to get medicines they want, and they don't have to wait for long line.

2. At the supply side, due to the NHI implementation is recently launched nationwide in 2017, many health facilities, especially the health centers, can hardly handle the implementation in many circumstances. According to the NHI assessment (2018), many concerns are raised due to the NHI implementation that (1) increasing number of patients and workload with no incentive; (2) pending of the reimbursement at the subnational level; (3) irregular monitoring of supportive supervision; (4) requirements of

improve the quality of services and health facility; and (5) limited of medical equipment and drugs.

3. Based on the above concerns, patients are not yet satisfied with the NHI implementation, and health center staff are limited in term of both numbers and capacity in managing, planning and budgeting, and implementation, which have been considered as major system-wide challenges. In addition, this component will finance to health centers by using the existing channel that provides fixed capitation payments from the NHI system. Thus, definitedly health center staff must be improving the quality of health services to meet the needs of population, and strengthening the public finance management capacity at all levels to ensure funding adequacy, predictability, efficiency, transparency and accountability.

Recommendations for the Improvement of the NHI implementation include:
(1) Provide refresher training on NHI related topics to the health staff at the subnational level;
(2) Conduct regular monitoring and focus on coaching at the health facility staff;
(3) Improve quality of health care services for better services to meet the needs of population;
(4) Allocate enough of qualified staff to appropriate work at the health facilities; and
(5) Encourage and closely support village authorities to promote NHI at the community level.

B. Summary of key findings, constrains and recommendations related to the implementation of Component 2

The key findings mainly came from EGDP 2017 of the HGNDP, PHC 2015, and LSIS 2017. Recent studies have shown that both MNCH service delivery and demand for MNCH services by individuals, families and communities could be strengthened in order to make MNCH services more accessible to those in remote rural areas. Each of these aspects will be detailed below.

a) MNCH Service Delivery issues

Four recent MNCH service evaluations provide a comprehensive picture of the challenges faced by remote ethnic communities in accessing quality MNCH services: the internal and external evaluations of the National Strategy for MNCH Service Provision 2009-2015 and the World Bank Health Services Improvement Project (HSIP) EGDP (2005) and consultations held for HSIP additional financing in 2014.

Both the internal and external reviews of the MNCH Strategy 2009-2015 argued that current MNCH program interventions are channeled through an existing health system that struggles to support universal basic health services. The capacity at the different levels and in various

elements of the health system varies widely depending on two key dynamics: first, the level of facility (central level hospital, provincial hospital, district hospital or village-level Health Center), and second, the level and type of development partner assistance in supporting MoH staff in program implementation, supply of health equipment and consumables and support for infrastructure development. Generally, health services are better funded and supported at Central and Provincial level, with highly significant decreases in support (both funding and personnel deployment, training and supportive supervision) when District and Village level services are evaluated. More support for the health system aimed at strengthening capacity of staff to provide high quality basic health care at district and village levels could contribute significantly to engaging communities to seek health care from health facilities, including MNCH services.

Many fixed site health facilities are not adequately provisioned with MNCH related drugs, personnel and equipment, so encouraging women to deliver at facilities where the standard of care is inadequate will not necessarily improve MNCH outcomes, and is likely to discourage others in the community from delivering at the site in the future if one or more community members have a negative birthing experience while at a health facility. This finding is supported by the WB HSIP consultations, which was based on wide community consultations and stated that beneficiaries involved in the consultations reported that staff at Health Centers were rude to people accessing free services, staff did not keep facilities in a clean and reasonable condition and that equipment related to MNCH was dirty or broken. The internal evaluation of the MNCH Strategy found that staffing at Health Centers was inadequate to supply basic MNCH health care, with only 30% of all Health Centers nationally having a trained Skilled Birth Attendant (SBA) on staff. The gender of SBA is also a significant issue in enabling access to MNCH services for ethnic women in Lao PDR. In many ethnic communities it is considered inappropriate for women to receive obstetric treatment form a male, therefore, training and deploying male SBAs risks investing in a workforce that may not increase ethnic women's access to MNCH services (WHO 2014, Albone 2011, WB 2014).

The physical environment of the delivery rooms was another barrier to greater service utilization cited in the external evaluation. It was argued that the design of birthing rooms across the country, with stirrup beds that require women to give birth in a prone position is not in line with current international standards and is antithetical to many rural women's traditional birthing practices (which do actually reflect current, international best practice in birthing protocols, such as giving birth in a supported squatting position) (UNFPA 2005). For rural (and indeed urban) women to give birth in the prone position with their legs secured in the air is highly uncomfortable, both physically and culturally. Cost-effective, yet well designed alternatives to the current standard of stirrup beds can be readily developed and deployed, making the design of birthing rooms across the country more medically appropriate and in line with current

international best practice standards, which aim to make the birthing space more welcoming for women and less medicalized, without compromising on standards of hygiene or medical care.

b) Traditional and Culture Practice

Where traditional cultural practices are positive and helpful to the birthing process, incorporating and valuing women's knowledge into medical protocols would demonstrate that women's cultural practices are recognized and valued by the medical establishment and would be very empowering for women. This recommendation is supported by the findings of the evaluation of the midwifery component of the SBA development plan (Skinner and Phrasisombath, 2012, pp 48), where they state that:

> "The observations of the Health Centers [in remote villages where non-Lao Lum women live] did not reveal any attempts to make the physical environment more culturally acceptable, nor to incorporate any of the non-harmful cultural practices."

Currently, women come to the birthing room at the Health Center or hospital and into an environment that is very foreign to them, with no recognizable or familiar aspects. If some aspects of traditional birth practices could be incorporated into facility design (for example, birthing 'stools', ropes that women can hold suspended from the ceiling, comfortable beds), the birthing experience could be much more empowering and positive.

Common beliefs about pregnancy and childbirth in remote rural communities can be a barrier to service utilization, specifically that pregnancy and childbirth are 'natural' occurrences and do not require any special treatment or medical intervention. In the results reported in the external evaluation of the MNCH Strategy (2009-2015), many focus group discussions and in-depth interviews respondents involved in the evaluation reported that they would not seek medical care during childbirth unless the mother had been in labor "too long" (by which time it is often too late for health center staff to ensure a positive outcome). This finding is supported by the results of the WB HSIP consultations, which found that respondents reported a lack of understanding of the importance of facility-based delivery and other MNCH services. In addition, the MNCH strategy external evaluation reported that, people in remote rural communities may not be aware of the differences in expertise between traditional birth attendants and SBA, with traditional birth attendants being seen as "qualified" to assist "normal" deliveries and provide Antenatal Care (ANC).

c) Language barriers and culture beliefs

Language barriers and culture beliefs impact in low accessibility to health care services among ethnic groups. Due to the geography where ethnic groups live mostly in the rural and quite remote areas, these people have difficulty in access to both basic health care services, and education. If school and health facility are available, they are not so well functioning, and lacking of teachers and supplies as well as lacking of health staff and medical tools. Thus, illiteracy rates are higher among ethnic groups, especially ethnic women. Language barrier is significant low to health information. Because of the language barrier, poor physical access to health facility, and difficulty in road access, when ethnic people are sick, they are most likely to practice their culture beliefs or traditional healing/ treatment that have been taught from generation to generation. This practice beliefs really impact the use of health care services. If traditional treatment is failed, ethnic people would try the take patients to health facility that is already quite late for successful curative outcomes. Although majority of all ethnic groups in Lao PDR commonly practice and easily accessible to traditional healing/ treatment, the studies on these topics are very limited. As a result, the risk is to increase the maternal, infant, and young child morbidity and mortality rates.

d) Demand for MNCH Services by Individuals, Families and Communities

In terms of engaging communities with the health system, there are many excellent programs being implemented by MoH personnel, supported by development partners (based on the WHO, Individuals, Families and Communities model of community mobilization). In many sites there is evidence of increased knowledge around MNCH and the need for ANC, delivery at Health Centers, post-natal care and child nutrition (WHO 2014, Albone 2011, De Sa et al 2013, JICA 2015). Yet even in sites where increased knowledge is demonstrated, it does not necessarily equate to behavior change. The external MNCH evaluation found that, in a focus group discussions conducted in Hoay Mong village, Bokeo Provence, both women and men clearly stated that they were aware of the importance of exclusive breastfeeding for the first six months of life, but participants said that they did not follow this proscribed behavior because women need to go back to work in the field very quickly after birth and therefore could not breastfeed while working. Because of the perceived need for women to return to work quickly, babies' diets were supplemented with foods such as pre-chewed sticky rice from as early as one week of age. This example illustrates that there more work to be done in initiating and sustaining behavior change in remote rural communities around health seeking, and MNCH in particular. As mentioned above, strengthening the health system in order to make making visits to health facilities more positive for service rights holders is a key aspect of ensuring sustained behavior change around health seeking behavior for remote community members.

It is widely documented (De Sa et al 2013, Albone 2011, Maloney 2011) that Lao PDR is a country with a culture where men hold significantly more power over decision making than women, particularly at community and household levels. These studies report that men hold decision-

making power over whether or not members of the household seek medical care, including MNCH related services. This evidence is supported by a recent external evaluation of the MNCH Strategy 2009-2015, where it was strongly recommended that community engagement be done on the WHO Individuals, Families and Communities (IFC) model, and aim to actively engage men in improving MNCH and nutrition outcomes in their own families and communities.

Common beliefs about pregnancy and childbirth in remote rural communities can be a barrier to service utilization, specifically that pregnancy and childbirth are 'natural' occurrences and do not require any special treatment or medical intervention. In the results reported in the external evaluation of the MNCH Strategy (2009-2015), many focus group discussions and in-depth interviews respondents involved in the evaluation reported that they would not seek medical care during childbirth unless the mother had been in labor "too long" (by which time it is often too late for health center staff to ensure a positive outcome). This finding is supported by the results of the WB HSIP consultations, which found that respondents reported a lack of understanding of the importance of facility-based delivery and other MNCH services. In addition, the MNCH strategy external evaluation reported that, people in remote rural communities may not be aware of the differences in expertise between traditional birth attendants and SBA, with traditional birth attendants being seen as "qualified" to assist "normal" deliveries and provide ANC.

The SIA for the HSIP (2005), and the more recent external evaluation of the MNCH Strategy completed in 2015, found that language (and by extension culture) are major obstacles to women's access to MNCH services. In several areas, villagers reported they were not able to visit the clinic or the hospital without an interpreter. The interpreters are few and asking them to accompany a patient is a major financial problem as well as a social one of incurring debt according to the norms of reciprocity in the village, usually calculated in terms of labor. The result is that villagers rarely avail themselves of public health services.

Where health personnel are available, who are members of the same ethnic group, the situation is greatly improved, as with the clinics in Xaysomboun where Hmong is spoken by health service personnel. In this particular instance, Hmong written language could be of value as well since the observed literacy rates in the Hmong language are found to be high. Other written minority languages in the project area are less well-known, but some potential exists for Khmou and Katu and perhaps others. At least it is worth experimenting with on a trial basis.

Other than for the Hmong in Xaysomboun, however, non-Lao-Tai ethnic minority personnel in the health service system are rare. One reason for this is the high educational qualifications that are required for admittance. For the lowest level one must have completed lower secondary school and then study medicine for 3 years. The second level requires completion of upper

secondary plus 5 years of medical study. And the highest level requires completion of upper secondary and 10 years of additional medical study. Thus, the majority of the ethnic minority people are unqualified due to lack of educational opportunity. This lack of opportunity then leads directly to a lack of access to health services for the respective ethnic populations.

Inclusion, according to the MNCH and nutrition services learned from the literature review, some of the constrains can be concluded that despite of the economic growth, and the improvement of the quality and access to MNCH and nutrition services across the country are in better progression, Lao PDR still continues having high maternal and child morbility and mortality in both gobally and in the East Asia and Pacific region as well as to facing challenges of the transition of the initiative process of reducing or withdrawing funds and supports from donors and development partners. Thus, the risk is that Lao government must increase budget plans for the health expenditures from 4.3 percent to 9 percent, and for others large critical pending agenda on health. Moreover, it also impacts patients and families have to pay higer costs, which the poor and ethnic minorities cannot afford accessing to health services as necessary (Work Bank report 2014).

Recommendations for the improvement of the MNCH service delivery include:

(1) allocate ethnic health facility staffs to be based in the HC and district hospital;

(2) strengthen knowledge and capacity building for the frontline health facility staffs in provision of standard and quality of the basic health care services;

(3) strengthen knowledge on the Infant Young Child Feeding (IYCF) SBCC to the village facilitators who will be the first contract for support ethnic groups at the village level;

(4) ensure the IECs on IYCF SBCC in up to date and appropriately use with each ethnic group;

(5) continue on promoting appropriate health and nutrition education and information to the target groups at the village level on social behaviour change campaigns in order to positive impacts of the health outcomes; and

(6) apply convergence methods working in the target villages.

VII. Lessons learned of social safeguards from the HGDNP

The EGDF for HANSA project will build on the EGDP of HGNDP (2017). Learning through the EGDP of HGNDP is that when started implementing the HGNDP, Social Safeguards was quite new to the MoH staff at all levels. As a result, the consultations were delayed due to mainly limited capacity and awareness on safeguards among relevant NPCO staff. The NPCO worked with World Bank to

improve the overall capacity and knowledge of staff for effective implementation. In addition, MoH also addressed the safeguards issues by: (i) officially appointing safeguard staff and village focal points, and establishing a structure to oversee implementation of social and environmental safeguards plans and activities in February 2017; (ii) integrating safeguards to all the relevant staff training; and (iii) conducting a series of Free, Prior and Informed Consultations of the HGNDP.

In July 2017, under the additional financing budget to support the technical assistant of HGNDP, NPCO revised the EGDP to provide a clearer plan and guidelines for FPIC, feedback and resolution mechanisms where local communities can get access to information and provide feedback to safeguards focal points at all levels, and set up a simplified reporting system for feedback and how they have been addressed in a timely manner. Currently, the consultations were already applied to all 14 provinces for the component 2, and to 720 out of 881 target villages for the component 3 of the HGNDP, and the safeguard section already included in the village facilitator monthly report. However, the safeguard information from the monthly reports since starting of the implementation of component 3 have not been consolidated, analyed, and used for the component 3 reports.

Safeguard limitations were identified - In practice, although consultations and all the basic foundations related to safeguards have been established, and trained to the relevant staff from the central to the village levels, the HGNDP project still faces limitations. These limitations would need to be taken into consideration when developing EGDF for HANSA project.

Key limitations include:
(1) weak coordination among relevant sectors at the provincial to the health center level;
(2) quality of the consultation reports from provincial focal points need to be improved to provide more details of what has been discussed and addressed at the meetings;
(3) limited knowledge on safeguards among the target health center staff and village facilitators;
(4) limited on monitoring, suportive supervision, and on the job training regarding to safeguard issues and feedback reponse mechanism system to provincial, district, and health center, and village community focal points;
(5) limited budget support regarding to implememting the safeguard activity; and
(6) safeguards issues mentioned in the village facilitator' monthly reports have never been consolidated, analyzed, and reported.

Recommendations:

The project will need to improve the safeguard coordination at all level. It is important to revise safeguard committee to include representative from other relevant technical units/department

within the health sectors. The committee will need to actively review the feedback from project beneficiaries as well as helping with addressing any issue/concerned raised by the beneficiaries at all levels.

The project will need to prioritize strengthening capacity of and cultural awareness among health officers and safeguards focal points at all levels to better understand ethnic group health care practices and beliefs. The project also aims to improve the quality of free, prior, and informed consultation, as well as, supervision and monitoring of the implementation of the EGDP and feedback resolution mechanisms and ensuring there is sufficient budget for addressing these challenges.

Increasing community awareness on the importance of social and environmental safeguard will be needed, especially focus on the indigenous and gender issues, as the project many of beneficiaries are from different ethnic groups.
Regular reporting the feedback from beneficiaries and timely addressing the concerns is essential for improvement of project implementation. The project will need to consider integration of the safeguard feedback resolution information to the existing web-based district health information system version 2.0

VIII. Key Findings of the Free, Prior, Informed Consultations:

Free, Prior, Informed Consultations (FPICs) with target villagers and health center staff at the target health centers in the 4 target project provinces, on Mar 10 – 23, 2019 – key findings of the FPICs are briefly noted below:

8.1 The Free, Prior, Informed Consultations (FPICs):

As the initial phase of the HANSA project will be implemented in the 4 northen target provinces and covered remote and rural areas, where many ethnic groups are concentrated. The projectis designed in a manner that is fully consistent with Operational Policy 4.10 of the Bank and is expected to positively impact ethnic groups. The objectives of the consultations are:

i. to ensure and enhance the inclusion of different ethnic groups to benefit from project intervention,
ii. to provide affected ethnic groups opportunities to voice their concerns and perspectives, and
iii. to ensure their informed participation in and broad community support to the project

During Mar 10 – 23, 2019, the MoH staff from central NPCO together with provincial and district health officers have conducted Free, Prior, Information Consultations (FPIC) at a health center level. The participants have separate into two groups: representatives of village target groups, and the key informants from that health centers. The consultations are organized in 6 health centers under the 6 districts of the 4 target project provinces of HGNDP. Selection of districts, health centers, and village was purposive in order to select villages that represent a considerable portion of the ethnic groups' population and with poverty incidence rates of 60 percent and higher. Before organizing the consultations, the designated district health staff sent invitations and relevant project documents to participants one week in advance.

The consultations held at the 6 selected health centers with commnunity people consist of 121 participants of 22 villages in 10 ethnic origin communities, including village chiefs, Lao Front Union, Lao women's union, village facilitators, pregnant women, and fathers and mothers of under- 5 years old as well as representatives from the poor and vulnerable groups, not limited to ethnic groups living in the areas participated. Representative from the NPCO led the consultation in each area providing an overview of the project object, components, impacts gathering from social assessment, and safeguard measures including feedback and resolution mechanism. After completing the consultation with community participants, the NPCO together with provincial and district health officers conducted a consultation meeting with the health center staff who are mainly responsible for the implementing on NHI, and provinding MNCH services - names of the target villages, ethnic groups, health centers, and districts are indicated in the table 3, 4, and 5 respectively.

Table 3: Ethnic Origin in the target villages of the consultations from Mar 10 – 23, 2019

Province/ District/ Health center	**No of villages**	**Total participants**		**Lao**		**Hmong**		**Khmu**		**Phong**		**Thai deng**		**Thai dam**		**Akha**		**Kor**		**Yang**		**Lue**	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
HP/ Xon/ MuangKao	5	12	9	1	2	4	2	4	2	0	0	3	3	0	0	0	0	0	0	0	0	0	0
HP/Houamuang/ Lanxieng	1	10	6	2	2	0	0	3	2	5	2	0	0	0	0	0	0	0	0	0	0	0	0
XKH/ Nonghed/ Chamuan	1	10	12	0	2	0	0	10	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ODX/ Namor/ Bankhuang	3	7	10	0	0	0	1	2	3	0	0	0	0	0	0	0	0	3	0	0	0	2	5
PSL/ Khua/ Buamphan	6	13	9	3	2	0	0	2	3	0	0	0	0	1	0	6	4	0	0	1	0	0	0
PSL/ Mai/ Kiewkacham	6	13	10	0	0	0	0	8	6	0	0	0	0	0	0	5	0	0	4	0	0	0	0
Total	**22**	**65**	**56**	**6**	**8**	**4**	**3**	**29**	**26**	**5**	**2**	**3**	**3**	**1**	**0**	**11**	**4**	**3**	**4**	**1**	**0**	**2**	**5**

Table 4: Name of the target villages of the consultations from Mar 10 – 23, 2019

Province	District	Health center	# of villages	Names of villages
HP	Xon	MuangKao	5	Mouangkao, Huaisou, Huaiyam, Vangkouang, Samsoum
	Houamuang	Lanxieng	1	Lanxieng
XKH	Nonghed	Chamuan	1	Kabor
ODX	Namor	Bankhuang	5	Khoung, Mixai, Mainatao, HuaiOne, Muteung,
PSL	Khua	Bouamphan	5	Kokphao, Kokphaokang, Kokphaotai, Peechermai, Huaila
	Mai	Kiewkacham	6	Kewkacham, Sanlouang, Phia, Pakleng, Konglok, Yaka
4	**6**	**6**	**23**	

Table 5: Health centers interviewed during the consultations from Mar 10 – 23, 2019

Provinces	Districts	Health centers	Health center staff interviewed		
			M	F	Total
HP	Xon	MuangKao	3	0	3
	Houamuang	Lanxieng	1	0	1
XKH	Nonghed	Chamuan	0	1	1
ODX	Namor	Bankhuang	0	1	1
PSL	Khua	Bouamphan	1	1	2
	Mai	Kiewkacham	2	0	2
4	**6**	**6**	**7**	**3**	**10**

In conclusion, the project has received broad community support. All community participants shared their views and experiences mostly related to ANC, PNC, birth assisted by skilled birth attendants, health care for children under five and young child feeding, and nutritional behavior change and communication throughout pregnancy and early childhood at the community level as well as challenges of acessibility to NHI services. On the other hands, the consultation with health center staff mainly the key issues discussed on the challenges of implementing NHI and providing MNCH services, and recommendations for the improvment.

At the consultations, the project received board community support. The health center staff agreed without any conditions on the implementation of the HANSA project. For example, majority of participants said that "this project will safe people lives, and help people reduce health care expenditures, and both the rich and poor families can also access to a health facility.'' Similarly, health center staff also added on about the positively thinking about decreasing out of pocket money of the poor and ethnic minorities for utilization of the MNCH services through the NHI implementation.

The brief summary of the consultations with both the community participants and the health center staff are concluded below.

8.2 Consultations with community participants can be summarized as below:

1. **Knowledge on NHI information and accessibility to NHI services** – Participats (including all ethnic groups) confirmed similar information to the NHI assessment report (2018) in term of that
    * Limited of NHI information and services, participants don't know about NHI services, but they know it as a service of "low co-payment and fee schedule, and free services.", and they cannot give explanation in details.
    * Knowing only family book as the eligible document for exemption. Participants added that currently many of the family books are with the district security office for the updated which would take several months. Thus, they had to pay for full services cost.

2. **Challenges in NHI services** – Due to limitation of understanding of NHI services, lot of complains were given at the consultations such as
    * Not clearly understand about rational drug used for NHI services, participants complainted that "when first knowing about NHI services, we went for the services, and most of the time, we only got small amount of drugs. Thus, some of us decided not to use NHI services anymore, and go back to the normal services, which we think that we get better services compared to the NHI services."
    * Limited of IEC materials on NHI services either in Lao or ethnic languages, participants mentioned that they have never seen any kind of posters on NHI information either at the villages or health facilities. For example, NHI information in Lao language only found and displayed in 1 out the 6 selected health centers wall, and other ethnic groups won't be able to understand if they cannot read Lao.
    * Not have had not good experiences utilizing of health care services, ethnic participants said that they don't feel confident visiting health facilities due to language barrier and culture beliefs. So, they don't like to visit health center where there is no their own ethnic health staff.
    * Reluctant to go for the health care services, partipants mentioned that some of health facilities tend not to provide services during out of working hours or during the weekend, which is causing community people either waiting for longer times, or spend more money and go further to the district hospital, and pay extra money

for transportation. The risk is that some patients decided to go home instead of not going to further health facility because they cannot afford it.

3. **Constrains of accessibility and affordability to MCHN services of the poor and ethnic minority women** – Participants mentioned that ethnic women are not only facing poverty and language barriers, but they also have to depend on tradition beliefs and decisions of the most influence members in the family. At the consultations, these women said that they are quite worries about their people, who are in the mid ages and older generation in their communities, especially husbands, parents and grandparents are not aware of risky inappropriate health behavior practices. The risk is that if there is no one who can speak Lao or offer to take pregnant women to a health facility, these women are hardly to manage it by themselves. Here are some of the reasons mentioned by the ethnic women for not able to accessibility and affordability to a health facility. For example,
    * Mostly Akha, Khamu, Hmong and Phong women don't like to access to the NHI and MNCH services because of their husband's beliefs. In addition, many of their husbands are drug addicted, no money, and no transportation.
    * Akha women said that they are too shy to let others know that they are pregnant, so as a result they don't go for the ANC at the early as possible, but they would go for the ANC almost at the late trimester of her pregnancy.
    * Khmu women do heavy works while getting pregnant due to fear to trouble the husbands and parent's husbands.
    * Hmong community, the husbands aged 30 and older tend not to take their pregnant wives for ANC, delivery at a health facility, or allow under- 5 years old to get vaccinated. These people think that get pregnant and give birth are natural process, and not getting child vaccinated also won't have any harm to their children.
    * The risk is that many ethnic women said that they don't ride a motorbike, and must depend on the husbands taking theme to a health facility, and they are too shy for delivery at a health facility. In fact, their husbands don't like other to touch or see their wives' bodies.

4. **Maternal and child health related to gender issues** – At the consultations, participants mentioned that in rural and remote areas, teenagers get married as very young ages at 14 years old, and have babies soon after marriage. Difficulty in physical accessing health facility, no transportation and shy, Lue, Phong, Khmu, and Hmong pregnant women did not attend ANC, and delivered babies at home with assistance from husbands, parents, and relatives. Ethnic women said that during and after delivery babies, they usually practiced food taboos, and worked hard as usual with the beliefs that those practiced

behaviors would help them deliver easily. The risks are that all ethnic women are not aware of benefit of the PNC at all, as well as get child vaccinated soon after delivery at home. Some women said that although they know what to do during pregnancy, their husbands, parents, and grandparents around her don't understand or consider as unnecessary to do such as take more rest, no food taboos, and not working overloaded. For example,

* Khmu women said that maximum 10 days after delivery, new mothers have to go back to their field work.
* Akha women said they still practice on the culture beliefs that if a mother delivers a baby twin, parents of the twin have to leave community, or give the twin to other family outside the village, so that parents can continue staying in the community. Another practice is that an Akha new mother cannot go outside of her home for 13 days, but others can visit her at home.
* Hmong community belief is that if a woman get pregnant before marriage, she has to delivery in a small hub, and continue staying there for a month before she can move back to her parents' house. Although she delivers at a health center, she has to stay in the small hub separated from her parents' house as well.

5. **Traditional healers or practice -** At the consultations, participants reported that there are 2 – 3 traditional healers, mostly are men, in almost every village in Lao, Lue, Phong, Khmu, and Hmong communities. The traditional healers are the only persons to lead a traditional ceremony, spiritual beliefs, and guide for traditional treating to the illnesses. Based on the consultations, it can be concluded that patients of the urban and rural with road access have choices for trying both traditional and western medicines. However, the risk is for the patients who are poor, have language barriers, and live in the rural and remote without road access are firstly depending on the traditional healers. Thus, it is already too late for many patients to be taken to health facility. NPCO discussed with the traditional healers, they do not oppose the project due to the different forms of practice.

6. **Recommendations –** At the consultations, participants provided recommendations with regards to getting access to both NHI and MNCH services. They would like to:
   (1) have ethnic health facility staff at a health facility;
   (2) have regular outreach team provide MNCH services, and provide NHI and Free MNCH services in their communities;
   (3) have village chief and health facility staff to talk with their family members or villagers who are still practicing health risk behaviors;
   (4) to have an active emergency number which the poor, ethnic, and illiterate groups can communicate with when any NHI and MNCH issues raised; and
   (5) ensure availability of essential of drugs and supplies at the health center level

8.3 Consultations with health center staff can be summarized as below:

Challenges in providing on NHI and MNCH services – Based on consultations with health center staff, the findings are similar to NHI assessment report (2018). The challenges raised by the health center staff on the issues related to the NHI implementation were that

* Some patients don't present on the eligible document at a health facility. In addition, health centers also don't have list of poor families and exemption records for their catchment areas. The risk is that patients must pay for the full cost.
* Limitation of NHI posters or information displayed on the wall. However, the NHI information displayed was on hand writing in Lao either on A4 paper or on flipchart.
* Most of the key health center staff responsible for the NHI implementation are Lao that create difficulty in communication with ethnic patients.
* Due to shy and language barriers, many ethnic women are still reluctance to come for ANC and delivery services at a health facility.
* Limitation of health staff have caused workload and delayed MNCH services.
* Slowly in funding reimbursement caused inadequate drugs available at the health centers, and force patients to spending more money on medicines. For example, the week of conducting consultations in Mar 2019, the health centers only received the last reimbursement for the third quarter of 2018.

Recommendations – the health center staff have recommended that they would like:(1) to have health staff with higher professional skills, especially males staff;
(2) to be trained on medical treatments, management skills, including finance, and other topics that can improve the capacity to support the HANSA implementation as well as to support NHI and MNCH services; and
(3) to get support on computer, motorbike, medical tools and equipment such as delivery set, operation set, ear checking set, oxygen tank, patients' beds for the health centers.

IX. Development of Ethnic Group Development Plan

The Ethnic Group Development Framework (EGDF) of 2019 provides a strategy and a programmatic approach to ensure and enhance the inclusion of different ethnic groups in the HANSA project. The EGDF also ensures compliance with policies of the Lao People's Democratic Republic concerning ethnic groups, as well as the World Bank's Operational Policy 4.10 on Indigenous Peoples.

The World Bank Operational Policy 4.10 on Indigenous Peoples aims to ensure that ethnic groups are afforded opportunities to participate in, and benefit from, the project in culturally appropriate ways. As the HANSA project will be implemented nationally, it will cover remote and rural areas, where many ethnic groups are concentrated, it has been designed in a manner that is fully consistent with Operational Policy 4.10 and is expected to positively impact ethnic groups. Once the government decides where the project will be implemented, the NPCO will develop an Ethnic Group Development Plan (EGDP) at the district level. The EGDP will describe in detail the socio-economic and demographic characteristics of ethnic groups in project areas, the consultation processs and results, and the manner in which the project's core activities will be carried out to ensure ethnic groups benefit from the project and the project will be implemented in the culturally appropriate manner.

An EGDP will include:

1. baseline data: socio-economic characteristics relevant to health and nutrition.

2. information on consultations and local participation;

3. culturally appropriate action plan that provides actions that would be taken in the participating districts;

4. institution responsible; ;

5. implementation schedule;

6. monitoring; and

7. budget.

Unique challenge to Ethnic Group Access	**Culturally Appropriate Action**	**Institution Responsible**	**Timeline**	**Budget**	**Monitoring/Indicator of success**

9.1 Institution Arrangement and Staff

In 2017, MOH appointed a safeguard committee for the HGNDP. On September, 9th 2019, the committee has been revised to oversee the implementation of the environmental and social safeguards framework and the EGDF for the HANSA project. The same structure of the committee has been appointed at provincial and district level. Keys information are as follows:

a. At the policy and oversight level:

1. Dr. Khamphet Manivong, Dr. Funkham Rattanavong, and Dr. Mrs. Phasouk Vongcichit Director General and Deputy Director General of Department of Planning and Cooperation, were appointed. They are also director and deputy director of the project, who manage the NPCO, and they will continue to also oversee other aspects of the project.

b. ***At the technical level:*** it consists of central and provincial technical team members.
The Ministry of Health team members include

1. Dr. Southanou Nathanontry (Deputy Director of Department of Planning and Cooperation),
2. Dr. Chansaly Phommavong (Deputy Director of Department of Planning and Cooperation),

Noted: Dr. Southanou Nathanontry, and Dr. Chansaly Phommavong will directly supervise the central and provincial consultants hired by the project, in implementation of safeguard activities based on the EGDF.

1. Mr. Sinthala Pathommavanh (Deputy Head of Administration Division, Department of Planning and Cooperation);
2. Dr. Bouathong Simanovong (Head of M&E and Surveillance Unit, center of HIV and STI Unit, Department of Communicable Disease Control),
3. Dr. Latanavanh, (Technical officer of center of HIV and STI Unit, Department of Communicable Disease Control)
4. Dr. Phitsada Siphanhthong (Deputy of technical Unit, National Tuberculosis center, Department of Communicable Disease Control),
5. Dr. Dasavanh Manivong (Technical officer of Department of Health Insurance System Management, National Health Insurance Bureau),
6. Dr. Rasamy Vongkhamsao (Head of Diseases Prevention from animals to humans and border point, Department of Communicable Disease Control),

7. Dr. Vixaiyang Chaivangmanh (Technical officer of Prevention and non-communicable disease Control, Department of Health Care and Rehabilitation),
8. Dr. Somphathai Bouathong (Deputy Head of Child Health Unit, MCH center),
9. Dr. Phengjoy Panyalath (Technical officer of Child Health Unit, MCH center,

The central consultant team members include

1. Dr. Amphone Keooudom
2. Dr. Sounthone Nanthavongduangsy

The provincial consultant team members that will be in place until December 2020. Include

1. Mr. Somphanh Xaythany (Oudomxay),
2. Mr. Inpone Soukkasak (Xiengkhuang),
3. Mr. Thinnakone Vongsopha and Mr. Yongthong Xayalath (Phongsaly) and
4. Mr. Somphone Pachaiyang and Bounthong Lorphengyong (Houaphan)

Roles and responsibilities at the technical levels:

1. ***At National Project Coordination Office (NPCO)***

   NPCO leads and works closely with the consultants from central and provincial level, provincial coordinators, and the technical team members mentioned above to ensure that social and environmental safeguards are conducted in line with Legal and Institutional Framework on Ethnic Groups in Lao PDR and the Bank's safeguard policies.

Roles and responsibilities of the NPCO include, but not limited to the followings:

i. Planning and conducting activities to fulfill social and environmental and safeguard requirements
ii. Work together with the provincial coordinators, provincial consultants and PHO to ensure that safeguards related activities including consultations are implemented properly and timely in the project provinces;
iii. Coordinate with MOH's key technical departments involves in social safeguard in order to provide technical support at all levels;
iv. Produce safeguard consultation reports with the project oversight committee to address issues or concerns received from the consultations, and provide report to the World Bank;
v. Develop Feedback and Response Mechanism (FRM) that is appropriate to the local context;

vi. Ensure that the IEC and training materials produced by the project address the gender and ethnicity issues;
vii. Include the social safeguard related activities in the action plan, and ensure adequate budget plan for conducting FPIC consultations and supportive supervision from provincial to community levels;
viii. Produce safeguard consultation reports with the project oversight committee to address issues or concerns received from the consultations as well as prepare semi-annual report on social safeguards in agreed form and submit to the World Bank prior to its supervision missions;
ix. Collect, review, and provide feedback to the safeguards reports from provincial project coordination office.

2. ***The relevant departments and centers***

The Roles and responsibilities of the relevant departments and centers include, but not limited to the followings:

i. Have the responsibilities to support in development of Feedback and Response Mechanism (FRM) to appropriate with local context, and address concerns received from the consultations in relation to the departments and centers' works.
ii. Participate at meetings and other as per assigned duties.
iii. Joint social and environmental safeguard implementation as per required.

3. ***The central and provincial consultants***

The central and provincial consultants are officially the project safeguard focal persons.

The roles and responsibilities of the central and provincial consultants of the NPCO include, but not limited to the followings:

i. Closely provide support to all related social safeguard activities at all levels, starting from assisting in the preparation stage to planning, coordination, development of IECs and trainings, conducting safeguard activities, and reporting in order to fulfill social and environmental safeguard requirements based on the EGDP;
ii. Compile all the consultation reports and recommendations and submit them to NPCO as well as make copies and distribute of these reports to each participating province, district and health center, and will be displayed at the health center notice boards;

4. ***At Provincial health office (PHO)***

Provincial Project Coordination Office leads and works closely PHO, provincial coordinators, consultants, technical team members, and target districts to ensure that social and environmental safeguards, and the target DHOs are conducted in line with

Legal and Institutional Framework on Ethnic Groups in Lao PDR and the Bank's safeguard policies. Noted that PHO will appoint the provincial technical team members as well as assign roles and responsibilities.

Roles and responsibilities of the Provincial Project Coordination Office include, but not limited to the followings:

i. Planning and conducting activities to fulfill social and environmental and safeguard requirements;
ii. Work together with the provincial and district coordinators, and target DHOs to ensure that safeguards related activities including consultations are implemented properly and timely in the districts and target HCs;
iii. Coordinate with PHO's key technical divisions involves in social and environmental health in order to provide technical support at DHOs and target HCs;
iv. Produce safeguard consultation report with the district coordinators oversight committee to address issues or concerns received from the consultations, and provide report to NPCO;
v. Ensure that the IEC and training materials produced by the project address the gender and ethnicity issues;
vi. Include the social and environmental safeguard related activities in the action plan, and ensure adequate budget plan for conducting FPIC consultations and supportive supervision from districts to community levels;
vii. Produce safeguard consultation report with the project oversight committee to address issues or concerns received from the consultations as well as prepare semi-annual report on social safeguards in agreed form and submit to the NPCO before the World Bank's supervision missions;
viii. Collect, review, and provide feedback to the safeguards reports from target DHOs.

5. ***At District health office (DHO)***

District coordination office leads and works closely with provincial coordinators, provincial consultants, district technical team members, and the target HCs to ensure that social safeguards are conducted in line with Legal and Institutional Framework on Ethnic Groups in Lao PDR and the Bank's safeguard policies. Noted that DHO will appoint the district technical team members as well as assign roles and responsibilities.

Roles and responsibilities of the District Project Coordination Office include, but not limited to the followings:

i. Planning and conducting activities to fulfill social and environmental safeguard requirements

ii. Work together with the provincial and district coordinators, and target HCs to ensure that safeguards related activities including consultations are implemented properly and timely in the target HCs and communities
iii. Coordinate with DHO's key technical units involves in social safeguard and environmental health and in order to provide technical support at target HCs and communities;
iv. Produce safeguard consultation report with the district coordinators oversight committee to address issues or concerns received from the consultations, and provide report to Provincial Project Coordination Office;
v. Ensure that the IEC and training materials produced by the project address the gender and ethnicity issues;
vi. Include the social and environmental safeguard related activities in the action plan, and ensure adequate budget plan for conducting FPIC consultations and supportive supervision from HCs to community levels;
vii. Produce safeguard consultation report with the project oversight committee to address issues or concerns received from the consultations as well as prepare semi-annual report on social safeguards in agreed form and submit to the provincial project coordination office before the World Bank's supervision missions;
viii. Collect, review, and provide feedback to the safeguards reports from target HCs.

6. ***At Health center (HC)***

Under closely supervised by the head of the target HCs, the health center coordinators lead and closely work with provincial consultants, district coordinators, district technical team members, and the target communities to ensure that social safeguards are conducted in line with Legal and Institutional Framework on Ethnic Groups in Lao PDR and the Bank's safeguard policies.

Roles and responsibilities of the health center coordinators include, but not limited to the followings:

i. Planning and conducting activities to fulfill social and environmental safeguard requirements
ii. Work together with the provincial and district coordinators, and target communities to ensure that safeguards related activities including consultations are implemented properly and timely in the target HCs and communities
iii. Coordinate with DHO's key technical units involves in social safeguard and environmental health and in order to provide technical support at target communities;

iv. Produce safeguard consultation report with the district coordinators oversight committee to address issues or concerns received from the consultations, and provide report to Provincial Project Coordination Office;
v. Ensure that the IEC and training materials produced by the project address the gender and ethnicity issues;
vi. Include the social and environmental safeguard related activities in the action plan, and ensure adequate budget plan for conducting FPIC consultations and supportive supervision to communities;
vii. Produce safeguard consultation report with the project oversight committee to address issues or concerns received from the consultations as well as prepare semi-annual report on social safeguards in agreed form and submit to the district coordination office before the World Bank's supervision missions;
viii. Collect, review, and provide feedback to the safeguards reports from target communities.

7. ***At Community level***

Under closely supervised by the village author members, the village facilitators lead and closely work with health center coordinators and relevant technical staff from provincial and district level to ensure social safeguards are conducted.

Roles and responsibilities of the village facilitators include, but not limited to the followings:

i. Have the lists of each target group such as numbers and names of pregnant women, mothers and children under 5 year old, children under 5 who are malnourished, and etc;
ii. Inform and ensure all the target groups attend the consultation;
iii. Record, report, and assist in solving concerns received from social safeguards in the community.

9.2 Measures to enhance inclusion of vulnerable and ethnic groups.

Government and National Project Coordination Office (NPCO) safeguard focal points will:

1. Work with provincial and district coordinators to compile all the consultation reports and recommendations and submit them to NPCO. Copies of this report will be distributed to each participating province and health center, and will be displayed at the health center notice boards;

2. Develop IEC in key ethnic languages and distributed to the health center in a timely manner;

3. Develop a list of ethnic groups that are hard to reach in each province so that the government could develop further the outreach plan to include ethnic groups to participate and benefit the project;

4. Recruit more female ethnic staff to work at the health centers;

5. Conduct consultation prior to implementation of the project;

6. Provide the training on safeguards to relevant government agencies and staff at the national, provincial, district, and health centers;

7. Ensure that local communities and government agencies know about the FRM. FRM will be collected, analyzed and reported to the national safeguards committee on a timely basis to ensure that key issues are addressed appropriately. Information on the FRM will be transferred to the government database information system DHIS2;

8. Remind and prepare budget to four nutrition provinces to conduct training separately for different ethnic groups and use appropriate translators to ensure that they fully understand and can apply the training. As for the training, it takes much longer time to ensure that participants from ethnic groups fully understand the messages. Language and vocabulary/terminology would need to be explained. Most of the time, male village facilitators can understand the training well, but not women. Especially among Hmong villages, the project decided:

    i) Having separate training for Hmong villages together and
    ii) Training should include men and village elderly who could work and persuade men in the villages to change their behavior and perspective.

9.3 Technical Guidelines for Consultation Framework with Ethnic Groups

As the HANSA will be implemented nationally and covered remote and rural areas, where many ethnic groups are concentrated, it has been designed in a manner that is fully consistent with Operational Policy 4.10 of the Bank and is expected to positively impact ethnic groups.

The objectives of the consultations are:

i. To ensure and enhance the inclusion of different ethnic groups to benefit from project intervention,
ii. To provide affected ethnic groups opportunities to voice their concerns and perspectives, and
iii. To ensure their informed participation in and broad community support to the project

9.3 Consultation plan

Consultation with ethnic groups during HANSA implementation will apply to all project provinces, including the 4 HGNDP project provinces due to the HANSA implementation has broader focuses than just nutrition SBCC activities. Thus, Free, prior and informed consultation will be conducted in these areas prior to the implementation using the project orientation at provincial and district level as platform for consultations.

9.4 Consultation report

Minutes of consultation meeting on ……..

Village : Number/date

District:

Province:

1. Consultation subject:
2. Objectives of consultation meeting:
3. Project information, objectives, activities and scope of implementation with visualized materials (posters, drawings, LCD used to display project and location):
4. Name of Project developer(s)/ owners and implementing agencies and their contact details
5. Potential project impacts and risks Environmental, social, livelihood, access etc (both positive and negatives)
6. Do project beneficiaries, project affected people or households (PAPs/PAHs) or other stakeholders fully support the proposed project?
7. Concerns, issues and expectations raised by the PAPs/PAHs (both negative and positive)
8. Proposed mitigation measures and support required by men and women (through group discussion if necessary)
9. Next steps/ agreed action, persons responsible, resources/budget and timeframe (if known)
10. Information disclosure, and feedback and resolution mechanism if established or to be established
11. Signatures of the minute taker, village head man/woman, representatives of NPCO and others as deemed appropriate

12. Annex: List of participants and signatures or finger prints (for those who cannot read and write)

X. Feedback and resolution mechanism

The purpose of the Feedback and Resolution Mechanism (FRM) is to ensure that the project has in place a system to receive feedback from citizens, assuring that the voices are heard from the poor and vulnerable, and that the issues are resolved effectively and expeditiously. Such a system is expected to enable the project to be fully responsive to its beneficiary communities and empower the ethnic groups and poor in villages who are the principal target of the Project.

The World Bank and the government reviewed the feedback and resolution mechanisms of the original project and found that the current structure of the feedback and resolution are not often accessible to the local communities that they are designed to address. For example, the system requires that local communities write or provide grievances to the provincial health staff. There are no clear staff and structure of the FRM focal points at all levels. In addition, there is no FRM reporting system for the government to monitor and manage grievances. In response to these constraints, the government agreed to set up a new FRM system with a clearly assigned staff and reporting structure. It was also agreed that this newly established system will be reviewed regularly with the World Bank staff.

10.1 Feedback and Resolution Mechanism Structure and Process

At the village level: Monthly Village Meeting at village

- Villages Facilitators (village head, Lao Women Union, Village Health Volunteer) will also act as the village feedback and resolution team. Village FRM focal points will:
    - Display contacts of the feedback and resolution focal persons including 3 villages' facilitators at the village office at health center catchment areas.
    - Organize monthly meetings to gather feedback/input from villagers. Village facilitators will include information with regard to FRM in the monthly report form. The village reports will be consolidated in the monthly report of Health Center, District Health Office, and Provincial Health Office. The final monthly consolidate report will be sent to NPCO for recording in Project Semi-Annual Report.

- Review and take actions to all concerns/feedback at the village level within 10 working days. FRM focal points would also seek clarification or referring cases to the district health staff level if necessary.

- Village head (also FRM focal points) will work with representative from mass organizations to gather feedback from hard-to-reach populations in remote areas. In the areas where there are hard-to-reach ethnic groups, village head will work with representatives of mass organizations to ensure these ethnic populations to solicit inputs and report to the monthly village meeting

- Any feedback/input during the home visits will also be included in the monthly village report.

- Feedback will be recorded confidentially. Summary of feedback and responses will be submitted to health center for consolidation, then submitted to the health center.

At the Health center level: Health Center Staff (HC) will:

- Provide FRM information and make contacts of health center coordinator, provincial consultant, and provincial and district project coordinators, and village facilitators of the target communities. Contacts will be displayed at the district hospital, health center catchment areas, and at the village offices.

- Attend meetings organized at the villages. Health center staffs will provide reports on the overall feedback/ input and seek clarification will also be included in the monthly health center report or referring cases if necessary.

- Feedback will be recorded confidentially. Summary of feedback and responses will be submitted to district health office or district coordinator for consolidation, then submitted to the DHO.

At the district level: District Health Staff (DHO) will:

- Provide FRM information and make contacts of district project coordinator and health center staff available to target population in the communities. Contacts will be displayed at the district hospital and at the village offices in DHO and health center catchment areas.

- Attend meetings organized at the health centers. Health center staffs will provide reports on the overall feedback and seek clarification or referring cases if necessary.

- Review and take actions to all concerns/feedback that are referred to the district level within 10 working days. DHO would also seek clarification or refer cases to the national level if necessary.

- Compile all village feedback reports as well as feedback received from phone or emails at the district level into a district FRM report to be submitted to the Provincial Health Staff (PHO) or Provincial Coordinator every month.

At the provincial level: Provincial health staff or Provincial Coordinator will**:**

- Review and take actions on all concerns/feedback that are referred to the provincial level within 10 working days. Provincial coordinator would also seek clarification or refer cases to the national level if necessary.

- Provide FRM information and contacts to all participants at the provincial meetings, provide information on the district FRM monthly report, and gather feedback from participants. Contacts will be displayed at the PHO. Compile all district FRM reports as well as feedback received from phone or emails at the provincial level into a provincial FRM report to be submitted to NPCO every month.

At the national level: The NPCO will be responsible for:

- Reviewing and taking actions on all concerns/feedback that are referred to the national level within 10 working days.

- Establishing a simplified reporting and database system for the project. Provincial FRM reports will be used to improve the project process.

- Ensuring that safeguards-related staff are properly trained.

- Ensuring that FRM information and responses are included in the project information system, and in the progress and annual reports to be submitted to the WB.

At the semi-Annual Meeting at HC, DHO, PHO and NPCO

Participants from health and relevant sectors and mass organizations will be invited to provide feedback. The HCs, DHO, PHO, and NPCO staffs will be responsible to record the feedback and responses in their semi-annual report.

10.2 Feedback and Response via Telephone and E-mail

The government has designed staff at all levels to oversee the feedback and provide responses through phones and emails. Staffs at each level will also record feedback received from e-mail and phones in their monthly report and provide direct informant/complainants with answers and information providing solutions to their concerns.

At the National Level: The National Program Coordination Office will be responsible for feedback and resolution mechanisms.

At the Provincial, District, Health center, and Village level: The provincial coordinators, district, health center staffs and village FRM committee members are the FRM focal points who will be responsible for gathering feedback and provide responses. Their contact numbers and email addresses will be displayed at their offices and will be distributed to relevant agencies including mass organizations in the areas.

10.3 Type of feedback

The NPCO has set up three types of feedback to be reported into the FRM system:

- Feedback in the form of a comment, suggestion or query for project activities.
- Feedback involving complaints against health staffs, project staff, and staff of other organizations participating in the project.
- Other feedback which may include feedback involving violations of certain rights or non-performance of obligations.

Types of feedback will be monitored and discussed with the World Bank during the Implementation Support Missions.

10.4 Acknowledgement and Processing of Feedback

Feedback and Resolution focal persons are responsible for handling all cases, categorizing them based on the completed Feedback Resolution section in monthly reporting form of each level, and deciding on whom to consult and the subsequent actions.

When a case/issue has been referred for investigation, the Feedback and Resolution focal persons (VFs) at village will investigate the cases, and discuss and consult with the involved/affected parties.

All feedback will initially be dealt with at the village level. If a case cannot be resolved at the village level, it will then be transferred to the upper level (district level) for further investigation. If the case could not be resolved at the district level, it would then be transferred to the provincial level.

10.5 Response to Feedback

The response to informant/complainant feedback will be disseminated and the final results of the Feedback process shared with the community and in particular, with the informants/complainants themselves.

Cases received/resolved and their status in the resolution process should be reported to the community assuring anonymity at the Village SBCC monthly meeting and semi-annual meeting at health center.

10.6 Feedback Monitoring System.

The NPCO will:

- Develop a simplified feedback monitoring system. The system will include appropriate features for entering, tracking, monitoring and addressing feedback on a timely basis. Process of tracking request/complaints and assess the extent to which progress is being made to resolve them.
- Analyze feedback data so that policy and/or process changes can be made to minimize problematic issues in future. Analyzing feedback data helps management reorient project processes in order to increase project effectiveness.
- Report to management which typically includes information on the number of feedback/complaints, geographical spread of feedback/complaints, characteristics of the feedback/complainants, etc.

XI. Capacity Building, Timeline, and Budgeting

Implementation timeline for the EGDF and budget will set once the project become effective. Project will ensure there is sufficient budget for the implementation as highlighted in the table 5 below by using budget in the component III.

Consultation for the expanded areas would need to be conducted prior to the implementation of the project activities. Consultation at the provincial and district level could be organized either

during the project orientation or NPCO provincial meetings with participants from all districts and from ethnic leaders and mass organizations using budget in the component III.

Moreover, NPCO should lead technical discussion meetings regarding to the key concerns and recommendations raised by social assessment, key lessons learned of social safeguard from HGNDP implementation, and key finding of the Free, Prior, Informed Consultations.

Table 6: Implementation timeline and budgeting for EGDF

No	Detailed Activities	Year					Budget (USD)
		2019	2020	2021	2022	2023	
1	Prepare for the social safeguard activities	1200	1200	1200	1200	1200	6,000
2	Translate the EGDF for HANSA project	600	600	600	600	600	3,000
3	Conduct technical discussion meetings regarding to key concerns raised by the SA, key lessons learned from HGNDP, and FPIC	4,483	4,483	4,483	4,483	4,483	22,413
4	Develop appropriate social safeguard IEC materials for specific target groups regarding to accessing to MNCH services, tuberculosis, HIV/STI, NHI, and etc.	9,062	9,062	9,062	9,062	9,062	45,310
5	Establish a simplified FRM data and information system to ensure effective monitoring and management of feedback and resolutions	4,545	4,545	4,545	4,545	4,545	22,725
6	Revise FRM reporting system for local community to easily access and concerns are addresses, and for government to monitor and manage grievances	4,306	4,306	4,306	4,306	4,306	21,530
7	Revise/ develop training manual on social safeguard session for both government staff at all level as well as community level	1,500	1,500	1,500	1,500	1,500	7,500

8	Train the FRM focal points at all levels from central to HC staffs and community level on social safeguard, FRM structure, and report system	4,759	4,759	4,759	4,759	4,759	23,795
9	Conduct orientations in the project and expanded provinces/ areas to relevant staffs from central to HC staffs and develop an ethnic group development plan to at the health center level to ensure ethnic groups can participate and benefit from the project.	11,918	11,918	11,918	11,918	11,918	59,590
10	Conduct integrated supportive supervision regarding to social safeguard and other project activities at all levels	15,439	15,439	15,439	15,439	15,439	77,195
	Total	**57,812**	**57,812**	**57,812**	**57,812**	**57,812**	**289,058**

XII. Monitoring & Evaluation and Reporting

The HANSA project has a monitoring and evaluation system which is based on an agreed project results framework. Reporting of the progress and results will be done through the existing web-based system – District Health Information System Version 2.0 (DHIS2). The project will also integrate the FRM into the DHIS2. **Implementation of activities related to social and environmental safeguards will be monitored and evaluated through the Quality Performance Score card**. Summary of the implementation of both social and environmental safeguard will be included semi-annual reports. The World Bank will conduct project implementation support every six months with the counterparts. In addition, the monitoring reports will be maintained in the NPCO and made available for the Bank's review.

Once an EGDP is developed for each district in the project implementing areas, the NPCO will submit the EGDPs to the World Bank for clerance prior to the implementation of the project.

XIII. Disclosure Arrangements

The NPCO conducted a consultation on the draft EGDF and the Environmental Assessment Framework (MSF) on October 31, 2019. The EGDF for HANSA project is made available in both Lao and English, and will be disclosed on the Ministry's website and distributed to provincial, district, health centers, and village health center offices.

References

Albone, S. (2011), Study on barrier to accessing maternal, child and reproductive health services for remote ethnic groups and vulnerable urban women.

De Sa, J. et al (2013), Identifying priorities to improve maternal and child nutrition among Khmu ethnic group, Laos: a formative study, *Maternal and Child Nutrition.* Volume 9.

Lao Department of Statistics (2010) "Poverty in Lao PDR 2008: Lao Expenditure and Consumption Survey 1992/93-2007/08", Ministry of Planning and Investment, Department of Statistics, Vientiane: Lao PDR

Lao Department of Statistics (2015) "Results from the Population Household Census 2015", Ministry of Planning and Investment, Department of Statistics, Vientiane: Lao PDR

Lao People's Democratic Republic (1991) Constitution of Lao People's Democratic Republic, Adopted by the 6th session of the People's Supreme Assembly, Vientiane: Lao PDR

Lao People's Democratic Republic (2016) "8th Five-year National Socioeconomic Development Plan (2016–2020)", Ministry of Planning and Investment, Vientiane, Lao: PDR

Lao Statistics Bureau (2018) "Lao Social Indicator Survey II 2017, Survey Findings Report", Vientiane, Lao PDR: Lao Statistics Bureau and UNICEF.

Ministry of Department of Planning, Investment and Finance, Ministry of Agriculture and Forestry (2017), "Ethnic Groups Engagement Framework." Agriculture Commercialization Project.

Ministry of Health (2012) "Decree on National Health Insurance No 470/ GO", Ministry of Health, National Health Insurance Bureau, Vientiane: Lao PDR

Ministry of Health (2016) "8th Health Sector Development Plan 2016 to 2020", Ministry of Health, Vientiane: Lao PDR

Ministry of Health (2016) "Health Sector Reform Framework 2013 to 2025", Ministry of Health, Vientiane: Lao PDR

National Health Insurance Assessment (2018) "Assessment of the social health protection schemes targeting the informal sector: National Health Insurance Scheme", Ministry of Health, National Health Insurance Bureau, Vientiane: Lao PDR

Pholsena, V. (2005) "A liberal Model of Minority Rights for an illiberal State: the Case of Lao PDR" in Kymlicka, W., and He, B., (2005) Multiculturalism in Asia, Oxford: Oxford University Press

WHO (2014), Mid-Term Evaluation of the integrated MNCH initiative at the district level in Lao PDR.

World Bank (2005) Ethnic Group Development Plan for the Health Services Improvement Project.

World Bank (2014) Health Services Improvement Project – Additional Financing. Consultations with Ethnic Groups during Project Implementation: final report.

World Bank (2017) Ethnic Group Development Plan for the Health Governance and Development Project – Additional Financing.

World Bank report on Challenges in health financing for Lao PDR (2013) available on at http://www.worldbank.org/en/news/feature/2013/04/18/challenges-in-health-financing-for-laopdr

World Development Indicators (2010) available online at http://data.worldbank.org/data-catalog/world-development-indicators

Appendix A - Other additional information related on MNCH service delivery as mentioned below:

1. **Health system and staffing**

Referring to the EGDP for HGNDP mentioned that MoH records on public sector health workers for 2014 showed a total health staff of 19.703 of which 62.8 percent are women, and 11.811 are posted to health facilities. Management positions held by women (49.3 percent) compare more favorably than many other ministries. The health staff is predominantly Lao-Tai (79.2 percent). There are 747 community midwives with 44.2 percent at Health Center level, 48 percent at District Hospitals, 3.5 percent at Provincial Hospitals, and the remainder at the central level. Of the 950 health centers, 90 percent have less than 4 staff, and around 22 percent have only 1 or 2 staff.

The internal evaluation of the MNCH Strategy found that staffing at health centers was inadequate to supply basic MNCH health care, with only 30 percent of all health centers nationally having a trained Skilled Birth Attendant (SBA) on staff. The gender of SBA is also a significant issue in enabling access to MNCH services for ethnic women in Lao PDR. In many ethnic communities it is considered inappropriate for women to receive obstetric treatment form a male, therefore, training and deploying male SBAs risks investing in a workforce that may not increase ethnic women's access to MNCH services (WHO 2014, Albone 2011, WB 2014).

Government frameworks for the health sector have aimed to achive the universal health coverage by 2025 by focusing on expand and improve the quality of public health services, which aim for reduction ration rates of underweight, stunting, and mortality in under- 5 years old; reduction of maternal mortality rates; and increase percentage of population use clean water and latrine, and covered by the health insurance (NSEDP 2016 – 2020). In addition, the frameworks of the Health Sector Reform (HSRF) 2013 – 2025 has also targeted to increase access to basic services by 2020.

2. **Health Information system**

The MoH considers health information system significant important. For example, the health information system has included in (1) the MoH's 8th Health Sector Development Plan (HSDP8) runs from 2016 - 2020, which activities contain (a) improving health information systems, (b) human resources for health, (c) health financing and (d) a reproductive health strategy; and (2) the Health Sector Reform Framework (2013 -2025), which 5 priority areas contain for the reform agenda, namely: (a) human resources for health; (b) health financing (to increase government funding for basic health services); (c) governance, management and coordination; (d) service delivery; and (e) health information system.

In addition, the current World Bank health project, HGNDP, has been supporting the Government strategy and plan on: (1) the development, implementation and maintenance of an improved HMIS of MoH through the DHIS2; and (2) technical support and capacity building for MoH staff at all levels to use such system. Currently, several data platform and formats of malaria, tuberculosis and HIV/AIDS, Human Resources, the Expanded Immunization Program (EPI), and financial management information have been fully created and integrated into DHIS2. The Additional Financing have continued to support the MoH through implementation of the Health Information Strategic Plan, and integration of HMIS for all vertical programs into DHIS2. Such support process are provision and maintenance of IT equipment, technical assistance and training of staff at all levels to ensure data quality and use of information for planning and decision making purposes. It is also envisaged that the Village Health Information System will be integrated into DHIS2.

3. Maternal health issues

Women aged 15 – 49 years who were attended at least once antenatal care (ANC) by a skilled health attendant is at 78.4 percent. The pregnant women in urban (93.3 percent) are two times more likely to attend the ANC compared to rural without road (55.4 percent), and the poorest (51.7 percent) wealth quintile (LSIS 2017).

Safe delivery at a health facility is at 64.5 percent. It is almost three times higher that pregnant women in urban (87.9 percent) like to give birth with a skilled birth attendant compared to rural without road (37.7 percent), and the poorest (33.9 percent) wealth quintile delivery at health facility. As the consequences that home delivery is high as 60 percent and over for the rural without road (59.9 percent), non-education mothers (61.9 percent), and mothers who have never visited ANC checkup (85 percent). In addition, home delivery is about 20 times higher for the poorest (64.5 percent) compared to the richest (3.7 percent) wealth quintile (LSIS 2017).

Post-natal health care (PNC) for the newborn is at 47.1 percent compared to urban (69.1 percent), and rural without road (25.9 percent). The richest (80 percent) are almost 5 times higher access to PNC compared to the poorest (19.2 percent) wealth quintile (LSIS 2017).

Total fertility rate of women age 15 – 49 years is at 2.7 compared to urban (3 percent), and rural without road (3.9 percent). The richest (2 percent) is two times less likely to have many children compared to the poorest (4.1 percent) wealth quintile (LSIS 2017).

Adolescent birth rate aged between 15 – 19 years old is at 83 percent. Early childbearing is very high in the rural without road (136 percent), and none education mothers (176 percent). In

addition, it is about eight times higher compared between the poorest and richest wealth quintile (156 percent and 20 percent respectively) (LSIS 2017).

4. Child health and nutrition issues

Child immunization for under- 2 years old vaccination who have been received fully immunized by the first years of life is at 48.1 percent compared to urban and rural without road areas (53.4 percent, and 40.7 percent respectively). However, the immunization coverage for all the vaccines is still below the target of 90 percent. Child immunized coverage for BCG is at 81.5 percent; Polio3 is at 69 percent; DTP-Hib-HepB is at 60.8 percent; and Measles and Rubella (MR1) is at 66 percent (LSIS 2017).

Under- 5 years old malnourished children remains significant high with underweight is at 21 percent, stunted is at 33 percent, and waster is at 9 percent. All types of child malnutrition are two to three times higher in the rural without road, mothers with less education, and the poorest wealth quintile. Moreover, geographic and social-economic are the factors. For example, stunting rates among Hmong-Mien children are two times higher compared to Lao-Tai children. And Phongsaly province is about 4 times higher of stunting compared to Vientiane Capital (LSIS 2017).

5. Maternal and child mortality

The 2015 Lao Census (PHC 2015) report showed on maternal and child mortality rates between year 2005 and 2015. For example, maternal mortality rate declined from 405 to 206 maternal deaths per 100,000 live births in 2015; the infant mortality rate decreased from 70 to 57 deaths per 1,000 live births in 2015; and the under-5 mortality rate dropped from 98 to 86 deaths per 1,000 live births in 2015.

6. Clean and safe environment

The LSIS 2017 report showed that there has been good improvement of the water supply coverage. Over 83 percent of population have been using improved water sources of drinking, and only 58 percent among the poorest quintile has been accessed. The main issue is quality of water. Over 80 percent of water quality tested are found positive of E-Coli. Over 73 percent of population have been using improved sanitation, and 24 percent of them have been practicing open defecation (LSIS 2017).

Appendix B: Public Consultation Report.

Lao People's Democratic Republic

Peace Independance Democracy Unity Prospority

Ministry of Health

Department of Planning and Coorperation

No. /DPC

Vientiane Capital, Date....

Minutes Meeting Note

On DLIs implementation result launching in year 4th of Health Governance and Nutrition Development Project and Health and Nutrition Services Access Project Preparation with line departments, relevant Centers and target 14 provinces on October 31st, 2019 in National ASEM Hall.

According Ministry of Health's decree No. 3354/MoH in October 30th, 2019 for DLIs implementation result launching in 4th year of Health Governance and Nutrition Development Project and Health and Nutrition Services Access Project Preparation with line departments, relevant Centers and target 14 provinces to be president by Deputy Assistant Professor Bounkong Sihavong, Mininster of Health including Several Department Director, Centers Head and Deputy Head and Provincials Health Office from 14 target provinces with technical staff and World Bank staff totally 90 participants (participant's annex).

Minister of Health addressed the critical implementation through project review, efficient & effective of DLIs approach, to enhance the health's 14 target benificary, otherwise, it might all sectors from central and provincial health office level to solve the previously weakness and other

challenges and in coming year (2020) to rehabilitate from last disaster as many provinces flooding and several indicators trend to not achive such as delivery by skill birth attendant, child immunisation, water & sanitation and other indicators.

I. Purposes :

- To launch the DLI implementation result in 4th year, challenges, lessons learnt from HGNDP project;
- To discuss on HANSA Project preparation;
- To consult the social and environmental safeguard of HANSA project.

III. planary discussion, consultation and recommendation:

A./ Health Governance and Nutrition Development Project implementation

Advices from Minister of health

1. Request to all sectors from national and provincial level to summarize what activities funded by DLIs money, highlights, weakness and how much spent and fund rest because few assemblee's indicators don't achieve yet; especially nutrition and critical indicators to be paid attention thus immunisation, delivery by SBA, water and sanitation in 2020.
2. Request to cancel 5th year DLIs implementation and allocate budget to support last year disaster and unsuccesfull assemblee's indicators as consultation with World Bank.
3. Request to increase budget to boot immunisation for low EPI rate province.
4. Request all province to review which health facilities don't meet milestones.
5. Request who are responsible for project and relevant people on HANSA project preparation; particularly DLI to review on implementation plan before hand.
6. Request to Department of Planning and Cooperation to coordinate with MoH office in amendment dicument drafting of use DLIs in 5th year budget to combine for last disaster and unsucessful assemblee's indicators.

Oudomxay Province

1. Should have only one integrated MCH outreach book
2. Request to train on DLIs inpection, right, role & responsabilities of coordination committee.

Nutrition Center

- Request to department of food and drugs consider the nutritionous drugs to national health insurance system that could purchase some in province level.

Department of Hygiene and Health Promotion

1. Request to whome are responsible for implementing to explore why it's not successful for few indicators.
2. To divisions who are responsible to manage the HGNDP implementation in each provinces such as budget is not adequated in MCH and prevention and health care section in provinces.
3. Use DLIs budget to boot the provinces priority issues throught detail budgeting, proposals and planning.
4. Request to Department of planning and cooperation to conduct the end line survey for DLIs implementation result.

Department of food and drugs

1. Over estimation number than real need, should minimize time to store
2. Sometimes, drug distribution for each time still not respect distribution mecanism (used but not lock out)
3. Delay planning for all sections, step of approval is also delayed, provincials food and drug don't recieve the budget.
4. Request to financial filing for all sectors after inpection and accounted

Department of Finance:

1. Request to all sectors to review the indicators and milestones whether can achieve
2. Request to review the project preparation period or financial management of health center with fund flow.

Xiengkhouang Province

1. Request to departments, ministries to write the detail instruction ordering, orientate to implementation, 5th year DLIs money to ensure for auditors and implemention reference.

Bokeo province

1. Request to human resource capacity building for additional management and implementing for new recruitment of project committee.
2. Request to have ministry instruction order for policy, right, roles and responsibilities in each level.

Luangprabang province

1. However DLI money is fexible to use for other activities thus emergency response but it's essential to have narrative and financial report with relevant audit inpection and financial registration, control quotation and respect to defined plan.
2. Request to allocate the DLI money in 2020 that each provincial successed to relevantly use 5th year of DLI budget.

Saravanh Province

1. Request to have same standard of Health facilities assessment in each topics throught what kind of HC fence, stove and other things.

B./ HANSA Preparation

1. Request to department of planning and cooperation for other sectors consultation with revelant sectors, ownership to project coordination and HCs role for DLI-C of HANSA project.
2. Defined the indicators, milestones, DLI inspection method to be verified by Ministry of Home Affairs in December 2019 to comment and modify before HANSA project need assessment.
3. Request to organise the meeting to agree for implementation as performance quality score card.
4. Request to review project implementation to clasify the management related three build policy.

C. / HANSA project Social and Environmental Safeguard including sharp waste managemant framework

1. Before hand new project, ministry of health might focuss the project documents and target provinces consultation thus (1) Ethnic Group Development Framework to ensure that ethnic minirity population access to health services; (2) Social and Environmental Safeguard such as Helth facilities has safe water, sanitation and stove for medical equipment waste, constrution or renovate, whether population are satifactory and get the maximun benificiary from this project.
2. At present; this project finished dratf all related documents and will share with provinces to add the comments before announcement in website or other social media as donors regulation.

The meeting closed at 16 o'clock with all success as well.

Meeting Chair

Department of Planning and Coorperation

Appendix C: Government Policies and Strategies

1. The 8th National Social and Economic Development Plan (NSEDP 8) runs from 2016 until 2020 and incorporates health and nutrition under several of its program objectives. It incorporates a specific focus on mother and child health under the pursuit of MDG 4 and 5. The NESDP sets sector targets for all GoL line ministries which are then used as guiding principles for agency annual workplans and budgets.

2. The MOH's 8th Health Sector Development Plan (HSDP8) runs from 2016 to 2020 and seeks to strengthen the capacity and professionalism of health workers and the quality of health facilities and training institutions. It contains a series of activities that include improving health information systems, human resources for health, health financing and a reproductive health strategy.

3. The MOH launched a National Strategy for Human Resources for Health (2010-2020) which provides adequate allocation of staff quotas to Health Centers and additional training for 1,500 community midwives (also known as skilled birth attendants) to address high levels of maternal and child mortality. However health posts allocated by the Ministry of Home Affairs continues to be low (in 2011 only 10 percent of the quota requested was filled).

4. The Health Sector Reform Framework (2013 to 2025) contains 5 priority areas for the reform agenda, namely: (a) human resources for health; (b) health financing (to increase government funding for basic health services); (c) governance, management and coordination; (d) service delivery; and (e) health information system.

5. The current (2nd) National Strategy for the Advancement of Women contains specific targets focused on women and children's health; the National Committee for the Advancement of Women, established in April 2003 by Prime Minister's Decree No. 37/PMO is responsible for its implementation. The National Committee has responsibility to support line Ministries integrate gender into their planning, budgeting, and monitoring and evaluation cycle. Networks are currently being established in all line Ministries, with the aim of having representation at the sub-national levels (down to the District) as well. The MOH has appointed its Committee for the Advancement of Women whose focal point is the Division for Advancement of Women; this office has drafted a Strategy for the Advancement of Women in the Health Sector (2011-2015), which contains both institutional (inclusion of women in training, and management positions) as well as community impact targets. In

addition, the MOH's Division for Advancement of Women plays a role in collecting data for compiling health MDG progress reports regarding health.

6. The first National Nutrition Strategy and Plan of Action covered the period 2010-2015, and the follow-on Multisector Food and Nutrition Security Plan of Action (2014-2020) is at an advanced stage of development. It recognizes the importance of a multisector approach to nutrition to address some of the highest stunting rates for under-fives (44 percent). Some of the causes being feeding and care practices, food and nutrient intake, and diarrhea, as well as the nutrition status of the mother. The Plan of Action identifies 28 activities in the agriculture, water sanitation and hygiene, education and health sectors, to be implemented in 26 high priority districts in 7 Provinces.

7. The goal of the National Policy on Health Communication, decreed by the Prime Minister in 2012, is to set up efforts to make health-related information accessible to population and to promote health including the prevention against contagious and non-contagious diseases, new infectious diseases, outbreaks and health emergencies. The MOH has been designated to coordinate with relevant sectors to elaborate and effectively implement this national policy. The Center of Information and Education for Health acts as the focal point of the central level to coordinate with the Ministry of Information, Culture, and Tourism and other relevant authorities. At the provincial level, the provincial health education division acts as the focal point in coordination with the Department of Information, Culture, and Tourism and other relevant authorities. The district health education unit acts as the focal point of the district level in coordination with the district office of information, culture, and tourism and relevant authorities.

8. The LWU established in 1955, was recognized in 1991 under the Constitution of the Lao People's Democratic Republic (Lao PDR). Its mandate is to represent women of all ethnic groups and to "protect women's rights and interests", mobilize and increase women's involvement in national development. It falls under the Party's Central Committee and plays a key role in the development of policies relation to national development and women. It has representation from all ministries down to village level. The provincial and district level representatives are very active in, among other things, village level health. Their vast network has made them logical partners in a variety of activities, particularly those in rural areas.

Appendix D: Provinces and their Ethnic Composition

Province	Total Pop	% EMG	2014 EMG Popn	% and No. of Lao-Tai		% and No. of Mon-Khmer		% and No. of Tibeto-Burma		% and No.of Hmong-Lewmien		% and No. Other	
Oudomxai	329,110	78.5%	253,177	20.6%	54,281	60.5%	150,584	5.7%	10,466	12.3%	35,340	0.0%	156
Phongsali	180,996	80.4%	145,203	18.9%	25,198	20.7%	31,240	53.6%	78,921	6.1%	8,811	0.0%	0
Luang Namtha	181,000	72.2%	123,975	26.9%	34,632	34.3%	35,892	31.2%	43,209	6.8%	9,175	0.0%	0
Bokeo	182,198	62.4%	111,294	37.1%	39,137	28.4%	43,266	18.2%	11,202	15.1%	16,074	0.1%	268
Xiengkhouang	263,465	51.3%	129,540	48.0%	55,326	10.0%	15,037	0.1%	120	41.2%	58,115	0.0%	0
Luang Prabang	472,618	70.7%	302,364	30.0%	79,866	51.4%	151,169	0.2%	419	17.6%	52,343	0.1%	313
Houaphan	340,828	44.4%	150,345	55.7%	66,283	20.3%	28,812	0.0%	38	23.1%	34,628	0.0%	13
Sayabouly	403,504	27.2%	106,955	73.6%	58,727	15.8%	27,685	0.1%	206	9.9%	13,397	0.0%	115
Xaysomboun	81,801	67.1%	54,824	32.0%	13,876	19.3%	8,198	0.1%	67	47.7%	32,202	0.3%	158
Vientiane Prov	446,270	30.8%	143,469	70.7%	69,680	16.6%	31,956	0.1%	91	11.5%	19,657	0.0%	22
Bolikhamxai	294,707	29.7%	76,420	74.6%	42,182	8.8%	9,067	0.1%	68	14.5%	16,252	0.7%	1,007
Khammouane	434,199	19.5%	64,896	76.4%	41,230	21.5%	21,600	0.1%	176	0.0%	12	0.7%	870
Savannakhet	1,004,646	29.2%	222,757	69.9%	114,959	29.2%	105,742	0.0%	0	0.0%	0	0.2%	348
Champasak	727,821	13.4%	100,654	85.1%	57,208	13.4%	41,925	0.0%	0	0.0%	0	0.2%	401
Saravan	403,575	48.9%	151,431	49.8%	47,751	48.9%	101,195	0.0%	0	0.0%	0	0.6%	1,529
Sekong	115,165	89.3%	98,765	10.0%	11,958	89.3%	86,082	0.0%	0	0.0%	0	0.1%	80
Attapue	143,934	69.3%	87,857	29.2%	25,180	69.6%	61,550	0.0%	0	0.0%	0	0.1%	77
Vientiane Capital	903,747	3.7%	40,090	95.0%	36,731	1.4%	601	0.2%	72	2.3%	2,320	0.1%	38
Total	**6,909,583**	**34.2%**	**2,364,017**	**54.1%**	**874,208**	**28.3%**	**951,603**	**4.6%**	**145,055**	**11.9%**	**298,326**	**0.2%**	**5,395**

Sources: The 4th Population and Housing Census (PHC) 2015

Appendix E: list of participants in March 2019

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...12.../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ.....[illegible]......,ບ້ານ:.....[illegible].......ເມືອງ:......[illegible]......ແຂວງ:.....[illegible].....

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການ ສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ. [illegible]	ຍິງ	20	ມົ້ງ	[illegible]	[illegible]	ແມ່ຍິງບ້ານ	02097713955	[illegible]	[illegible]
2	ນ. [illegible]	ຍິງ	20	ມົ້ງ	[illegible]	[illegible]	ແມ່ຍິງບ້ານ		[illegible]	[illegible]
3	ນ. [illegible]	ຍິງ	18	ມົ້ງ	[illegible]	[illegible]	[illegible]	02092716550	[illegible]	
4	ນ. [illegible]	ຍິງ	28.	ມົ້ງ	[illegible]	[illegible]	[illegible]	0304433637	[illegible]	[illegible]
5	ນ. [illegible]	ຍິງ	21	ລາວລຸ່ມ	[illegible]	[illegible]		020915512?3	[illegible]	[illegible]
6	ນ. [illegible]	ຍິງ	26	[illegible]	[illegible]	[illegible]		030576555?5	[illegible]	[illegible]
7	ນ. [illegible]	ຍິງ	27	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]

8	ນ.ພັນ	ຍິງ	33	[illegible]	ມ.1	ບ.[illegible]	4 ນ [illegible]	020971270 635.	ນ.ພັນ	[illegible] 5 ປີ
9	ນ.ນຸດ	ຍິງ	31	[illegible]	ປ.5	ບ.[illegible]	ພ.ອ.ບ.	0309412334	[signature]	
10	ນ.ອ່ອນ	ຍິງ	25	[illegible]	ປ5	ບ.[illegible]	ປະກັນ	0304594 551	ນ.ອ່ອນ	[illegible]
11	ນ.ສີວິໄລ	ຍິງ	22	[illegible]	ມ2	[illegible]	5ດ [illegible]	8099649846	[signature]	
12	ນ.[illegible]	ຍິງ	23	[illegible]	ມ2	[illegible]	[illegible]	02097470019	[signature]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[signature] ຄຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

[stamp: ສຸກສາລາ ...] [signature] ສຸດາ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:........../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ....ເມືອງເຫົ່າ......................,ບ້ານ:....ເມືອງເຫົ່າ.....,..............ເມືອງ:...ຂວາ.......................ແຂວງ:..ພົງສາລີ.......................

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
01	ທ.ໄຊອິນທີ	ຊ.	42	ໄທດຳ	ມ6.	ເມືອງເຫົ່າ	ອະນະບານ	020.99992442		
02.	ທ. ສົມທາ –	ຊ.	62.	ໄທແດງ	ປ.5	ເມືອງເຫົ່າ	ຄນະພັກຮຸ່ມ	020.9952506		
03	ທ ວິນັດ	ຊ	25	ເຜົ້າ	ມ7	ຫ້ວຍຍານ	ສ:ນະບານ	0309131913		
4.	ທ. ພັນວິໄພ	ຊ	34	ເຜົ້າ	ມ1	ທາວັນຊ໌	ອ ສບ	02096768441		
5	ທ. ມຸດ	ຊ	23	ໄທແດງ	ມ7	ເມືອງເຫົ່າ	ສະບະ ຊາວໜຸ່ມ	0305119907		
6	ທ.ໄມທອງ	ຊ	27	ຂມຸ	ມ3	ສາມແສນ	ອ. ສ. ປ.	02099434391		
7	ທ.ວິສັນ	ຊ	33	ຂມຸ	ປ.ອ.	ບ. ຫ້ວຍອຸ	ຣພນພດ	0309458834		
8.	ທ. ຈົ່ງຄຳລັບ	ຊ.	31	ລາວ	ມ3.	ບ. ເມືອງເຫົ່າ.	ອສ.ບ.	02055311350		
9	ທ. ສຸລີ	ຊ	30	ລາວ	ມ6	ສາທາລະນີ	ຄົນຂອງ	0304492225		

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ຈັນພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ສຸລີດາ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...14.../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ......ວ່າເໜືອ......................,ບ້ານ:.......ກະບໍ່.......................ເມືອງ:...ໜອງແຮດ...........ແຂວງ:.....ຊຽງຂວາງ..................

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ. ຢີ່ນ	ຍ	46	ຂະມຸ	ປ2	ກະບໍ່	ປ/ຊ		ໝ່ຽງ ຢີ່ນ	
2	ນ ດວງຈັນ	ຍ	27	ຂະມຸ	ມ3	ກະບໍ່	ປ/ຊ		ນ ດວງຈັນ	
3	ນ. ລີ	ຍ	32	ກຶມມຸ	ມ1	ກະບໍ່	ປ/ຊ		ນາງ ລີ	ຄືພາ.
4	ນ. ຄຳ	ຍ	28	ກຶມມຸ	ມ1	ກະບໍ່	ແມ່ຍິງບ້ານ		ນາງຄຳ	
5	ນ. ແພງ	ຍ	47	ກຶມມຸ	ບໍ່ໄດ້	ກະບໍ່	ປ/ຊ			

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...14.../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ......ລ່າເຫີນ......................,ບ້ານ:.......ກະບໍ່......................ເມືອງ:...[illegible]...........ແຂວງ:.....[illegible].................

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ. ຮິນ	ຍ	46	ຂະມຸ	ປ2	ກະບໍ່	ບ/ຊ		[illegible]	
2	ນ ດອງຈັນ	ຍ	27	ຂະມຸ	ມ3	ກະບໍ່	ບ/ຊ		ນ ດອງຈັນ	
3	ນ. ລີ	ຍ	32	ກຶມມຸ	ມ1	ກະບໍ່	ບ/ຊ		ນາງ ລີ	ຄື່ພາ.
4	ນ. ຄຳ	ຍ	28	ກຶມມຸ	ມ1	ກະບໍ່	ແມ່ຍິງບ້ານ		ນາງຄຳ	
5	ນ. ແພງ	ຍ	47	ກຶມມຸ	ບໍ່ໄດ້ຮຽນ	ກະບໍ່	ບ/ຊ		[fingerprint]	

1

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:........../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ.......ລ່າເຫີນ.......................,ບ້ານ:.......................................ເມືອງ:...................................ແຂວງ:..

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ທ. ບົວກາຍ	✓	43	ຂະມຸ	ຊັ້ນສູງ	ກະບໍ່	ນາຍບ້ານ	0305775888	[signature]	
2	ທ ທອງສີ	✓	43	ຂະມຸ	ມ2	ກະບໍ່	ແນວລາວສ້າງຊາດ	0304724683	[signature]	
3	ທ ຄຳສຸກ	✓	55	ກຶມມຸ	ຊັ້ນກາງ	ກະບໍ່	ຄູສອນ	0302290 592	[signature]	
4	ທ ຄຳເພີ	✓	50	ກຶມມຸ	ມ1	ກະບໍ່	ບ/ຊ.	0304703140	ຄຳເພີ	
5	ທ ທອງບົວ	✓	52	ກຶມມຸ	ບ.3	ກະບໍ່		0305742865	[signature]	

6	ທ ບຸນ ທັນ	✓	59	ຂະມຸ	ປ3.	ກະບ້	ປ/ຊ.	0305066030		
7	ທ ສົມ	✓	37	ຂະມຸ	ປ3.	ກະບ້	ປ.ກ.ຊ.	0304649370		
8	ທ ສາຍພອນ	✓	49	ຂະມຸ	ມ3	ກະບ້	ຮຽນບໍ່	0305372807		
9.	ທ ສົ່ງ	✓	28	—	ມ3	ກະບ້	ຂອງການເຮັດບັດ	0304949029.		
10	ທ ຊີ.	✓	44	ຂະມຸ		ກະ ບ້	ການຄ້າ	0305076498.		
11	ທ. ໄຊ	✓	35	ລື້	ມ6	ກໍໄຊ	ບໍລິການ	99553661		
12	ທ. ສົມພອນ	✓	36	ລາວ	ມ.6	ກໍໄຊ	ບ/ນ ອາຫານ	0309701157		

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ສຸກສາລາ ຈ່າບົ່ມ

ສົມວັນ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:........../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ......ລາຍສູດ......ບ້ານ:......ລາຍສູດ......ເມືອງ:......[illegible]......ແຂວງ:......ຫົວພັນ......

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
01	ສົມພອນ	ຊາຍ	24	ຂະມຸ	ມ.5	ບ. ລາຍສູດ	[illegible]	0309374615		
02	[illegible] ອິນ	ຊ	48	[illegible]	ປ2	ບ້ານລາຍສູດ	[illegible]	030 9218949	ອິນ	
03	[illegible]	ຊ	42	ລາວ	ປ.5	ບ້ານລາຍສູດ	[illegible]	0309911735		
04	ທ. ພົນ	ຊ	35	[illegible]	ປ.2	ບ້ານ ລາຍສູດ	[illegible]	0304888[illegible]	ເຊັນ	
05	ທ. [illegible]	ຊາຍ	36	ຂະມຸ	ມ6	ບ້ານລາຍສູດ	ປະທານ	02055441156		
06	ນ. [illegible]	ຍ	33	ລາວລຸ່ມ	ມ6	ສາທາລະນະສຸກເມືອງ	ວິຊາການ	28605432		

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[illegible]

ລາຍເຊັນພະນັກງານສຸກສາລາ

[illegible]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...19.../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ........ລາວຊຽງ.................,ບ້ານ:.......ລາວຊຽງ.................ເມືອງ:...~~ຊ່ອນ~~ ຫົວເມືອງ..............ແຂວງ:.......ຫົວພັນ..............

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການ ສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
	ນ. ເພັງ	ຍ	20	ຂະມຸ	ປ.2	ລາວຊຽງ	ປ/ຊ		ນ. ເພັງ	ແມ່ລູກອ່ອນ
	ນ. ໄຊອາຍ	ຍ	18	ຂະມຸ	ປ3	ລາວຊຽງ	ປ/ຊ		ນ. ໄຊອາຍ	ແມ່ຍິງຖືພາ
	ນ. ກຽງ	ຍ	20	ຂະມຸ	ປ3	ລາວຊຽງ	ປ/ຊ		ນ. ກຽງ	ແມ່ຍິງຖືພາ
	ນ. ອຸ້ຍ	ຍ	18	ລາວລຸ່ມ	ມ3	ລາວຊຽງ	ປ/ຊ	0304938 719	ນ. ອຸ້ຍ	ແມ່ຖືພາ
	ນ. ບົວພັນ	ຍ	25	ລາວ	ມ1	ລາວຊຽງ	ປ/ຊ	0304794 701	ນ. ບົວພັນ	ຖືພາ

	ນ. ຈູນ	ຍ	19	ມົ້ງ	ປ.4	ນັກຮຽນ	ປ/ຊ	0305155 839	ນ.ຈູນ	ກຳພາ
	ນ. ນັ່ງ	ຍ	16	ມົ້ງ	ມ.1	ນັກຮຽນ	ປ/ຊ		ນາງ ນັ່ງ	ກຳພາ
	ນ. ແພັດ	ຍ	18	ມົ້ງ	ມ.2	ນັກຮຽນ	ປ/ຊ	0304797 163	ນ.ແພັດ	ກຳພາ
	ນ. ເຕັ່ງ	ຍ	28	ມົ້ງ		ນັກຮຽນ	ປ/ຊ			ກຳພາ
	ນ. ຊົ	ຍ	20	ມົ້ງ	ປ3	ນັກຮຽນ	ປ/ຊ	0709196 317	ນາງຊົ	ກຳພາ

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ຄຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ທາພອນ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:..18...../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ....ນາເມີ ຊວາງ......................,ບ້ານ:.....ຊວາງ..........................ເມືອງ:.....ນາໝໍ້..........................ແຂວງ:.....ອຸດົມໄຊ..............

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
01	ທ ກາລີ ຕາລີບລີຍາ	✓	51	ລື້	ປ.5	ຊວາງ	ຮອງນາຍບ້ານ	23959220	[signature]	
02	ນ ຄຳອົ້ນ	✓	36	ຂະມຸ	[illegible]	[illegible]	[illegible]	0305995696	[signature]	
03	ທ. ແພງ		53	ລື້	ປ5	ຊວາງ	[illegible]	0305447475		
04	ທ. [illegible]		48.	ລື້	ມ.1	ຊວາງ.	[illegible]	54933806	[signature]	
05	ທ. [illegible]		33	ລື້	ມ.3	ຊວາງ	ອ.ສ.ວ	020 58843433	[signature]	

6										
7										
8										
9										
10.										

ลายเซ็นหัวหน้าหมู่งานเก็บข้อมูล

ลายเซ็นเจ้าหน้าที่งานสุขาภิบาล

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໄພຂຸຂະບາການ (ຫັນສາ)

- ຄັ້ງວັນທີ:....18../ 03 / 2019
- ສະຖານທີ່: ສຸກສາສາ.....ຂວາ.....,ບ້ານ:.....ຂວາ.....,ເມືອງ:.....ນວາໝໍ້.....ແຂວງ:.....ອຸດົມໄຊ.....

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັ່ນ	ໝາຍເຫດ
1.	ນ. ແສງ.	ຍ	31	ລ	ມ6.	ບ. ຂວາງ.	ປ: ສຸກສຸ	03058441037	. ແສງ.	
2	ນ. ເອດ	ຍ	35	ລ	ມ.3	ບ. ຂວາ	ປ: ສຸກສຸ	03056462	ເອດ	
3.	ນ. ວຸທາເຢ	ຍ	17	ກໍ	ມ5	ບ. ຫ້ວຍ	ນ/ຣ.	020523172	ວຸທາເຢ.	
4	ນ. ລີ	ຍ	25	ຫ່ານ	ປ2	ບ້ານ ນາ	ປ: ສຸກສຸ		ນ. ລີ	
5	ນ. ໄຊວ	ຍ	20	ຫ	ມ.7	ບ. ຜູ້ຕ້ານ	ປ/	020	ນ. ໄຊວ	

໑	ນ.ແກ້ວ	ຍ	24	ຂະມູ	ມ4	ພູທອງ	ປະຊາຊົນ	0305703934	ນ.ແກ້ວ	
໒	ບ.ສີທອງ	ຍ	18	ກໍ	ມ4	ພູທອນ	ນັກຮຽນ	02058966213	ບ.ສີທອງ	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ຄຳວັນ ສີວັນໄຊ.

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:..14../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ...[illegible]......,ບ້ານ:...[illegible]......ເມືອງ:...[illegible]......ແຂວງ:...[illegible]......

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1.	ທ.ສົມ ຈິດ.	ຊາຍ	29.	ອາຄາ.	ມ.3.	[illegible]	[illegible]	020822304418	[illegible]	
2.	ທ.[illegible]	—	34	ອາຄາ	ປ/5	[illegible]	ອສບ	0304899165	[illegible]	
3	ນ.[illegible]	ຍິງ	37	ລາວສູງ	[illegible]	[illegible]	ຄະນະບ້ານ	0305433132	[illegible]	[illegible]
4	ທ.[illegible]	—	42	ກຶມມຸ	ປ/5	[illegible]	ຮອງບ້ານ	02052895879	[illegible]	
5	ນ.[illegible]	ຍິງ	32	ກຶມມຸ	ມ2	[illegible]	ອສບ	0305688943	[illegible]	

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6	ທ. [illegible]	✓	36	ຊາວນາ	ປ.5	ບ. [illegible] ເລຂາ [illegible]		02055625979	[signature]	
7	ທ. [illegible]	✓	28.	ຊາວນາ	ປ.5.	ບ. ຫ້ວຍລາ	[illegible]	0309346461	[signature]	
8	ທ [illegible]	✓	45	[illegible]	ມ7	[illegible]	[illegible]	0309460288	[signature]	
9	ທ. [illegible]	.	33	[illegible]	ມ6	[illegible]	[illegible]	[illegible]	[signature]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[signature]

ອຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

[signature]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໄພຂຸຕບາການ (ຫັນສາ)

- ຄັ້ງຈັນທີ:...19..../ 03 / 2019
- ສະຖານທີ່: ສຸກສາສາ.....ນ.ນ.ນ.ນ.....,ບ້ານ:.....ນ.ນ.ນ.ນ.....ເມືອງ:.....ຂ.ວ.....ແຂວງ:.....ຫ.ຫ.ຫ.ຫ.....

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັ່ນ	ໝາຍເຫດ
1	ນ.ແປ	ຍ	29	ໄທດ໋າ	ป.4	ວ.ພ.ວ	ພ.ງ.ບ	030 5933752	ນ.ແປ	
2	ນ.ອັນ.ງ.ຍ	ຍ	24	ງ.ຄ.ງ	ป5	ຫ.ວ.ຍ.ງ	ພ.ງ.ບ		ນ.ອັນ.ຍ	
3	ນ.ງ.ຄ.ນ	ຍ	22	ງ.ຄ.ງ	ม.1	ພ.ເ.ໃ.ພ	ພ.ງ.ບ		ນ.ງ.ຄ.ນ	
4	ນ.ກ.ງ	ຍ	28	ງ.ຄ.ງ	-	ພ.ໃ.ໃ.ພ	ພ.ງ.ບ			
5	ນ.ງ.ປ	ຍ	25	ງ.ຄ.ງ	ป2	ຫ.ວ.ຍ.ງ	ພ.ງ.ບ		ນ.ງ.ປ	

6	ນ. ມອຍ	ຍ	21	ກຶມມຸ	ມ4	ບວມພັນ	[illegible]	.	ນ. ມອຍ	
7	ນ. ອົ	ຍ	29	ກຶມມຸ	ມ1 (ຮຽນ ບໍ່ຈົບ)	ບວມພັນ	[illegible]		[illegible]	
8	ນ. ອົງໄລ	ຍ	31	ລາວ	ມ6	ບວມພັນ	[illegible]	.	[illegible]	
9	ນ. ຄຳວີ	ຍ	30	ອາຄາ	ບໍ່ໄດ້ຮຽນ	[illegible]	[illegible]			
10	ນ. ຄຳພັວ	ຍ	33	ລາວ	ປ5	[illegible]	[illegible]		ຄຳພັວ	
11	ນ. ອົ	ຍ	25	ໄທດຳ	ປ4	[illegible]	[illegible]		ນ. ລີ	
12	ນ. ລັບ	ຍ	45	ລາວ	ປ4	[illegible]	[illegible]		ນ. ລັວ	
13	ນ. ງາເພັ	ຍ	39	ອາຄາ	ປ2	[illegible]	[illegible]		[illegible]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອ່ານ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...20.../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ...[illegible]..........,ບ້ານ:.............................ເມືອງ:...[illegible]..........ແຂວງ:...[illegible]..........

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ. ລູຈະ	ຍ	22	ອາຄາ (ຮິລມາ)	ປ1 (ເຂົ້າ)	[illegible]	ປະຊາຊົນ			ກົມພາ
2	ນ. ປີປະ	ຍ	24	ອາຄາ (ຮິລມາ)		[illegible]	ປະຊາຊົນ			ກົມພາ
3	ນ. ລໍ່	ຍ	20	ອາຄາ (ຮິລມາ)		[illegible]	ປະຊາຊົນ			ກົມພາ
4	ນ. ບໍ່ເຢີ	ຍ	24	ອາຄາ (ຮິລມາ)		[illegible]	ປະຊາຊົນ			ກົມພາ
5	ນ. ເຈົ້າເປຍ	ຍ	37	ອາຄາ (ຮິລມາ)		[illegible]	ປະຊາຊົນ			

6	ນ. ບົວສອນ	ຍ	30	ກຶມມຸ	ມ3	ປ/ສ ນ້ອຍແດງ	ພອນ	0309669070	ນ. ບົວສອນ	
7	ນ. ບຸນ	ຍ	23	ກຶມມຸ	ມ5	ປ/ສ ນ້ອຍແດງ	ພອນ	0309665086	ນ. ບຸນ.	
8	ນ. ບົວວັນ	ຍ	33	ກຶມມຸ	ມ3	ນ. ຫຼ້າຄຳ	ພອນ	0309295961	ນ.ບົວວັນ	
9	ນ. ເພັງ	ຍ	40	ກຶມມຸ	ປ5	ນ. ຫຼ້າລຸດ	ສະຫະພັນແມ່ຍິງບ້ານ	0305357821	ນ: ເພັງ	
10	ນ. ເວັນ	ຍ	22	ກຶມມຸ	ມ7	ນ. ທອງຄຳ	ພອນ	0309302731	[signature]	
11	ນ. ໄວ	ຍ	37	ກຶມມຸ	ປ5	ບົວພາດີ	ແມ່ຍິງບ້ານ	030 4738512	ນ.ໄວ	

12	ນ. ບຸດ	ຍ	25	ກຶມມຸ	ມ4	ເພຍ	ນ/ລ		ນ.ແຫຼ້	
13	ນ. ແພັດ	ຍ	36	ກຶມມຸ	ປ5	ເພຍ	ສະຫະພັນແມ່ຍິງບ້ານ	0304657134	ນ. ແພັດ	
~~13~~										

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ຄຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ບຸນທາ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:..20..../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ.......ກິ່ວລະລົ່ງ..................,ບ້ານ:..ເມືອງ:..................................ແຂວງ:..

ລຳດັບ ວຸທີ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການ ສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
04	ທ. ຄຳເພື່ອ	ຊາຍ	21	ກຶມຸ	ມ.6	ບ. ຢັ້ງທາແຫລ	ອ.ພ.ບ.	02097699 035	ທ. ຄຳເພື່ອ	
09.	ທ. ຣະທອງ	ຊາຍ	36	ກຶມຸ	ມ2	[illegible]	ຮອງ ບ້ານ	55440364	ຣ. ທອງ	
07	ທ. [illegible]	ຊາຍ	45	[illegible]	ມ.1	ບ. ປາກແຫລ	[illegible]		[signature]	
05	ທ. [illegible]	ຊາຍ	36.	[illegible]	ປ4	[illegible]	[illegible]	0309300[illegible]	[signature]	
06	ທ. [illegible]	ຊາຍ	52	ກຶມຸ	ປ5	[illegible]	ອພບ	02054490774	[signature]	

04	ທ. ສີວິງາງ	ຊາຍ	32	ກໍ່	ມ.3	ບ.ແສນຫຼວງ	ນາຍບ້ານ	0309924103	[signature]	
03	ທ. ຕີແປະ	ຊາຍ	29	ກໍ່	ມ.2	ບ.ແສນຫຼວງ	ອ.ສ.ບ	0209224683	ຕີແປະ	
02	ທ. ບຸນຈັນ	ຊາຍ	25	ກໍ່	ມ.2	ບ.ແສນຫຼວງ	ອ.ພ.ບ	0304922331	ບຸນຈັນ.	
01	ທ. ຄຳສີ	ຊາຍ	35	ກຶມມຸ	ປ.5	ບ.ເພຍ	ຮອງບ້ານ	0309785798	[signature]	
10	ທ. ຄຳພອນໄຊ.	ຊາຍ	32.	ກຶມມຸ	ປ.5	ບ.ເພຍ.	ອ.ສ.ບ.	0309262766	[signature]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ຄຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ: 10-22/ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ..,ບ້ານ:..ເມືອງ:..................................ແຂວງ:..

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ. ສຸດາ ແພງສົມຊາຍ	ຍ	25	ໄຕດຳ	ພ.ດ ຕົ້ນ	ເມືອງ ສຸວໍເກົ້າ	ວິຊາການ	99944530	[signature] ສຸດາ	
2	ນ. ສີດາວອນ ອອນສີດາ	ຍ	25	ໄຕດຳ	ພະຍາບານ	ສ/ລ ເພົ່າ	ວິຊາການ	93334134	[signature] ສີດາວອນ	
3	ນ. ແສງເພັດ ພວັດທະລັວ	ຍ	26	ລາວລຸ່ມ	ຮສ2	ສ/ລ ເພົ່າ	ວິຊາການ	0308643023	[signature] ແສງເພັດ	
4	ນ. ອອນ ດາ	ຍ	27	ລາວລຸ່ມ	ສາທາລະນະສຸກ ຊັ້ນກາງ	ສ/ລ ລາວ ຊຸ.	ວິຊາການ	030 50 89908	[signature] ອອນດາ	
5	ທ. ສົມສັນ	ຊ	28	ລາວລຸ່ມ	ພະຍາ ຕົ້ນ	ສ/ລ ວ່າທົ່ວງ	ວິຊາການ	96102000	[signature] ສົມສັນ	

5	ທ. ຄຳຫອມ ສີວັນໄຊ	ຊ	36	[illegible]	ອາຈານແພດ ຊັ້ນສູງ	ສ/ລ [illegible]	[illegible]	0305995696	[signature]	
7.	ທ. ຄຳສາ. ພອນສາຍ	ຊ	34	[illegible]	ຊັ້ນກາງ	ສ/ລ ດອນເມືອງ	ຮອງ ຫົວໜ້າ	59856444	[signature]	
8	ນ ອ່ອນ ແກ້ວໄຊຍະດາ	ຍ.	25	ປາລາ.	ຊັ້ນກາງ	ສຸກສາລາ [illegible]	ພະນັກງານ ສ/ລ	59731159	[signature]	
9.	ນ. ເພັດສາ [illegible] ແສງ	ຍ	25	[illegible]	ຊັ້ນສູງ	ສ/ລ [illegible]	ວິຊາການ	02096242939	[signature]	
10.	ນ ສຸລິດາໄພ. [illegible]	ຍ	25	[illegible]	ຊັ້ນກາງ	ສຸກສາລາ [illegible]	ວິຊາການ	02095115910	[signature]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[signature]

ລາຍເຊັນພະນັກງານສຸກສາລາ

Appendix F: list of participants on meeting in October 31st, 2019

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ					31/10/2019
					ແຂວງ ຜົ້ງສາລີ			
1	ທ່ານ ບຸນເພັດ ຕັນສຸພັນ	✓			ຫົວໜ້າຫ້ອງການບໍລິຫານ	lounphet-tsp@yahoo.com	2293 8859	
2	ທ່ານ ນ ວິໄລ ບຸນເຖິງ		✓		ຮອງຂະແໜງແຜນການ	vilay2@yahoo.com.	55787043	
3	ທ. ຊຸມແກ້ວ	✓			ຂັບລົດ		55155452	
					ແຂວງ ຫຼວງນ້ຳທາ			
1	ທ່ານ ດຣ. ອຸ່ນເຮືອນ ພຸດສະຫວັດ	✓			ຮອງຫົວໜ້າພະແນກສາທາ		99991014	
2	ທ່ານ. ວິລະເດດ ຊຽວສົມພອນ	✓			ຜູ້ປະສານງານ	viladethksp@yahoo.com	22990972	
3	ທ ຕາພົ	✓			ຂັບລົດ		56663488	
					ແຂວງ ບໍ່ແກ້ວ			
1	ທ່ານ ດຣ. ຄຳແດງ ດວງປະເສີດ	✓			ຜູ້ປະສານງານ	Kd doung@gmail.com	22382370	
2	ທ່ານ ດຣ. ທອງແທ່ງ ບຸນສີ	✓			ຫົວໜ້າຂະແໜງແຜນການ	thangthon52@yahoo.fr	22383680	
3	ທ. [illegible]	✓			ຂັບລົດ	ສາທາບໍ່ແກ້ວ	56134126	

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ					31/10/2019
					ແຂວງ ອຸດົມໄຊ			
1	ທ່ານ ດຣ. ທຸມພັນ ອິນທະມຸງຄຸນ	✓			ວ່າການຫົວໜ້າພະແນກສາທາ		55782052	
2	ທ່ານ. ຄຳຜ່າຍ ສຸວັນດີ	✓			ຫົວໜ້າຂະແໜງແຜນການ		22372200	
3	ທ. ຈັນທະ ວອນ ສຸພພັນ	✓			ຂັບລົດ		55780837	
					ແຂວງ ຫົວພັນ			
1	ທ່ານ ດຣ. ວິລະພອນ ພົມວົງສີ	✓			ຫົວໜ້າພະແນກສາທາ			
2	ທ່ານ. ເພັດສະໝອນ ໄຊຍະວົງ	✓			ຫົວໜ້າຂະແໜງແຜນການ		54494433	
3	ທ. ແສງແພງ	✓			ຂັບລົດ		22339953	
					ແຂວງ ຊຽງຂວາງ			
1	ທ່ານ ດຣ. ບຸນໄຊ ນອນທະສິມ	✓			ຫົວໜ້າພະແນກສາທາ	Lounxay_60@yahoo.com	55660152	
2	ທ່ານ ດຣ. ບຸນເພັງ ສິນນະວົງ	✓			ຫົວໜ້າຫ້ອງການບໍລິຫານ	Snnvng@yahoo.com	22944409	
3	ທ. ເພັດສະໝອນ	✓			ຂັບລົດ	monephon@gmail.com	55100252	

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ					31/10/2019
					ແຂວງ ຫຼວງພະບາງ			
1	ທ່ານ. ອາດູນ ແກ້ວດາລາ	✓			ຫົວໜ້າຫ້ອງການບໍລິຫານ	adoun1970@gmail.com	5870022	
2	ທ່ານ ນ. ບົວແກ້ວ ສີຊຸພັນ		✓		ຮອງຫົວໜ້າຂະແໜງອະນາໄມ	bouakeobo@gmail.com	56073294	
3					ຂັບລົດ			
					ແຂວງ ໄຊຍະບູລີ			
1	ທ່ານ ດຣ. ຄຳຜິວ ພູທອນສີ	✓			ຫົວໜ້າພະແນກສາທາ	khamphiou@yahoo.com	55626140	
2	ທ່ານ. ຄຳໝັ້ນ ສີງງາມ	✓			ຫົວໜ້າຂະແໜງ ແຜນການ	Km.singngam@gmail.com	22365164	
3	[illegible]	✓			ຂັບລົດ		55557112[illegible]	
					ແຂວງ ຈຳປາສັກ			
1	ທ່ານ ດຣ. ວຽງສີ ສຸພັກດີ	✓			ຮອງຫົວໜ້າພະແນກສາທາ		57535566	
2	ທ່ານ ດຣ ນ. ຈັນມີນາ ອຸດທິກອນ		✓		ຜູ້ປະສານງານ		22226831	
3					ຂັບລົດ			

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ					31/10/2019
					ແຂວງ ສາລະວັນ			
1	ທ່ານ ດຣ. ບົວໄລ ແສນແກ້ວມີກ່	✓			ຫົວໜ້າພະແນກສາທາ		55648427	
2	ທ່ານ. ສົມພານ ສີລາວີ	✓			ແຜນການ	[illegible]	55431710	
3	[illegible]				ຂັບລົດ		97125553.	
					ແຂວງ ເຊກອງ			
1	ທ່ານ ດຣ. ພູຂັນ ຈັນທະວົງ	✓			ຫົວໜ້າພະແນກສາທາ		54429860	
2	~~ທ່ານ ຊຸລິນທອນ ສີໂຄດປັນຍາ~~ [illegible]	✓			ວິຊາການແຜນການ ແຂວງເຊກອງ	[illegible]@yahoo.com	55099159	
3	[illegible]	✓			ຂັບລົດ		55193232	
					ແຂວງ ອັດຕະປື			
1	ທ່ານ ດຣ. ອ່ອນຜີວ ໄພທິລາດ	✓			ຫົວໜ້າພະແນກສາທາ		55636469.	
2	ທ່ານ. ໄພສີ ທອງດີ	✓			ຫົວໜ້າຂະແໜງ ແຜນການ		98224557	
3	[illegible]	✓			ຂັບລົດ		22901293	

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ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງ
ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	E-Mail	ໂທລະສັບ
		ຊາຍ	ຍິງ				
					ແຂວງ ສະຫວັນນະເຂດ		
1	ທ່ານ ດຣ. ກົງຄຳ ອິນທະພູທອນ	✓			ຫົວໜ້າຂະແໜງແຜນການແລະການຮ່ວມມື	kongintpt.legk@gmail.	97569888
2	ທ່ານ ດຣ ນ. ວົງສອນ ຈັນທະວົງ		✓		ຮອງຫົວໜ້າຂະແໜງ ອະນາໄມແລະສົ່ງເສີມ	sonevpc@gmail.com	55237608
3	[illegible]				ຂັບລົດ	[illegible]	56825599
					ແຂວງ ໄຊສົມບູນ		
1	ທ່ານ ດຣ. ບົວເກດ ວົງປະເສີດ	✓			ວ່າການຫົວໜ້າພະແນກສາທາ	bkvongpaseuth@gmail.com	29919365
2	ທ່ານ ດຣ. ຢັງເຕັ້ງ	✓			ຫົວໜ້າຂະແໜງແຜນການ	tengyang544@yahoo.com	29806210
3	[illegible]				ຂັບລົດ		58985860

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງ
ໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	ໂທລະສັບ	E-Mail	ລາຍເຊັນ
		ຊາຍ	ຍິງ					31/10/2019
					ກົມການສຶກສາ ສາທາລະນະສຸກ			
1	ທ່ານ ຮສ ດຣ. ບີລັນ ພູມີນ	✓			ຫົວໜ້າກົມ			[signature]
2	ທ່ານ ດຣ. ທອງພູດ ໄຊຊະນະ	✓			ຫົວໜ້າພະແນກບໍລິຫານ	020 2246 3590		[signature]
					ກົມການເງິນ			
1	ທ່ານ ດຣ. ສົມພອນ ຜາງມະນີໄຊ	✓			ຫົວໜ້າກົມ			[signature]
2	ທ່ານ ດຣ. ວຽງໄຊ ວິລະວົງ	✓			ຫົວໜ້າພະແນກນະໂຍບາຍການເງິນ	020 2246 4545		[signature]
3	ທ່ານ ນ. ແສງມີນທາ ອຸແປງວົງ		✓		ຮອງຫົວໜ້າພະແນກບໍລິຫານ	020 9977 7811		[signature]
					ກົມຈັດຕັ້ງ-ພະນັກງານ			
1	[illegible]		✓	[illegible]	[illegible]	2223 2293		[signature]
2	[illegible]	✓			[illegible]	22445530		[signature]
					ສູນສະໜອງຢາ-ອຸປະກອນການແພດ			
1	ທ່ານ ດຣ ນ. ມະນີສອນ ໄຊຍະເສນ		✓		ຫົວໜ້າພະແນກຈັດຊື້	020 5565 5782		[signature]
2	[illegible]	✓			[illegible]	22404242		[signature]

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງ ໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	ໂທລະສັບ	E-Mail	ລາຍເຊັນ
		ຊາຍ	ຍິງ					31/10/2019
ກົມອະນາໄມ ແລະ ສິ່ງເສີມສຸຂະພາບ								
1	ທ່ານ ດຣ ນ. ລັດສະດາ ພະເມືອງ		✓		ຮອງຫົວໜ້າພະແນກແມ່ ແລະ ເດັກ	020 5548 5519		
2	ທ່ານ ດຣ ນ. ສຸວັນຄຳ ພົມມະເສງ		✓		ຮອງຫົວໜ້າພະແນກສິ່ງເສີມ ສຸຂະພາບ	020 5540 0439		
ກົມຢັ້ນຢືອ ແລະ ຟື້ນຟູໜ້າທີ່ການ								
1	ທ່ານ ດຣ. ບົວເຫບ ພູມີນ	✓			ຮອງຫົວໜ້າກົມ			
2	ທ່ານ ດຣ. ວິໄຊຢ່າງ ໃຈຫວ້ງໜັ້ນ	✓			ຮອງຫົວໜ້າພະແນກກັນ ແລະ ຄວບຄຸມພະຍາດບໍ່ຕິດຕໍ່	95144969	Vixayyang.cvm@gmail.com	
ກົມອາຫານ ແລະ ຢາ								
1	ທ່ານ ດຣ. ບຸນຊູ ແກ້ວຫາວົງ	✓			ຫົວໜ້າກົມ	55668439	khounxou@yahoo.com	
2	ທ່ານ ດຣ ນ. ບຸນຄ້ຳ ພົມມະສອນ		✓			55659549	boumpham.p@gmail.com	
ຫ້ອງການປະກັນສຸຂະພາບແຫ່ງຊາດ								
1	ທ່ານ ດຣ ນ. ບົວພັດ ພົນວິໄຊ		✓		ຮອງຫົວໜ້າຫ້ອງການປະກັນ	020 2286 4195		
2	ທ່ານ.ດຣ.ພນທອງ	✓				55648822	Phanthong_b@yahoo	

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງ ໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	ພາກສ່ວນ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ						
1	ທ່ານ ຄຳເພັດ ມະນີວົງ	✓		ລາວລຸ່ມ	ຫົວໜ້າກົມແຜນການ	ກົມແຜນການ		020 9980 1744	✓
2	ທ່ານ ດຣ ຝຸ່ນຄຳ ຣັດຕະນະວົງ	✓		ລາວລຸ່ມ	ຮອງຫົວໜ້າກົມແຜນການ	ກົມແຜນການ		020 5550 9676	
3	ທ່ານ ດຣ ນ. ຜາສຸກ ວົງວິຈິດ		✓	ລາວລຸ່ມ	ຮອງຫົວໜ້າກົມແຜນການ	ກົມແຜນການ		020 9919 8909	
4	ທ່ານ ດຣ ສຸດທະນຸ ນັນທະນົນຕຼີ	✓		ລາວລຸ່ມ	ຮອງຫົວໜ້າກົມແຜນການ	ກົມແຜນການ		020 5547 5129	✓
5	ທ່ານ ດຣ ຈັນສາລີ ພົມມະວົງ	✓		ລາວລຸ່ມ	ຮອງຫົວໜ້າກົມແຜນການ	ກົມແຜນການ		020 2200 2722	
6	ທ່ານ ປອ ດຣ ປະສົງສິດ ບຸບຜາ	✓		ລາວລຸ່ມ	ທີ່ປຶກສາອາວຸໂສ	ໂຄງການ ຜ-ບສພ		020 2222 2293	
7	ທ່ານ ຄຳແສນ ສຸດທິສັກ	✓		ລາວລຸ່ມ	DLI	ໂຄງການ ຜ-ບສພ		0202244 0909	
8	ທ່ານ ພຸດທະສອນ ແພງສັກດາ	✓		ລາວລຸ່ມ	DLI	ໂຄງການ ຜ-ບສພ		020 2345 6760	
9	ທ່ານ ພອນປະເສີດ ສຸພັດທອນ	✓		ລາວລຸ່ມ	DLI	ໂຄງການ ຜ-ບສພ		0205855 3373	
10	ທ່ານ ນ. ອຸໄລວັນ ຈັນທະວົງ		✓	ລາວລຸ່ມ	ບໍລິຫານ	ໂຄງການ ຜ-ບສພ		020 5560 5280	

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ຫະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງ ໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	ໂທລະສັບ	E-Mail	ລາຍເຊັນ
		ຊາຍ	ຍິງ					31/10/2019
	ສູນຕ້ານເອດ ແລະ ຍຕພ							
1								
2								
	ສູນຮັກສາສຸຂະພາບແມ່ ແລະ ເດັກ							
1	ທ່ານ ດຣ ນ. ປະນອມ ໄຊຍະມຸງຄຸນ		✓			030 5179 546		
2	ທ່ານ ດຣ ນ. ສົມພະໄທ ບົວທອງ		✓	ລຸ້ມ	ຮອງຫົວໜ້າ2:ແພງຕ້ານ	55614865	muck_bouathong@hotmail.com	
3	ທ່ານ ດຣ ນ. ແພ້ງຈ້ອຍ ປັນຍາລັດ		✓		ວິຊາການ	55621782	panyalath.p@gmail.com	
4	ທ່ານ ດຣ ນ. ຂັນທອງ ສີຫາລາດ		✓					
	ສູນຄວບຄຸມພະຍາດອັນຕະລາຍ							
1	ທ່ານ ນ. ພິດສະດາ ສີພັນທອງ		✓		ຮອງຫົວໜ້າຂະແໜງວິຊາການ	020 2220 8935	phitsada@yahoo.fr	
2								
	ສູນໄພຊະນາການ							
1	ທ່ານ ດຣ ນ. ລັດທິພອນ ອຸລາ		✓		ຮອງຫົວໜ້າສູນ	020 5433 3790	raththiphone@yam.co	
2	ທ່ານ ດຣ ສຸພະໄຊ ຄຳພັນທອງ	✓				020 5665 1988		

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນຜົນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ຫະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງ ໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	ພາສາລ່ວນ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ						
21		✓							
22									
23		✓							
24	Chanhsy Samaneng	—			STC	WB	—	55977775	
25	Vatthana Nanthana	✓			STC	WB		57771326	
26			✓				moviengzakhone@yahoo.com	55663579	
27	Sophavanh Thitsy		✓		Operations	WB	sthitsy@worldbank.org	57771388	
28									
29									
30									

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນດຳເນີນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	ພາກສ່ວນ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ						
11	ທ່ານ ນ. ວຽງພິນ ບຸລົມມະວົງ		✓	ລາວລຸ່ມ	ບໍລິຫານ	ໂຄງການ ຜ-ບສພ		020 5568 7878	[signature]
12	ທ່ານ ດຣ ປະວິດ ເຂັມມະນິດ	✓		ລາວລຸ່ມ	ຫົວໜ້າບໍລິຫານກົມແຜນການ	ກົມແຜນການ		020 2206 0693	
13	ທ່ານ ວຽງທອງ ຈົ່ງທາວຊົງ	✓		~~ລາວລຸ່ມ~~ [illegible]	IT	ໂຄງການ ຜ-ບສພ		020 9113 2319	[signature]
14	ທ່ານ ຊົ່ງຢ່ງ ບຸນມາ	✓		~~ລາວລຸ່ມ~~ [illegible]	IT	ໂຄງການ ຜ-ບສພ		020 9244 4414	[signature]
15	ທ່ານ ນ. ວິໄລລັດ ແສງສະຫວ່າງ		✓	ລາວລຸ່ມ	ບໍລິຫານ	ໂຄງການ ຜ-ບສພ		020 5678 7026	[signature]
16	ທ່ານ ສົມທະລາ ປະຖົມມະວົງ	✓		ລາວລຸ່ມ	ຮອງຫົວໜ້າບໍລິຫານກົມແຜນການ	ກົມແຜນການ		020 2222 8996	[signature]
17	[illegible]	—		—	[illegible]	—		58101035.	[signature]
18	[illegible]				ຂັບລົດ	—		29116890	[signature]
19	[illegible]	✓		[illegible]	ຂັບລົດ	—			[signature]
20									

ລາຍຊື່ເຂົ້າຮ່ວມກອງປະຊຸມເຜີຍແຜ່ແຜນດຳເນີນການຈັດຕັ້ງປະຕິບັດ DLI ປີທີ 4 ທີ່ທະນາຄານໂລກຮັບຮອງແລ້ວ ແລະ ແຜນການ DLI ປີທີ 5 ຮ່ວມກັບ ກົມ, ສູນທີ່ກ່ຽວຂ້ອງ ແລະ 14 ແຂວງເປົ້າໝາຍຂອງໂຄງການ ຜ-ບສພ, ວັນທີ 31/10/2019 ທີ່ ຫໍປະຊຸມແຫ່ງຊາດ.

ລ/ດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ		ຊົນເຜົ່າ	ຕຳແໜ່ງ	E-Mail	ໂທລະສັບ	ລາຍເຊັນ
		ຊາຍ	ຍິງ					
					ນັກຂ່າວ			
1	[illegible]				[illegible]		23160115	[signature]
2	[illegible]				[illegible]		02056623061	[signature]
3	[illegible]				[illegible]			[signature]
4	[illegible]				—		54140959	[signature]
5	[illegible]				[illegible]		58656988	[signature]
6								
7								
8								
9								
10								