LAO PEOPLE'S DEMOCRATIC REPUBLIC

Peace Independence Democracy Unity Prosperity

MINISTRY OF HEALTH

Health and Nutrition Services Access Project Phase II (P178957)

RAPID SOCIAL AND ENVIRONMENTAL ASSESSMENT

ANNEX 5 to ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK

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Abbreviations

ANC	Antenatal Care
ART	Antiretroviral Therapy
CCM	Country Coordination Mechanism
DCDC	Department of Communicable Disease Control
DHHP	Department of Hygiene and Health Promotion
DHIS2	District Health Information System version 2
DHO	District Health Office
DHPE	Department of Health Professional Education
DHR	Department of Health Care and Rehabilitation
DOF	Department of Finance
DPC	Department of Planning and Cooperation
DPT	Diphtheria, Pertussis, and Tetanus
ECE	Early Childhood Education
ECOP	Environmental Code of Practice
EG	Ethnic Group
EHSP	Essential Health Service Package
EPI	Expanded Program for Immunization
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESS	Environmental and Social Standards
FDD	Food and Drug Department
FSW/SW	Female Sex Worker commonly called as Service women
GOL	Government of Lao PDR
HANSA II	Health and Nutrition Services Access Project II
HCWM	Health Care Waste Management
HGNDP	Health Governance and Nutrition Development Project
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
IPC	Infection Prevention and Control
IPD	Inpatient Department

KAP	Knowledge, Attitude, and Practices
LGBTI	Lesbian, gay, bisexual and transgender, Intersex
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information System
MOF	Ministry of Finance
MOH	Ministry of Health
MPI	Ministry of Planning and Investment
MR	Measles and Rubella
MSM	Men Having Sex with Men
NERI	National Economic Research Institution
NHI	National Health Insurance
NHIB	National Health Insurance Bureau
NNC	National Nutrition Center
NNSAP	National Nutrition Strategy and Plan of Action
NPCO	National Program Coordination Office
OOP	Out-of-Pocket
OPD	Out-Patient Department
PDO	Project Development Objective
PHO	Provincial Health Office
PLHIV	People Living With HIV/AIDS
PNC	Postnatal Care
RESA	Rapid Environmental and Social Assessment
QHC	Quality of Health Care
QPS	Quality and Performance Scorecard
RMNCAH	Reproductive, Maternal, Neonatal, Child, and Adolescent Health
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behavioral Change Communication
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SHG	Self Help Group
SOGI	Sexual Orientation and Gender Identity
SOP	Standard Operating Procedure

SEP	Stakeholder Engagement Plan
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TG	Transgender
TOR	Terms of Reference
UXO	Unexploded Ordnance
VAC	Violence Against Children
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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1. INTRODUCTION

The Rapid Environmental and Social Assessment (RESA) – prepared for HANSA II, aims is to identify and assess key environmental and social risks and impacts that are associated with investment activities under HANSA II. Based on the RESA results, mitigation measures are proposed and integrated into project design and E&S instruments to ensure identified E&S risks and impacts are managed effectively.

The purpose of consultation for the ESA is to a) solicit feedback from selected key project stakeholders who have been participating in Poverty Reduction Fund (PRF III) on the management of ES risk and impact; C) use such feedback as lessons learned/ opportunities for enhanced project design under HANSA II through the promotion of equal opportunities for participation and inclusion by all target project beneficiaries as well as to be more effective and practical on ways to avoid and manage the risk related to environment, health, and safety especially those related to UXO and different types and locations of civil works.

The Rapid ESA also looked in the contexts (i.e. how risks/opportunities apply to different groups of people – vulnerable including ethnic groups; different priorities, how different groups (i.e. ethnic groups) are socially structured. Key group of stakeholders to be consulted are presented under the Methods section.

Feedback (as primary data) collected through this consultation includes the following key aspects:

- Aspects of ESMF implementation under HANSA that have worked well.
- E&S Aspects (from ESF perspective) that could be improved (through lessons learned from HANSA and other project within the WB's convergence program), including those related to social, environment, health, and safety.
- Opportunities and challenges under HANSA II (considering also new provinces nationwide).

2. METHODS

This RESA was conducted based on a combination of review of relevant literature (secondary data) and consultation with stakekholders of the project (primary data). Meetings were held with beneficiaries, health facilitators, project staff based at district and provincial levels, and project stakeholder at the national level, including Ministry of Health, Ministry of Agriculture and Forestry, Ministry of Planning and Investment.

In line with the above, meetings were conducted with beneficiaries at village level, project staff at district and provincial levels, and subsequently with project stakeholders at national level during project preparation. Various meetings have been conducted between 27 February and 10 March 2023 with the participation of 126 people who represented current beneficiaries and staff (HANSA) and potential beneficiary households and staff (HANSA II). These participants are from three project provinces including Bolikhamxay, Oudomxay and Sekong which were selected to represent North, Central and Southern regions of the country. These 126 participants include 36 male and 90 female participants from various ethnic groups including the Trieng, Akha, Hmong, Khmu, Tai Leu, Lamed, and Lao Tai. After consultation at the field level was completed in March 2023, the national consultation workshop was conducted in Vientiane Capital on 21 April 2023 to validate consultation results from the field. The national consultation workshop was attended by 35 people (25 male and 10 female) who represented related governmental agencies at national and project provincial levels.

Altogether, a total of 161 people (61 male and 100 female) have participated during consultation meetings at village, provincial, and national levels between February and April 2023.

The consultation meetings at village, district and provincial levels focused on soliciting feedback from current project beneficiaries on project achievements (HANSA), and asked for their suggestions and expectation as the project continues as HANSA II. The consultation also collected feedback from project staff at district and provincial levels on achievements, areas of work that need improvement under HANSA II to inform partially project design, particularly how HANSA II can manage effectively identified environmental and social risks and impacts associated with proposed project activities (See summary of consultation results in Annex 1 of this document).

The findings from project sites (Feb and March 2023) were presented at the national consultation workshop (conducted on 21 April 2023) to validate the site-specific findings and check if such findings are also found in project provinces that the consultation exercise could not cover. Findings from the field consultations, validated at national level and combined with findings from previous analytical reviews carried out as part of HANSA implementation review provided opportunity for 35 participants at national consultation workshop to discuss and propose measures to address key bottlenecks that arise during implementation of HANSA. The consultation also facilitates for better project implementation arrangement under HANSA II with a view to enhancing overall project development effectiveness (See Annex 1 – Summary of Consultation for details).

Key groups of stakeholders subject to consultation under HANSA II

The consultation under HANSA II covered both affected stakeholder and interested stakeholders – as per WB's ESF.

Project affected stakeholders include individuals, groups, communities and local organizations

Project beneficiaries (project affected parties)

- Women (including pregnant, lactating mothers, mothers with children under 2), adolescent girls, infants, and young children
- User of health services that the project finances
- Patients with HIV/AIDS and TB
- Female Sex Worker (FSW) commonly called as Service women
- Men Having Sex with Men (MSM)
- Health Staff in target project area
- Village Facilitators (VF)

National stakeholders (interested parties)

- Ministry of Health
- National Nutrition Center
- Ministry of Agriculture and Forestry
- Ministry of Public Works and Transportation
- Ministry of Education and Sport
- Ministry of Labor and Social Welfare

- Representative from Provincial District Government (PAFO, DAFO, Women's Union, Dept of Labor & Social Affairs, Youth's Union)

Data collection techniques:

Techniques used for the consultation include: 1) Key informant interview, 2) Focus group discussion, 3) Field observation, as well as data collected through desk review of existing documents available under PRF. Therefore, questionnaires have been prepared for focus group discussion and key informant interview. Questionnaires are prepared exclusively for different groups such as a) mother and pregnant women, b) patient with HIV/AIDS, c) patient with TB, d) female Service women (FSW), d) men having sex with men (MSM).

Key Informant Interviews*:* Interviews were conducted with selected project key stakeholders at district and village levels, including:

- DAFO and existing HANSA district teams (Nutrition, Livelihood, Technical Assistance)
- Representative of village authority including village women union and ethnic groups representatives.
- Patients with HIV/AIDS and TB
- Female Sex Worker (FSW)
- Men Having Sex with Men (MSM)

Focus Group Discussion (FGD): Groups of men and group of women from Ethnic Minorities

- Mothers and Pregnant Women
- Project staff at district and provincial levels

Field Observation: While carrying out assessment process, the team also recorded what they've seen by taking notes and photo taking.

Section of Study site

- Due to time constraint and because the other RESA teams already conducted information in other parts of the project areas, the result of the study from the other teams is used as secondary data to complement this RESA. The following provinces were visited: Bolikhamxay, Oudomxay and Sekong.

Consultation Participants

- A total of 161 people (61 male and 100 female) have participated during the consultation from February to March at village, district and provincial levels, and during the national consultation workshop in Vientiane Capital on 21 April 2023.
- At project sites in three select provinces, a total of 126 participants (36 male and 90 female) participated in focus groups and one-on-one interviews. These participants are from various ethnic groups including the Trieng, Akha, Hmong, Khmu, Tai Leu, Lamed, and Lao Tai.

3. FINDINGS

1.1 Poverty Profile in Laos PDR

This section (3.1) is drawn from the WB report published in 2020, namely, Lao PDR Poverty Profile – Poverty Report for the Lao Expenditure and Consumption Survey 2018-2019. The information in Section 3.1 provides a snapshot of the poverty of Laos (seven project provinces are marked with yellow bar).

1.1.1 Overview of Poverty in Laos and in Project Provinces

According the WB 2020 (WB - 2020 - Lao PDR Poverty Profile), the national poverty headcount rate in 2018/19, estimated using the revised poverty methodology, was 18.3 percent. This indicates that almost a fifth of the Lao PDR population were living on less than LAK 9,364 a day (approximately USD 1.10, or 2.40 per person per day in 2011 PPP USD). Although Poverty in Lao PDR continues to decline, the impact of growth on poverty reduction was low. Between 2012/13 and 2018/19, the annual GDP growth rate averaged about 7 percent, and GDP per capita grew at an annual rate of 5.6 percent. But a one-percent increase in GDP per capita during this period was associated with a mere 0.67 percent decline in the poverty rate. Average consumption grew by only 3.3 percent, falling behind the rate of economic growth.

Poverty has fallen more rapidly in rural areas than in urban areas The depth and severity of poverty followed a similar trend, declining markedly in rural areas while remaining largely unchanged in urban areas. Poverty depth, as measured by the poverty gap, is the extent to which individuals fall below the poverty line. The larger the poverty gap, the poorer on average people below the poverty line are, and the more resources are needed to lift them out of poverty.

According to the Lao Expenditure and Consumption Survey (LECS) that was implemented between June 2018 and May 2019, the following key findings are important:

- Poverty declined from 24.6 percent in 2012/13 to 18.3 percent in 2018/19. The rate of poverty reduction has been rapid in rural areas, while urban poverty reduction has stagnated.
- The incidence of poverty is typically higher among agricultural households, Hmong-Iumien households and house- holds headed by a person who has not completed lower secondary education or an unemployed person, and such gaps have widened.
- Multidimensional poverty declined between 2012/13 and 2018/19, especially in rural areas, the northern region, and the southern region, mirroring a decline in monetary poverty.
- Notwithstanding improvements in monetary indicators of poverty and non-monetary aspects of household welfare, food insecurity remains a pressing problem among low-income households in rural areas.

In project provinces, poverty remains among the highest compared to other provinces. Project provinces are marked in yellow shade below.

Table 1 - Poverty and Distribution of The Poor by Province (2012/13–2018/19)

	Poverty Headcount Rate			Poverty Gap			*Squared Poverty Gap*		
	2013	2019	Change	2013	2019	Change	2013	2019	*Change*
Lao PDR	24.6	18.3	-6.3	5.9	3.9	-2.0	2.1	1.3	*-0.8*

	Poverty Headcount Rate			Poverty Gap			*Squared Poverty Gap*		
	2013	**2019**	**Change**	**2013**	**2019**	**Change**	**2013**	**2019**	***Change***
Vientiane Capital	2.5	5.0	2.5	0.3	1.0	0.7	0.1	0.3	*0.3*
North									
Phongsaly	19.9	8.1	-11.8	3.4	1.2	-2.2	0.9	0.3	*-0.6*
Luangnamtha	25.0	10.5	-14.4	4.5	1.9	-2.6	1.2	0.6	*-0.6*
Oudomxay	36.6	29.2	-7.5	8.9	6.4	-2.5	2.9	2.0	*-1.0*
Bokeo	51.8	19.4	-32.4	15.0	4.2	-10.8	5.9	1.3	*-4.5*
Luangprabang	30.0	20.4	-9.6	6.8	3.1	-3.7	2.1	0.7	*-1.4*
Huaphanh	45.4	26.6	-18.8	13.3	5.8	-7.5	5.3	1.8	*-3.5*
Xayabury	15.7	21.1	5.4	2.7	4.5	1.8	0.7	1.5	*0.8*
Central									
Xiengkhuang	34.3	26.0	-8.2	8.6	6.2	-2.3	3.1	2.2	*-0.9*
Vientiane	10.9	5.3	-5.6	1.6	1.0	-0.6	0.3	0.3	*-0.1*
Borikhamxay	14.7	20.6	5.9	2.9	5.1	2.2	0.9	1.8	*0.9*
Khammuane	25.2	25.5	0.3	6.6	5.1	-1.5	2.3	1.5	*-0.8*
Savannakhet	29.1	27.5	-1.5	6.2	6.5	0.3	2.0	2.3	*0.3*
Xaysomboun		8.2			1.3			0.3	
South									
Saravane	52.1	24.9	-27.2	16.8	5.6	-11.2	6.8	1.9	*-4.9*
Sekong	44.4	30.6	-13.8	13.3	6.2	-7.1	5.7	1.9	*-3.8*
Champasack	19.6	8.7	-10.9	4.0	1.8	-2.3	1.2	0.5	*-0.7*
Attapeu	**9.1**	**27.8**	**18.8**	**1.4**	**5.7**	**4.4**	**0.3**	**2.0**	***1.7***

Source*: World Bank, 2020, Poverty Profile in Lao PDR.*

1.1.2 Vulnerable and poor groups

Households headed by an agricultural self- employed person and an unemployed or economically inactive person have the highest poverty rates. It was noted, in particular, that **poverty rate among people living in households headed by an unemployed or economically inactive person is 21.3 percent**. About 90 percent of unemployed household heads were previously engaged in agricultural activities but have **become unemployed due to seasonality**, while economically inactive persons are mostly the elderly. Poverty remains high and persistent among households headed by an agricultural self-employed person (24.6 percent in 2018/19) albeit falling by 7.3 percentage points over the previous six years. These households together with households headed by a seasonally unemployed person constitute 75 percent of the poor. Conversely, the poverty rate of households headed by wage workers and nonfarm self-employed workers is low, with each estimated to be around 5 percent in 2018/19, a marked decline from 9 percent in 2012/13.

Remittances from migrants have become an important source of income. In 2018/19, **14 percent of the population lived in households that received remittances**, up from 11 percent in 2012/13. The poverty rate among remit- tance-receiving households has fallen from 13.8 percent in 2012/13 to 10.2 percent in 2018/19: almost half the poverty rate than those without remittances.

It is noted that the **incidence of poverty is higher among households headed by the non-secondary educated, the unemployed, the Hmong-Iumien persons and individuals self-employed in farming**. The Hmong-Iumien group has also experienced the slowest pace of poverty reduction, with gaps between them and other ethnic groups widening as a result.

1.1.3 Key Ethnic Groups in Project Areas

There are various ethnic groups present in the four project provinces under HANSA (Table below). However, key ethnic groups that are included as current beneficiaries include two groups: Lao, Tai, Phong, Thai, Lue, Yuan, Yang, Aesk, Thai Nue, Khmu, and Pair (See Annex 2 for more information).

No.	Province	No. of ethnic groups	Some of the identified main ethnic groups
1	Phongsaly	28	Khmu, Hmong, Yao, Akha, Phounoy Tai Lue, Hor, Syla, Hayi, Lolo
2	Oudomxay	20	Khmu, Hmong, Yao, Akha, Lahu, Lanten, Tai Daeng,
3	Huoaphan	22	Khmu, Hmong, Yao, Tai Dam, Tai Daeng, Tai Phuan
4	Xiengkhouang	5	Khmu, Hmong, Yao, Tai (Tai Phuan, Tai Dam, Tai Daeng)
5	Savannakhet		Phouthai, Tai Dam, Katang, Mongkong, Vali, Lavi, Souei, Kapo, Kaleung, Ta Oi, Bru, Tri, Laha, and Katang Savannakhet

1.1.4 Food consumption and food security

The composition of food expenditure changed slightly between 2012/13 and 2018/19. Overall, households spent a slightly smaller share of their food costs on rice and fish and a greater share on milk, cheese and eggs, vegetables and tubers. Urban households devote a larger share of total food expenditure on beverages, restaurants meals and takeaways (12 percent) than rural households (2.5 percent). Conversely, **shares of rice and fish in total expenditure are higher among rural households** than urban households.

Almost 20 percent of the population experienced moderate-to-severe food insecurity in 2018/19. In 2018/19, **10 percent of the population experienced moderate food insecurity**, meaning they reduced the quality or quantity of their food, and were uncertain about their ability to obtain food due to lack of resources. **This increased their likelihood of malnutrition, including the risk of stunting in children.** In addition, **9 percent of the population faced severe food insecurity, meaning they ran out of food altogether and/or went for a day or more without eating.**

Poor households also spend more on vegetables and tubers while non-poor households spend a greater share on meat, beverages, and restaurants/ takeaway meals. Food poverty and food insecurity are regular occurrences. **Almost 20 percent of the population experienced moderate to severe food insecurity in 2018/19, particularly in rural areas and the central region**.

1.1.5 Household assets and living conditions

Poverty reduction across Lao PDR over the past six years has involved significant improvements to household living conditions. Ownership of consumer durables increased significantly between 2012/13 and 2018/19. Among poor households, possession of a motorbike, a refrigerator, a steam rice cooker, a television and a mobile phone significantly increases – as observed between 2012/13 and 2018/19.

Lao households, including the poor, typically invested in more expensive and better-quality housing materials since the last survey. **Between 2012/13 and 2018/19, poor households typically swapped their roofing material from grass, leaves or wood to metal sheets, while non-poor households upgraded from metal sheets to roofing tiles.**

1.1.6 Access to services

There was a remarkable improvement in access to basic services between 2012/13 and 2018/19. In 2018/19, 92.9 percent of households had access to safe water throughout the year, increasing from 83.8 percent in 2012/13, and approximately 82 percent of households had access to improved sanitation facilities. However, access to all services is significantly lower among the poor when compared to the non-poor. **Access to improved sanitation facilities was 74.3 percent among poor households,** well beneath 97 percent access among the non-poor. The gap is narrower for access to safe water and electricity, however.

Table 2 – Household Access to Improved Water, Sanitation Facilities and Electricity by Province (2018/19)

	Poor				Non-poor			
	Gas and electricity for cooking	Improved sanitation facilities	Safe water	Electricity for lighting	Gas and electricity for cooking	Improved sanitation facilities	Safe water	Electricity for lighting
Borikhamxay	0	100	100	100	6.2	99.4	98.6	99.7
Vientiane Capital	8.3	94.6	100	100	34.9	99.7	100	99.7
Xayabury	0	92.9	100	96.8	2.1	98.8	97.8	99.6
Xaysomboun	0	81.8	93.9	100	6.8	95.9	98.4	99.7
Bokeo	0	75.5	78.7	92.2	11.6	97.6	91.9	100
Xiengkhuang	2.1	74.8	98.1	77	12.8	93.3	96.8	96.9
Luangnamtha	4.5	71.6	98.5	70.4	13.6	90.2	96.9	90.9
Champasack	0	65.1	92.4	97.3	2.9	85.9	96	99.4
Huaphanh	14.7	62.1	100	63.8	10.2	93.8	99.7	91
Oudomxay	4.1	51.9	86	63.9	12.1	81.5	90.4	79.5
Luangprabang	3.4	44.3	91	67.1	10.2	80.8	95.9	87.8
Vientiane	3.8	44.2	95.3	96.7	8.9	98.8	99.6	99
Khammuane	10.7	42	79	91.9	15.1	80.1	95	98.1
Sekong	0.9	37.7	81.7	58.6	1.2	73.9	95.8	75.2
Attapeu	7.5	35.5	87	85.4	13.7	70.2	87.2	93.8
Phongsaly	0	29.7	100	42.3	6	67.7	97.7	77.9
Savannakhet	4.5	28.1	51.4	67.3	12.5	69.3	81.7	93.2
Saravane	6.1	22.3	82.8	80	5.5	64.7	83.9	96

1.2 Social capital

"Social capital refers to the internal social and cultural coherence of society, the norms and values that govern interactions among people and the institutions in which they are embedded. Social capital is the glue that holds societies together and without which there can be no economic growth or human well-being. Without social capital, society at large will collapse, and today's world presents some very sad examples of this" (Grootaert 1998, p.iii). Social capital is a concept that "describes circumstances in which individuals can use membership in groups and networks to secure benefits" (Sobel 2002, p.139). It is used to explain how problems of selfish incentives could be overcome to achieve a mutually beneficial cooperative way of getting things done (Ostrom & Ahn 2003, p. xiv). Social capital implies voluntary cooperation, which is self-enforcing based on informal, unwritten institutions. Voluntary organizations among farmers can help lower the costs thanks to informal transactions, which are not formally sanctioned, and it is not necessary to monitor and enforce all the transitions (Svendsen & Svendsen 2004, p.27).

"Social Capital refers to the norms and networks that enable collective action. It encompasses institutions, relationships, and customs that shape the quality and quantity of a society's social interactions" (World Bank 2008). "Social capital represents the degree of social cohesion which exists in communities" and that "it refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co- operation for mutual benefit. Social capital is created from the myriad of everyday interactions between people, and is embodied in such

structures as civic and religious groups, family membership, informal community networks, and in norms of voluntarism, altruism and trust. The stronger these networks and bonds, the more likely it is that members of a community will co-operate for mutual benefit. In this way social capital creates health, and may enhance the benefits of investments for health" (WHO 1998).

Assessing the stock of social capital in Laos, Sounthone Phommasone and Phosy Chanhming (2014) noted that social capital in Lao is still strong, indicative of network mechanism, ritual activities, social trust, norm, value, and livelihood being interwoven into a strong social texture. Social system functions as a pre-requisite for the formal administrative authority. Both informal and formal organizations play very significant roles of strengthening, developing, and passing social capital from generation to generation. In particular, they noted that:

- Mutual support among rural people is still strong. This is Supporting mechanism for social ties
- Mutual help system has been created and passed on from generation to generation (e.g., house building, and other activities that need mental and physical support)
- Communal agriculture work (mutual support albeit) is till practice despite increasing hired of labor among ethnic groups to rotate the plantation or harvesting from one family to another, particularly in relatives and close acquaintances.
- Seniority support: conflict resolution, mental and physical support.
- Informal social support on birth, death, marriage, illnesses. Strong support from the
- villagers, relatives, friends, and the whole community have been practiced.

1.3 Gender

1.3.1 *Gender Analysis*

First, traditional gender norms prescribe women's primary role as carers for children and the household in rural areas, limiting their ability to engage in paid productive activities and affecting their "time poverty". Traditionally, women carry out most tasks within the private sphere (household chores, child-rearing, subsistence farming, etc.), living a life of drudgery while men have greater opportunities to seek paid work outside the household. Women's access to income-generating labor, when it takes place at all for example as a result from increasing agricultural investment, has not lightened these household burdens, creating an unbalanced division of labor in the household. Women are more likely to carry a triple burden of productive, reproductive, and community work, whether paid or, as in most cases, unpaid. Women devote a disproportionate share of their time on unpaid care work, 1.4 times as much as men. In 2018, rural women spent over four times more time on household chores compared to men (208.6 minutes per day versus men's 44.8 minutes per day), limiting their ability to engage in both formal and informal work at the same level as men's. The COVID-19 pandemic has further exacerbated the disproportionate burden on women of unpaid care work and agricultural labor, as school closures and reduced remittances from migrant workers redefined household structures.

Second, skills and often language skills pose barriers, especially among some non-Lao Tai ethnic groups. A significant barrier to participating in and influencing decision-making processes is posed by a lack of fluency in the national language. About 70 percent of the population does not speak Lao as their first language. Ethnic minority women face disadvantages stemming from lower education level, high school drop-out rates among girls, and widespread illiteracy. Approximately 41.8 percent of girls aged 15-19 are out of school due to early marriage, preventing them from developing proficiency in

the national language and fulfilling their social and economic potential [add data by ethnic group]. The Chinese-Tibetan ethnic group is the least literate, 50 percent rate for men and 35 percent rate for women, followed by the Mon-Khmer (67 percent for men and 38 percent for women) and the Hmong-Mien (71 percent for men and 40 percent women), in comparison to Lao-Tais' 84 percent for men and 76 percent for women.

Third, traditional culture and engrained gender norms prescribe women vs men's roles in the community. These play out in two ways that affect women's participation in community decisions. On the one hand, women's responsibilities for childcare and the household, in addition to other livelihood activities, limit the time they have available to engage in other activities. In Laos, women's share of unpaid care work is four times that of their partners. Engrained social norms discourage women to voice their needs and concerns. At the community level, women are often not trusted that they have the skill set to analyze problems and propose solutions, therefore if not both husband and wife are called for community meetings, it is usually the men who will attend (See Annex 3 – Review of Gender Equality, for more information).

1.3.2 Gender-Based Violence

Laos has developed relevant laws on preventing and combating violence against women and children (2014) but levels of conceptual and practical understanding of the issue are low. At the same time cultural tolerance for certain forms of violence against women is high. Several areas of concern are identified: (i) consulted local authorities, village outreach, young graduates and ethnic group communities accept and justify certain forms of gender-based violence and sexual harassment; (ii) despite Lao PDR having substantial legal frameworks to safeguard the rights and interests of women and children, services and help systems are limited; and (iii) the issue is only vaguely understood at all administrative levels and at the individual level.

1.4 Key Findings from the Consultation conducted for preparing HANSA II

During project preparation, consultation has been conducted with stakeholders in the project sites (from 27 February to 10 March 2023), followed with the national consultation workshop with project implementation stakeholder at the national and provincial levels (on 21 April 2023). During the consultation at the project sites, both project beneficiaries and project supporting staff were interviewed, including project beneficiaries of ethnic groups such as Hmong, Trieng, Khmu, Tai Leu, La Med and Lao Tai. To increase the reliability of the findings, consultation has been conducted in all three out of four project provinces covered by HANSA (Phase 1). These provinces include Bolikhamxay, Oudomxay and Sekong. The consultation was also conducted in Savannakhet which is a new province to be included under the new HANSA II. The consultation focused on soliciting feedback from project beneficiaries and project supporting staff on the overall benefits of the projects – as perceived by project beneficiaries, and reviewing areas of works that need improvement under HANSA II.

The findings from project sites were presented at the national consultation workshop (conducted on 21 April 2023) to validate the findings with participation of national and provincial stakeholders who are directly involved in project implementation and support. Findings from the field consultations, combined with findings obtained from previous analytical reviews as part of HANSA implementation review, serve as opportunity for participants at national workshop to discuss and propose measures that can be taken to address common bottlenecks in project implementation, facilitate for better

project implementation under HANSA II, including enhancing project development effectiveness. Key consultation feedbacks are summarized below.

During meetings, project beneficiaries expressed their positive view and strong support for project activities. Beneficiaries interviewed believe the project plays an important role in assisting pregnant woman and mother with children in improving nutrition and health status of the children, pregnant woman, and people in the communities. The results of their views about the project can be summarized as below (see details in Annex 1).

1.4.1 Positive feedback

From mothers, pregnant women, and the elderlies

- Pregnant woman have used the local health service more regularly for antenatal care (ANC) and birth delivery. They also participate more in nutrition program initiated under the project. Children also have more access to vaccination, weighing, and deworming. Beneficiaries are overall happy because they have known how to take better care of their children. As a result, their children are healthier, less prone to illness, and the cost related to healthcare is reduced.
- Communication skills of health care workers have improved, including the use of local ethnic language compared to before the project when healthcare officer used to speak impolitely (e.g., speak loudly), or not pay appropriate attention to patient, or discriminate because of their dressing (e.g., speak nicely to those well-dressed). The villagers do not dare to make a complaint and do not know to whom they should report.

From Village facilitator and health center officer

- Services of local health centers has improved, indicative of the increasing number of pregnant women who visit local health center for antenatal care, medical treatment, and family planning. Health center also provide health counselling to the local youth which is appreciated. Service time needs to be further improved (e.g., currently work starting late but finishing early).
- The SBCC is quite effective with the use of posters, village loudspeaker, monthly awareness raising activities (half day). The use of Lao language is not a problem for some ethnic groups. There is good coordination between the village facilitators and village authority.

From Tuberculosis (TB) patients

- TB patients acknowledge project support in providing medical treatment which enables them to recover. Free treatment reduce patient's expense on the medical treatment which is beneficial to their family as a whole.
- The hospital provides regular advice and has shared with them the contact numbers for doctors who they can seek additional support or advice when needed
- TB patients know how to take care of themselves and prevent themselves and others from being infected.

From service women (some of whom may be underage) who may provide sexual services for clients

- Service women appreciated the service of the health officers and health volunteers who come to their place to provide them with knowledge on HIV/AIDs and other sexually transmitted disease (STD) such as how to recognize the disease symptom and how to protect themselves from such infections through use of appropriate condom. The training are conducted every 2-3 months at their place make them feel comfortable. The service women are also encouraged to a nearby hospital for free blood test. They also have the support from

restaurant owner for them to have blood test at the hospital. There is also mobile test available. They asked for free condoms.

From HIV/AIDS patients and Male having Sex with Male (MSM)

- HIV/AIDS patients appreciated free medical treatment provided by the hospitals, including provision of knowledge by local healthcare officers on self-care, being safe with others. However, HIV/AIDS patients are concerned about the stigma of the society which in some instance cause loss of job and affect the future career. So, confidentiality to be maintained by village facilitators and doctors is very important to them. HIV/AIDS patients should be supported in income generation activities (e.g., raising ducks and chickens, opening small shops, grocery stores, restaurants.
- Provision of nutrition advice was successfully delivered, partially because when the ethnic female cannot understand the Lao language (provided by nurses), their husband receive the nutrition advice.

1.4.2 Areas for improvement

- It is important to promote behavior change in the area of hygiene and nutrition to some family who have not yet recognized/adopted recommended nutritional practice in cooking for their children. Some do not have money to buy nutritional food for their children.
- Also, some have not been yet interested in coming to local healthcare center for the services because of lack of money to pay the registration fee and the far distance (which costs them around LAK 50,000 – 70,000 each time).
- More activities need to be carried to raise awareness raising of project beneficiaries on vaccinations, childbirth, antenatal care, and 1,000 days of child development, particularly for those who still keep traditional beliefs and practice.
- In addition, healthcare centers are keen on having project support in provision of equipment to improve the HC services. These include ultrasonic machine, glucose and HIV testers, blood test equipment, urine test for pregnant women, medicine supplies and computer.
- For certain project target groups who still prefer giving birth at home, this group need refresher training to promote behavior change.
- Incentive should be provided to VF who conduct public awareness campaign for villagers.
- The old and lack of medical equipment and facilities at district health centers slow down the medical treatment process. Old equipment should be replaced with new one and additional equipment should be provided for an overall improvement of medical service quality at the district level. These include oxygen tank, autoclave, incubators for infants, glucose, HIV/AIDS tester, and medicines which are short of supply and are patients' most common complaint. The internet connection is slow.
- There is not sufficient budget to cover costs related to telephone, printing, and paper. PHO has to use their own admin budget.
- Information management is not well done at district level which require them to spend more time for task allocation, work harder in the situation of lack of staff for appropriate information collection. For instance, information on injection, no. of the patient receiving the services, the maternal and child mortality rate are not recorded properly at provincial hospital. More QPS trainings should be provided to improve overall management information system
- Open waste burning still cause pollution of air for community in the neighborhood.
- Room for delivery and for family planning should be separated.

- Under HANSA project, the provincial Hospital (PH) has the main role to review the data entry on DLIF, the information on injection, no. of the patient receiving the services, the maternal and child mortality rate while PHO plays the main role in monitoring the work of each DLI (provincial and district hospital and HCs) 3-4 times a year and preparing the report submitting to MOH at the central level.
- TB patient is concerned of the stigma that they still face from society (e.g., others may be afraid of contracting the disease from them). They have to refrain themselves from going to work even though the treatment results indicate that they can come back to work.
- TB patient do not feel they are considered normal after medical treatment. This affect their work and business.
- Project should conduct more public awareness activities on TB to eliminate current stigma and consider supporting TB patients – through provision of nutritional food such as milk, meat, fish, and fruit during the first 2 months of medical treatment.
- Hospital should have TB centre (isolation centre) to follow-up the patients and provide medical treatment to patients during the first 2 weeks/2 months to monitor patients who are resistant to medicament. In case necessary, patients should be referred to TB treatment centre in Vientiane capital.
- Hospital providing TB treatment is expected to keep confidentiality and free medical treatment should be expanded to reach patients who are still sick (the program is very useful, and the medicine is very good).
- A village medicine cabinet should be set up for each village to provide essential medicine for headache (such as paracetamol), stomach ache, and first-aid kit, particularly for area where health centre is far away from the village. , as well as, they required the training on medicine and first aid; while the HC officer requested the project to increase the incentive (LAK30,000) against the inflation rate, they also required a support on the equipment to be used at HC such as echo machine,
- Compilation of reports may be delayed at the district-level healthcare centers.
- Under HANSA II, it was suggested that budget planning should be done locally – based on a framework which the MOH may outline for the local PHO & DHO to follow. Alternatively, budget planning exercise should be a joint planning between local and central levels. Budget increase could be made for TB sampling and sample delivery, and for the QPS work.
- Additional capacity building is still required for health officers, particularly for those working with HIV/AIDS and TB, to strengthen coordination and monitoring activities. The SBBC works for TB, HIV/AIDS should be further strengthened through the support of media such radio, Facebook, and other media channels.
- Male having sex with male (MSM) appreciated the free blood testing and medical treatment offered at Provincial Hospitals.
- They suggested HANSA II should ensure project access to a wider group of potential beneficiaries who are affected with HIV/AIDs by a) providing mobile services to patients with no access to such services near their homes, b) extending home medication from 4 months to 6 months to reduce travel frequency and save costs, c) providing free medicine delivery through Lao Post or private logistic companies located near their villages, d) providing financial support to poor patients who live far away from the hospital to cover public transport, meals and accommodation, e) identifying high risk groups and providing mobile blood test, f) providing supplements and vitamins for patients with high need, g) improving communication and service quality of healthcare staff.

- Service women suggested blood test be done monthly instead of quarterly as currently applied. They hope the project will continue such a service as there is no other project providing similar services.
- Free medical treatment for HIV/AIDS and TB patients should be widely disseminated for those who may need it (See also Annex 4 for a summary of key lessons learned).

1.4.3 Challenges

- Vaccination program still face some difficulties and has not fully cover all the target groups because of their absence from home and follow up need to be done by the village head. This is the most common challenge experienced by the healthcare staff because villagers are not at home. They either travel to work very early morning and/or stay overnight in their upland fields.
- Another common challenge found is related to the high turn-over of the Village Facilitators (VF) whereby the trained VF cannot participate fully in the activities and other untrained villagers have to replace them because the trained VF's husbands do not want them to work, particularly for VF who get married.
- Stigma remains for TB and HIV/AIDS patients.
- Lack of medical equipment, essential medicinal supplies, particularly for those who live far away from health centers.

1.4.4 Environment

The rapid environmental assessment was focused on the infectious and sharp waste management at the hospitals in two out of four provinces visited to obtain information and observe practices. Key findings can be summarized as below:

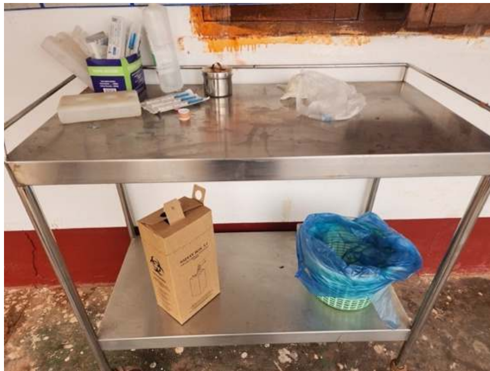
Oudomxay Province

The infectious waste is segregated from general waste using color coded bins provided. There are paper safety boxes (5L) for the staff in Khuang Village small hospital (Namor district) and Oudomxay Provincial hospital to dispose syringes safely after each use.

For the Khuang Village small hospital, the staff transfer and keep a full safety box in a storage area with fencing and roof that is located behind the new mother and child building. An average of 2 safety boxes is generated each month. A total of 8 boxes are currently stored in the storage area. Once reaching about 20 boxes, they will be transferred for disposal in the provincial hospital with provincial health office's cars visiting. The other small amount of infectious wastes will be burned on site together with other general waste in a dug pit located behind the building. Since this small hospital is located on the hill and no houses located in near vicinity, a small burning at a time when there are no in-patients and few numbers of staff working is likely to not create significant impact on the surrounding environment and local people. However, it is important to note that during the rainy season from June – October, burning of waste in this pit is likely to be difficult and stagnant water can occur causing odor and pest infestation that can be harmful for people's health. The staff said that they try to re-use the drinking water bottles and plastic bags to reduce non-hazardous waste since there is no waste collection and recyclable facility in the village. A small incinerator installed some 20-30 years ago by the province has no longer been operational. If a new option of disposing of the sharps in the concrete boxes underground is introduced, the staff has concerns that it will fill up the hospital area and it will be difficult to rehabilitate for future land use.

The staff here received one training course on environmental management including infectious waste separation and disposal during 25-27 July 2022. It will be helpful if the new Project can provide additional training on safe handling and disposal of infectious waste as well as providing an incinerator for them to handle waste on site. The small amount of wastewater generated from this small hospital is contained in the septic tanks separated from the rainwater.

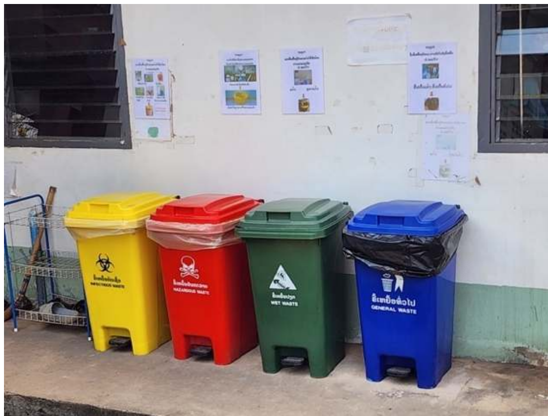
Figure 1: Infectious waste management in Khuang Village Hospital, Namor District, Oudomxay Province

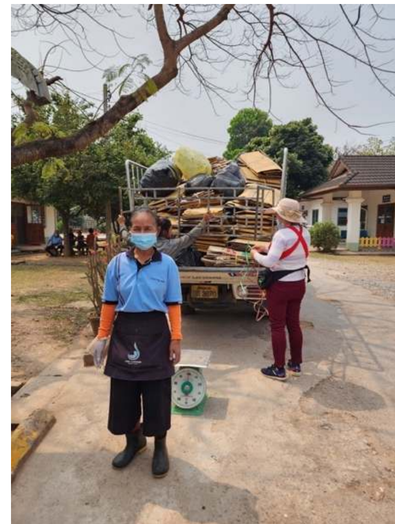


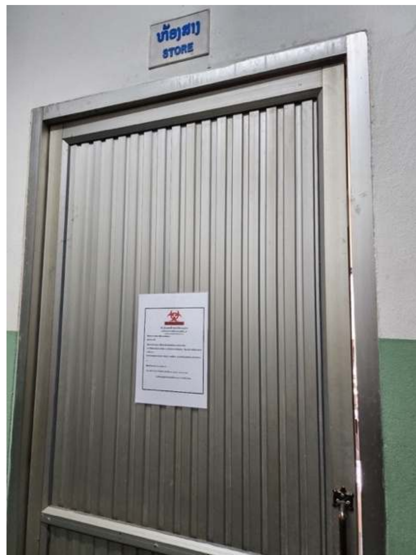
An interview with a waste collection service provider's (Contractor) staff at the Oudomxay Provincial hospital found that the hospital employs a local private waste service provider (Contractor) to do general and infectious waste collection and disposal (except sharps). The general waste is separated from other infectious waste in provided bins with labels. There is a small incentive for the Contractor's staff to sell their collected recyclables (mainly cardboard, plastic bottles and glass bottles) to the vendor who comes to purchase once a month for a small sum of cash. The Contractor's staff has been trained on waste management and safe handling. They were provided with appropriate PPE for their work as well.

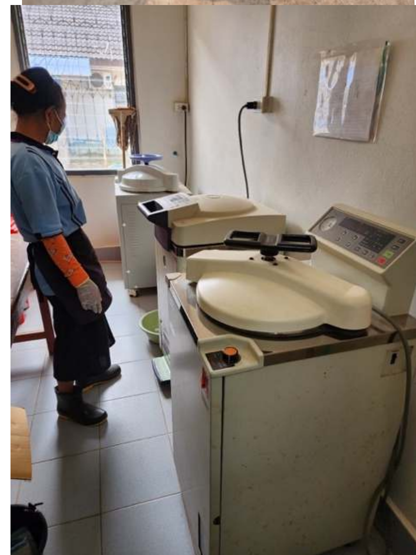
The staff informed that infectious waste will be autoclaved in a small room accessible to authorized personnel only. After that, it will be discarded for collection by municipal waste collector.

Figure 2: General non-hazardous and infectious waste management at Oudomxay provincial hospital





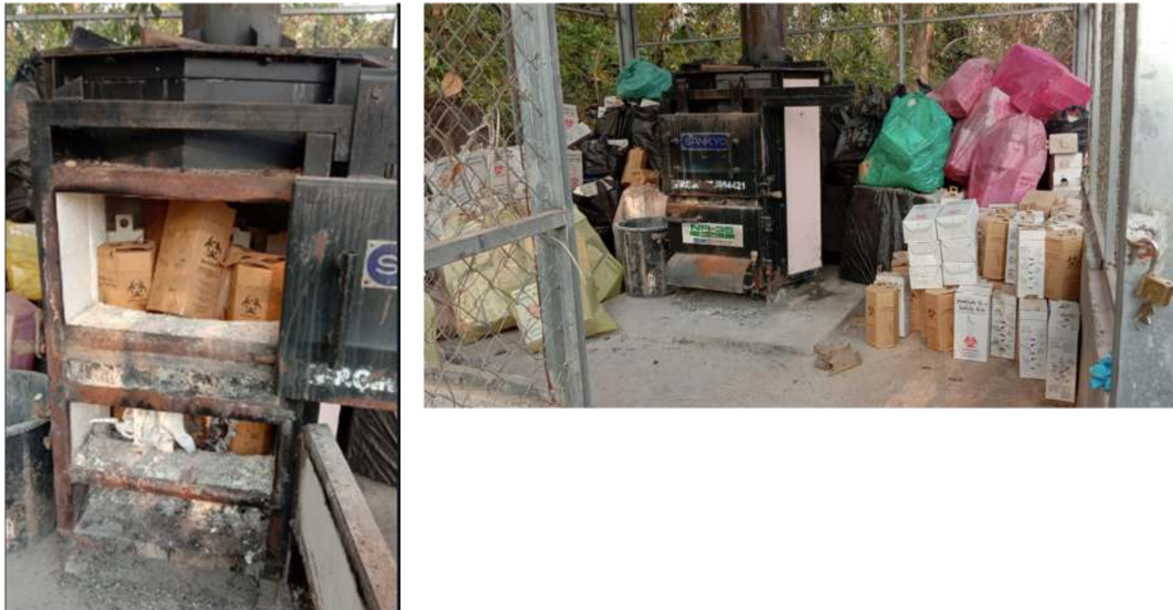




A phone interview was conducted with a female government staff in charge of burning sharp waste using an incinerator provided by GAVI Project some 10 years ago. The small incinerator is located behind the Provincial Health Department (not visited). She informed that the Provincial Department has assigned the Vaccination Unit to be responsible for destroying used syringes and she has been responsible for this work since 2010. During the COVID-19 outbreak, the workload had increased due to the increased number of safety boxes delivered. Since early 2022, she has destroyed about 5,000 – 6,000 safety boxes which is recorded. The safety boxes came from 7 districts and the provincial hospital. During the peak load, she burned 50 boxes a day (i.e. 25 boxes in the morning when arriving at the workplace until 4 p.m. cleaning the ash, removing the left over then continue burning 25 boxes in the evening overnight). On average, only 25 boxes are burned each day. She is the only one of the staff running the incinerator. The PPE has not been adequately provided and she has to purchase by herself such as boots and thick gloves. She heard about two training courses on the waste management provided by HANSA Project but has not been invited to participate and understands

that only the district staff in La and Namor Districts participated. She was trained by the GAVI project some years ago on the operation of the incinerator and occupational health and safety. There is an incentive of 1,000 Kip/safety box burned each day and has increased to 3,000 Kip according to a new Decree, but she has not received this payment for the last 2 years. She is very concern about her health from operating the incinerator and handling sharp waste without adequate PPE over a long period of time and requests the central government to assist in finding a replacement, increasing the allowance for this type of high-risk job and providing updated training.

Figure 3: An outdated incinerator has been used for burning disposed syringes delivered from all districts and hospitals in Oudomxay Province



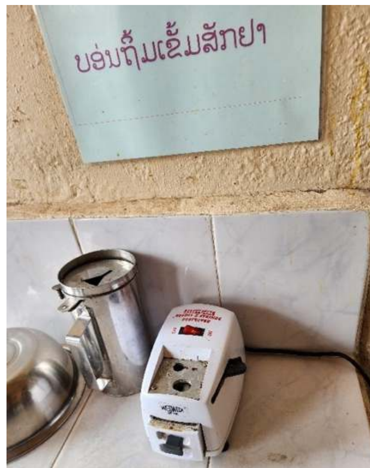
Savannakhet Province

There is a private company providing waste collection and disposal services at Savannakhet Provincial hospital. Each building will be the responsibility of a designated staff who is part of a committee called IC. Waste service provider staff and hospital staff in charge were trained on how to separate waste and safe waste handling/disposal. It was observed that there is a waste separation between general and infectious wastes, especially syringes that will be discarded in a designated metal bin and emptied in a concrete tank located outside the buildings far away from the public. A total of 10 concrete cylinder type tanks were constructed 10 years ago. It is unknown by the attended nurse responsible for the Infectious Disease building on the specifications of each tank. Currently the last 2 tanks are being used and the full tanks were already sealed off. In average, 2-3 metal boxes of syringes (3 quarter full) will be emptied each day in order to avoid risk for staff and patients.

It was informed by the attended nurses in that section that there are a total of 4 needle crushers provided to the hospital some years ago (they cannot remember the name of the Project) to pilot the disposal of the syringes. The crushers will destroy the needle to be fine materials which will be emptied in a metal box for disposal in the cement tank located outside the building. They said that it will be helpful if there are more similar needle crusher for them to use in the future to reduce the number of sharps being disposed in the cement tank.

Other infectious waste will be disinfected in an autoclave and discarded as other general waste for disposal by the municipality waste collector. The head of Infected Disease building said that it would be very helpful if the Project can provide an incinerator so that they can manage the infectious waste at the hospital. The current option of disposing in cylinder tanks may not be suitable due to the concerns on filling up the hospital area and rehabilitating the disposed area for use later on.

Figure 4: A needle destroyer and sealed cement tanks for disposing syringes and sharps



4. SOCIAL AND ENVIRONMENTAL RISKS AND IMPACTS

The proposed HANSA II project safeguard risk was classified by the World Bank prior to the appraisal stage as **Substantial** (*with Environmental risk being Substantial and Social risk Moderate*). This was mainly due to the possible adverse impacts associated with the generation and management of infectious waste from the health care activities and health treatment facilities as well as the limited capacity of the health sector staff at the district and provincial levels in the application of World Bank's Environmental and Social Framework (ESF) and relevant Standards when scaling-up to other remaining provinces. Possible positive and adverse environmental and social impacts of the proposed projects are described below.

4.1 Positive impacts

HANSA II will continue its support in current four provinces under HANSA. Meanwhile, it is expanded to cover the whole country (17 provinces and Vientiane Capital) with a particular focus on existing four provinces under HANSA plus two more provinces to be covered under HANSA II. HANSA II is expected to deliver healthcare services to the target populations of project provinces in Lao PDR, particularly women and adolescent girls, infants, and young children, the poor and vulnerable. Project interventions will focus on system strengthening and service delivery at primary care level and will focus particularly on the poor and ethic women, children, and key affected population including PLHIV, MSM and FSW and transgenders. As such, the project is expected to bring above an overall positive impact on existing primary healthcare system and overall health status of the project target groups.

4.2 Environmental Risks and Impacts

- **Potential environmental impacts due to minor renovation activities**

The project will not finance any new construction. Health care facilities (HCF) may be able to use earnings from health insurance capitation payments for minor repair. The renovation and refurbishing activities are minor and would be done in the same existing buildings, within the same footprint and without the extension of the respective buildings. These activities are considered minor civil works which may generate limited adverse environmental impacts such as dust, noise, vibration, waste, solid waste and safety issues. Also, there could be isolated health risks associated with exposure to asbestos containing materials in the case of old facilities that are using asbestos roofs. Additionally, in the case of building renovation activities including changes of internal layout (e.g., walls), there is a potential risk on the structure and safety of the existing buildings.

These impacts are assessed to be of small scale, localized, in short-term period and manageable if good design and construction practices are followed. In this project case, specific Environmental Code of Practices (ECOPs) will be followed to avoid any possible impacts during such renovation works. The HCFs staff or those who will carry out these works will be responsible to implement these ECOPs.

- **Potential environmental impacts during the operational phase**

The project will support mother and child health services, nutrition, immunization, and communicable diseases prevention and control as per the country's essential service package. Increased utilization of health services will result in increased generation of healthcare waste at health facilities.

The generation of healthcare waste has been studied and documented by World Health Organization (WHO), World Bank and other institutions. According to WHO's guideline on safe management of waste generated from healthcare activities, between 75% and 90% of the waste produced by health-care providers is comparable to domestic waste. The remaining 10 - 25% of health-care waste is regarded as "hazardous" and may pose a variety of environmental and health risks. A large part of the wastewater from health-care facilities is of a similar quality to domestic wastewater and poses the same risks[1]. Findings from published studies and from World Bank financed "Hospital Waste Management Support Project" are similar. Infectious waste generation primary health unit is 0,02-0.03 kg/patient/day; from maternity is 2.9 kg/patient/day; from district hospital is 0.1-0.15 kg/bed/day. In Vietnam, generation of wastewater from hospital is 0.4 m3 of wastewater per bed per day. In Laos PDR, generation of hazardous healthcare waste is 0.1 kg/bed/day at health centre and 0.12 kg/bed/day at district hospital[2]. Wastewater from health centre has insignificant weight approximately 1m3 per day and has the same basic component as the domestic wastewater.

The 10-25% of solid healthcare waste regarded as "hazardous waste" includes sharps waste, infectious waste, pathological waste, pharmaceutical waste, cytotoxic waste, chemical waste, radioactive waste. At primary healthcare settings, hazardous healthcare wastes are mainly sharps, infectious wastes, anatomical waste (placenta) and small amount of pharmaceutical waste.

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[1] https://www.who.int/water_sanitation_health/publications/wastemanag/en/

[2] Soulivanh Phengxay et al (2005). Health-care waste management in Lao PDR: a case study. *Waste Manage Res 2005: 23: 571–581*

Pathogens in infectious waste and wastewater may enter the human body by a number of routes: through a puncture, abrasion, or cut in the skin; through the mucous membranes; by inhalation; by ingestion. Sharps represent a double risk. They may not only cause physical injury but also infect these wounds if they are contaminated with pathogens. There is concern about infection with human immunodeficiency virus (HIV) and hepatitis viruses B and C, for which there is strong evidence of transmission from injury by syringe needles contaminated by human blood. Additionally, the general public is very sensitive about the visual impact of anatomical waste, that are recognizable human body parts including placenta.

All individuals exposed to hazardous health-care waste are potentially at risk, including those within health-care establishments and those outside these sources. The main groups at risk are the following: health staff, patients, patient relatives and visitors, workers in waste disposal facilities including scavengers.

The project will continue to promote good practices in healthcare waste management given its hazards to environment and health as well as public sensitivity. Potential impacts of healthcare waste to environment and health are deemed to be site specific, manageable and for which mitigation measures can be readily designed. In Health Governance and Nutrition Development Project, a sharp waste management guideline has been developed in line with MOH's regulations and international guidelines, and healthcare facilities in HANSA project will follow this guideline.

4.3 Social Risk and Impacts

Some project activities are likely to generate some key social risks and impacts that may be associated with implementation of the project. While the social impact of the project is overall positive, some social risks are anticipated, as follows:

- **Road Safety**

During project implementation, there is a risk of traffic accident that is associated with project workers who travel to support project works. The project workers include a) direct workers who are based in at central, district, village levels (e.g. consultants, project staff) who travel to villages by motorcycle to work at the project target villages), and c) community workers (e.g. Village Facilitators, Village Health Volunteers) who travel locally to meet with mothers and other participants in the villages. The risk of road accident may be present in area which is prone to natural disaster (e.g. flash flood that cause road damages) and is more likely associated with about 17,000 community workers who travel by motorcycle monthly to provide their voluntary support to the project (See also LMP - Section 11.2 Nature and scope of work. This risk is anticipated to be moderate and induced by nature.

- **Contracting/Spreading of Communicable Disease(s)**

During project implementation, the level of interaction between community members and other project workers will increase, particularly between beneficiary households and Village Facilitators and Village Health Volunteer at village level. This is due to the increased numbers of face-to-face meetings for the purpose of consultation, training, cooking demonstration, and between project beneficiaries with staff of commune health stations, particularly during healthcare sessions such as SBCC sessions, vaccination, ante- and post-natal care, growth monitoring, nutrition demonstration sessions. This risk is also identified with workers who are involved in procurement, delivery, and transportation of goods, services, supplies, and construction materials, particularly the risk of contracting communicable diseases such as COVID-19. This risk is anticipated to be low and induced by nature.

- **Sexual Exploitation & Abuse, Sexual Harassment, and Violence Against Children**

According to a WB's 2020 study, in 2013 alone, about 11,000 women (47.4% were young girls) were involved in sex trade (most in bars) in Laos. Of those who were trafficked, 60% were girls who are 12–18 of age. Under this project, people who work in entertainment establishments and restaurants (most are female) are among the key beneficiary groups. Despite the risk of SEA/SH comes with anyone: project workers, project beneficiaries, or community members, the following groups are more vulnerable because of their work environment: (i) **female health workers** (who are based in HCFs but travel frequently by motorcycles or on foot to hard-to reach villages to serve women beneficiary who stay in remote farmland during cropping season and thus cannot come to HCF for regular healthcare service, (ii) **female patients and adolescents** who have medical treatment, or stay in isolation because of their communicable disease, in HCFs, and (iii) **female village health volunteers** in all project provinces, particularly in six provinces with enhanced nutrition and primary care service interventions. It is noted that the village health volunteers, albeit living locally, travel often within their communes to facilitate monthly nutrition education session. The SEA/SH risk is also present in HCFs where minor repair is conducted by civil contractors. This risk is anticipated to be insignificant because workers are engaged for a short period of time (one or a few weeks) and are local.

To address this potential risk, key communication activities have been planned to raise awareness of those involved. These education activities will be initiated among project workers, then expanded to a) vulnerable groups (identified above), b) beneficiary groups, and c) project community at large. In particular, project workers are required to read and sign a Code of Conduct to be aware of the risks, prevention measures, and grievance redress procedures (See Annex 5 – LMP, for types and estimated number of project workers). Systematic trainings on SEA/SH (combined with other E&S risks and impacts) will be provided to project workers at central, provincial, district and commune levels. These trainings are delivered in the form of training of trainers to save project cost and assist in consolidating/strengthening the training knowledge, and thereafter change the attitude and behaviour/practices of the trainees (See detailed budget plan at Table 13, Section 7.5 below). These trainings are designed to roll out from central, provincial, district to commune/village levels. The risk is monitored and assessed regularly, and reported if happened. Incidence(s), if any, are addressed in accordance with the redress procedures for SEA/SH (See Annex 5 - LMP - Section 9.3.2 Redress Procedure for Complaints related to SEA/SH) and reported following the reporting arrangement in Appendix 4 of LMP). During early stage of project implementation, capacity of Lao Women's Union in responding to SEA/SH complaints will be assessed. If needed, refresher training will be provided to strengthen existing capacity. Given the nature and scope of SEA/SH risk and the arrangement that have been in place to minimize such risk, the risk of SEA/SH is anticipated to be "low".

- **Reputational risk related to female sex worker and other service person under 18 years of age**

Service women is one of the key target groups of the project. While most service women are above 18 years of age, there are those who may be under 18 years of age. All project workers, including health workers who provide training/healthcare services to this group, will be trained on the risk related to SEA/SH and will be required to sign Code of Conducts to be aware of the SEA/SH risk related to service women, including those underaged. This requires careful vetting and provision of training on Code of Conduct to health workers (who provide project services to this group), and other project workers to avoid committing any actions described in the Code of Conduct, and actions prohibited under active laws, such as the Law on the Protection of Rights and Interests of Children (for Article 35, 86, 89, 90, 91). The project will also further discuss and coordinate with concerned government agencies, other WB financed projects, and development partners, to provide the support that this

vulnerable group may need. These agencies may include the Lao Women Union (LWU) which is one of the government's mass organizations with local presence nationwide, UNICEF, UNWomen, UNFPA, and CSOs, to provide support that this group may need, and to enhance prevention and addressing the SEA/SH risks, particularly child sex, for this vulnerable group. A Worker's Code of Conduct is specifically prepared to describe actions that project workers should take to avoid involvement in SEA/SH/VAC. All project workers will be required to read and sign the Worker's Code of Conduct prior to commencing their work under the project and attend training to better understand SEA/SH/VAC risks and prevention measures (See Worker's Code of Conduct in Appendix 1 of LMP). A grievance redress procedure designed for SEA/SH issues is prepared to address grievance of affected person, if any (See SEP - Section 10.3.2), and reporting templates (See SEP - Annex 4).

- **Risk related to Community Health and Safety (CHS)**

Rehabilitation of facilities inside existing healthcare facilities may give rise to the risk of exposing people (e.g. healthcare and technical staff, project workers, patients and visitors) to risk of contracting community diseases and other environmental impacts such noise, dust, vibration, during the time when they are inside the health units under rehabilitation. This risk is anticipated to be low and induced by nature.

- **Domestic violence**

Under the project, the risk of domestic violence is recognized – as it may be inherent in some family before the Project. However, the risk of domestic violence may arise as a result of increased interaction outside the family of project workers, particularly Village Facilitators and Village Health Volunteers who are mainly female. Increased interaction of female VH/VHV and female beneficiary outside their family reduces their time being home. This may not be considered appropriate or widely accepted by both their family because of the social norms which define the traditional role of female members as being associated with child care, household chores, and expected restricted time for social activities, particularly among ethnic groups where the degree of social interaction is perceived differently and should be taken into account to minimize the risk of domestic violence, as mentioned above, for village facilitators, and other people who may work as voluntary for the project. This risk is anticipated to be low, inherent and induced by nature.

- **Child labor**

According to the World Bank's ESS2, the minimum working age required is 14 or higher as the national law specifies. In accordance with Laos PDR's Labor Law 2013 (amended), employers may accept employees from 14 years of age to under 18 years, but overtime work is prohibited (Article 101). Labor between 12 and under 18 years of age are prohibited from a) working in activities, duties and locations that are unsafe, dangerous to the health of the body, psychology or mind; b) performing hazardous works (as per list of hazardous works). Since office renovation (minor works) will take place in rural area where child labor is common, there is a possibility that local labor under 18 years of age is engaged by construction contractors. However, the risk of child labor is anticipated "low" since the scope of health facility renovation is minor, short time, and local, and take place within existing healthcare premise, and contractor will be required to engage workers under 18 years of age, the risk of child labor is anticipated to be "low".

- **Risk of project staff consuming/trading of wildlife and other Non-Timber Forest Product**

Some project staff may unknowingly become involved in consuming/trading of wildlife and Non-Timber Forest Product (NTFP). Project staff, including contractors, will be informed of the risk to

ensure they avoid possibility of involving in these unrecommended practices. This risk is anticipated to be low and induced by nature.

- **Risk of exclusion of vulnerable or disadvantaged groups**

These groups, including ethnic minorities, may not be able to access project benefits as readily due to a lack of targeted information, lack of services in their area, discrimination in accessing services. Vulnerable groups may also face indirect impacts, particularly women, ethnic minorities and those with disabilities for accessing to the health services, etc. The project will need to take the needs of these groups in mind and ensure they can adequately access services and benefit from the project, and that information provided to these groups is relevant, understandable and culturally appropriate. This risk is anticipated to be low and direct by nature.

- **Gender stereotype**

Gender stereotype still exists due to social norms in intra-household labor division and decision making thereby female typically spend most of daily time for unpaid domestic works whereas male spend most of their time for paid work and social activities outside their home. Albeit most decisions rest with female member, particularly for domestic works, daily diet, decision making in agricultural production is mainly made by male who is more directly involved in and thus knowledgeable about cultivation practices, innovation, labor arrangement, and market – thanks to their widely accepted social mobility. As a result, female appears less confident in income generation activities, such as identifying new income generation opportunities and making it happen. They are also less likely to be able to visit friends, relatives in nearly area (villages, neighbouring province) as they have to ask for permission of their husband. As gender stereotype is part of the social norms that is nested within the cultural practices of each ethnic group, there is a risk of reaction from male counterparts if the project promotes the role of their female counterpart – to a level that deviates from the traditional role of women, labor division, and decision making within their own family. This risk is anticipated to be low and induced by nature.

- **Lack of Cultural awareness of EG**

While it is anticipated that 80-90% of project's beneficiary are ethnic people, most of the project activities are designed and facilitated by the majority of project implementing members who are from Lao group. Given this, cultural difference, such as language, communication skill, understanding of cultural practices and social norms of each ethnic groups, etc. may be a constraint to those who are involved in the role of facilitating consultation, meeting, and behavior change communication. This risk is anticipated to be low and induced by nature.

5. MITIGATION MEASURES

Based on the individual social and environmental risks and impacts that are identified and assessed in Chapter 4, such E&S risks and impacts are summarized in three key groups of activities for which consolidated mitigation measures are proposed.

Activity	Risks and Impacts	Mitigation Measures
1. Minor office renovation and refurbishment activities	Dust, noise and vibration generated from rehabilitation or minor civil works	- The HCF staff is responsible for compliance with relevant national legislation with respect to ambient air quality, noise and vibration - The HCF Staff and the contractor(s) undertaking works shall ensure that the generation of dust is minimized and implement a dust control plan to maintain a safe working environment and minimize disturbances for patients, staff and surrounding community - The HCF Staff and the contractor(s) undertaking works shall implement dust suppression measures (e.g. water paths, covering of material stockpiles, etc.) as required. Materials used shall be covered and secured properly during transportation to prevent scattering of soil, sand, materials, or generating dust. Exposed soil and material stockpiles shall be protected against wind erosion - The HCF Staff shall ensure onsite latrine be properly operated and maintained to collect and dispose waste water from those who do the works - The HCF Staff should not carry out construction activities generating high level of noise during HCF activities, especially when services are being delivered to the clients. - Follow the Environmental and Social Codes of Practice (ECOPs) included in Annex 2
	Solid waste generated from rehabilitation or minor civil	- The HCF Staff shall develop and follow a brief site-specific solid waste control procedure (storage, provision of bins, site clean-up, bin clean-out schedule, etc.) before commencement of any financed rehabilitation works; - The HCF Staff shall use litter bins, containers and waste collection facilities at all places during works. - The HCF Staff may store solid waste temporarily on site in a designated place prior to off-site transportation and disposal through a licensed waste collector - The HCF Staff shall dispose of waste at designated place identified and approved by HCF management or local authority. Open burning or burial of solid waste at the HCF premises shall not be allowed. It is prohibited for the HCF Staff to dispose of any debris or construction material/paint in environmentally sensitive areas (including watercourse) - Recyclable materials such as wooden plates for trench works, steel, scaffolding material, site holding, packaging material, etc shall be segregated and collected on-site from other waste sources for reuse or recycle (sale). - Follow the ***Environmental and Social Codes of Practice (ECOPs) included in Annex 2***
	Asbestos containing materials (ACM) generated from renovation or minor civil works	- The asbestos audit will be undertaken as required prior to/at the beginning of refurbishment. - Safe removal of any asbestos-containing materials or other toxic substances shall be performed and disposed of by specially trained workers in line with the WBG guidelines on asbestos management (Annex 3). Because specific regulation has not yet been developed in Lao PDR, International occupational health and safety guidelines will be applied during removal of ACM from HCF undergoing Renovation.

		- If ACM at a given HCF is to be removed or repaired, the PMU will stipulate required removal and repair procedures in the contractor's contract. - Contractors will remove or repair ACM strictly in accordance with their contract. Removal personnel will have proper training prior to removal or repair of ACM. - All asbestos waste and products containing asbestos is to be buried at an appropriate landfill and not to be tampered or broken down to ensure no fibers are airborne. Disposal of waste containing asbestos should be agreed with MOH. - No ACM will be used for renovation works.
	Safety risks during works, health staff, patients and their relatives	- The HCF Staff shall comply with all national and good practice regulations regarding workers' safety. - The HCF Staff shall prepare and implement a simple action plan to cope with risk and emergency (e.g., fire, earthquake, floods) - The HCF Staff shall have or receive minimum required training on occupational safety regulations and use of personal protective equipment - Occupational Health and Safety (OHS) management plans will be developed by the contractors where ECOPs don't suffice. This OHS management plans will include OHS trainings, OHS monitoring at the construction site and maintaining records of work-related injury statistics and follow up on corrective actions. - The HCF Staff shall provide safety measures as appropriate during works such as installation of fences, use of restricted access zones, warning signs, lighting system to protect hospital/HCF staff and patients against falling debris and other risks.
2. Hazardous waste generation from primary healthcare activities	Solid healthcare waste, especially sharps, generated from healthcare activities	HCFs will develop the management process of solid healthcare waste including: segregation, containment, handling and storage, treatment and disposal of solid HCW. The principals of solid health care wastes management are described in accordance with MOH's regulation on drugs and medical waste disposal as bellow. Detailed instructions are presented in Sharp Waste Management Guideline. Segregation of solid HCW: - Need to segregate the waste immediately at the place of waste generation - Healthcare solid waste shall be segregated into 5 categories: infectious waste (sharp, non-sharp, highly infectious and anatomical waste), hazardous chemical waste, pressurized containers and general waste. Containment of solid HCW - Each HCF has to specify the location of waste containers for each type of healthcare waste where they are generated - The location of waste containers must have the instruction of waste classification and collection. - Each group of healthcare waste must contain in the bag or box fitted the code color and the technical standard which is suitable for the Regulations on healthcare waste management Treatment and Disposal of solid HCW:

		HCF can apply one or several treatment options as below: - Transporting to the nearest disposed place - Incinerating at high temperature Treating by friendly environment methods such as autoclave and needle shredder, concrete tank, bury pit
	Wastewater generated from medical facilities	- Wastewater shall be collected separately from rainwater. - Hygienic latrines shall be available and accessible to patients, health staff and visitors in HCFs. - Waste water from healthcare facilities should be disposed according to the reference of WBG EHS guidelines for the Health Care Facilities and WHO's guidelines for safe management of waste from healthcare activities All facilities should have simple and cost-effective pre-treatment facility and waste water should be treated before discharge to any natural water body.
	Occupational Health issues among healthcare staff	Occupational Health and Safety training program has been developed under the HANSA and provided to healthcare providers at some HCFs on aspects linked to sharp waste management. The project will continue delivery of the training and provide guidance and training to Provincial Health Department staff, District health staff, and HCF staff on health care waste management. Further, a Training of Trainers (ToT) program will be developed under the project to reach all primary stakeholders involved in HCFs. Component 3 would finance activities over the four-year period, which include among other aspects, capacity building for health care waste management targeting the strengthening of related procedures and regulations; skills of staff, and providing initial supplies to allow proper implementation of procedures in facilities. All health providers and workers will be provided with labor protection items. HCF staff are trained and follow procedures to solve unexpected situations such as injuries caused by needles (see Sharp Waste Management Guideline).
3. Activities are likely to generate social risks and impacts that may be associated with implementation of the project.	Sexual Exploitation & Abuse, Sexual Harassment, and Violence Against Children	- Public Awareness Raising for villagers (at village meetings, leaflet, SBCC) - Awareness raising for beneficiaries through regular meetings with VF and CM - Training of VF on risks of CHS - Vetting and training on Workers' Code of Conduct for project workers and health workers to prevent - Grievance Redress Procedures established with focal points assigned to handle and report on the SEA/SH incidents. - Further discussion and coordination with concerned government agencies including Lao Women's Union for dealing with the issue and relevant development partners for their support that this vulnerable group may need. - Engaging SEA/SH expert to support development of SEA/SH action plan at the beginning of the project or before implementing the activities.
	Reputational risk associated with Service women and	In addition to the above listed measures and requirements, other specific mitigation measures includes:

	service providers under 18 (engaged by local hospitality services such as entertaining businesses and restaurant)	- Identity these groups for each project village (as part of Village Development Plan meeting) (See Definition section for specific groups) - Introduce alternative livelihoods and income earning opportunities that may be provided under ongoing WB-financed projects such as Priority Skill for Growth Project and Micro, Small and Medium Enterprises Access to Finance Project, Community Livelihood Enhancement and Resilience (CLEAR), and other donors' program initiatives. As most of these child Service women are often found among the vulnerable groups, special considerations should be given to them to access and benefit from livelihoods options that may be available from these ongoing projects, where feasible. - Consult and collaborate with other program initiatives, on-going and pipeline operations financed by the WB, concerned development partners, and government agencies, to prevent and address the child sex labor and VAC risks. - Engage the groups in project's relevant consultation meetings using communication methods prepared for vulnerable groups - Incorporate feedback and expectations from these groups (in Annual Village Development Plan) and ensure they could participate and receive socioeconomic benefit from project. - Maintain regular contacts with the groups during subproject design and during implementation activities, particularly activities that involve loan use, adoption of project's training knowledge, and activities that promote behavior change (e.g. nutrition, home gardening). - Mainstreaming SEP into the POM and other technical guidelines and manuals; - SEP has included special consultation measures which are addressing the need of specific different groups (ethnic groups, people with disability, women, elderlies, children and disadvantaged groups) in Table 3. - Section 4 of the SEP provides measures to avoid misinterpret of information, misunderstand complaints, and social conflicts between different ethnic groups. This includes steps on how the views and concerns of vulnerable or disadvantaged groups will be sought during the project design and implementation, and measures to be taken to address potential barriers to the full participation of vulnerable individuals/households in project consultation. Project consultation is tailored to meet the need of specific groups.
	Domestic Violence	- Public Awareness Raising for villagers (at village meetings, leaflet, SBCC) - Awareness raising for beneficiaries through regular meetings with VF - Training of VF on risks of CHS
	Risk of exclusion of vulnerable/disadvantaged group	Key mitigation measure includes: - Identity these groups for each project village (as part of Village Development Plan meeting) (See Definition section for specific groups) - Engage the groups in project's relevant consultation meetings using communication methods prepared for vulnerable groups

		- For individual households who live far away from common place for trainings and/or absent from regular trainings during high farming seasons, separate training/education/service sessions will be conducted at the area of residence to overcome their travel challenges. Consultative sessions conducted for EG will be delivered in their mother tongue to promote their understanding, participation, and adoption of the introduced training knowledge. - Incorporate feedback from these groups (in Annual Village Development Plan) and ensure they could participate and receive socioeconomic benefit from project. - Maintain regular contacts with the groups during subproject design and during implementation activities, particularly activities that involve loan use, adoption of project's training knowledge, and activities that promote behavior change (e.g. nutrition, home gardening). - Mainstreaming SEP into the POM and other technical guidelines and manuals; - SEP has included special consultation measures which are addressing the need of specific different groups (ethnic groups, people with disability, women, elderlies, children and disadvantaged groups) in Table 3. - Section 4 of the SEP provides measures to avoid misinterpret of information, misunderstand complaints, and social conflicts between different ethnic groups. This includes steps on how the views and concerns of vulnerable or disadvantaged groups will be sought during the project design and implementation, and measures to be taken to address potential barriers to the full participation of vulnerable individuals/households in project consultation. Project consultation is tailored to meet the need of specific groups.
	Lack of cultural awareness of ethnic groups	- Guidance on Meaningful Consultation is incorporated into SEP - Mainstreamed into Project Operation Manual - Training of all Community Mobilizers and Village Facilitators on Meaningful Consultation
	Gender stereotype	- Guidance on Meaningful Consultation is incorporated into SEP - Mainstreamed into Project Operation Manual - Training of all Village Facilitators on Meaningful Consultation

ANNEX

Annex 1 – Summary of Consultation Results During Project Preparation

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
	Sekong province							
27/02/23	10:00 – 11:00 A.M Darkmouan village, Darkcheung district, **Sekong** province	▪ **Group 1:** 15 pregnant woman and mothers who have children under 5 years old) ▪ **Group2:** 4 elders (two are female)	2	17	Trieng	Health and nutrition services for mothers and child under HANSA Project and recommendation for HANSA II	▪ Pregnant woman regularly uses the health service at HC for antenatal care (ANC) and birth delivery, mothers also bring their children to have vaccination, deworming and participating in nutrition program. People are really happy because children are healthier, less prone to illness and reduce the cost of the family when they got sick, because before the project, they did not know how to take care of their health properly, but now there is a health center near their home. however, some people are still facing difficulty to access to the HC because they live far away and esp. during the rainy season and some of them has no vehicle to come to the HC; ▪ In the past, the HC officer used to speak impolitely, because of their workload, or maybe the communication is still challenge between Trieng ethic and HC officer. But now some of the health center workers are from the same ethnic group so the communication is much improved; ▪ In Phase II of the project, The Project beneficiaries suggested the project to improve the HC to have medical equipment such as Echo machine, blood glucose test and HIV test equipment as well as the medicine should be available at all time such as cold, pain and stomachache medicine, In addition, the pregnant woman required to receive the support from the project some particular cloth	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
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							after they delivery such as Diaper, bowl, fabric, soap, cloth (Lao skirt) for those who are pro-poor.	
27/02/23	11:30-12:00 A.M Darkmouan Health Center, Darkcheung district, Sekong province	▪ Village facilitator (VF) and health center officer	0	2	Trieng	Health and nutrition services for mothers and child under HANSA Project and recommendation for HANSA II	▪ Why asking about which extent that they find the project activities implementation effective? The interviewees shared that there is dissemination of nutrition; the no. of people come to receive services at the heath center such as antenatal care and treatment is increased, the family planning is also well implemented. In addition, the HC also provide the health counseling for the youth, but they think the constraints that need improvement is to promote knowledge on hygiene and nutrition to some family who still not see the importance and do not follow the nutritional practice in cooking for their children, however some of them do not have money to buy nutritional food for their Childs. ▪ The SBSS work is functioning at the village, there is poster on cooking and mother and child to be attached to each house, the awareness campaign is also implemented 2-3 times per month or during the women meeting at the village. ▪ The 3 main challenges that they're facing with the solution are i) Some people may still be indifferent and do not want to come to the health center. The officer must attempt to explain to those families to understand the benefits of receiving services at the HC; ii) some people do not have money, so they don't want to come to the HC, therefore, the HC allow them to pay the registration fee later and iii) some families stay far away from HC, the officers need to call them to come and get medicine;	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							▪ In the project phase II, they suggest the project to provide more on the awareness raising on vaccinations, childbirth, antenatal care and 1,000 days of child development to the project beneficiaries, because some family still keep traditional beliefs and practice; in addition, the HC require the project to support the equipment to the HC to be used such as eco machine, glucose and HIV testers and they also require capacity building on childbirth (because some of people still giving birth at home), they need refresher training in case of forgotten. ▪ Lastly, the VF requested the project to provide monetary incentives for the VF while conducting the awareness campaign to the villagers in the community.	
27/02/23	2:00 -3:00 P.M District Health Office, Darkcheung district, Sekong province	▪ 3 DHO officers and 3 District hospital (DO)	2	4	Lao and Trieng	Consultation with district hospital and district heath office under HANSA Project and recommendation for HANSA II	▪ The main role of the hospital is to monitor the implementation of HCs regarding the improvement of their HCs, following by various conditions and certification of QPS, while DHO is monitoring on budgeting; ▪ The DH also shared that the system is slow which make them need to wait and wasting time, so it needs the replacement of the equipment or improvement, moreover, the equipment is not enough either, while the DHO found that the HC has not yet recorded information properly, therefor they had to provide the training at work; ▪ The DH added that the officer to implement the assessment is still not enough, so they have to allocate tasks more precisely, spend more time working and work harder while the understanding of the HC is not yet high, so they need regular training on QPS;	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							▪ DH has reported that some HCs, sometimes has only on officer on duty, therefore they are unable to collect all needed information such as summary report; so, they need to spend times searching for such information; ▪ In the project Phase II, the DHO suggested to improve the HC to have separate room between the room for delivery and family planning; require the project to provide equipment such as oxygen tank, autoclave and medicines are still in short supply which make people complaint about this, some of HC has no incubators for infants; and no Glucose and HIV tester; ▪ Regarding environmental issues, there are still have open burning of waste which cause air pollution to nearby community; ▪ Lastly the DHO proposed the project to provide incentive money for Village Health Volunteer (VF) while they're working for the project's works and the coordination is also need to be improved to make clear understanding of DH while working for the project.	
28/02/23	8:30 – 9:30 A.M Sekong provincial health office, Lamam district, Sekong province	▪ 2 Provincial hospital officers and 1 PHO officer	1	2	Lao	Consultation with provincial hospital and provincial heath office under HANSA Project and recommendation for HANSA II	▪ Under HANSA project, the provincial Hospital (PH) has the main role to review the data entry on DLIF, the information on injection, no. of the patient receiving the services, the maternal and child mortality rate while PHO plays the main role in monitoring the work of each DLI (provincial and district hospital and HCs) 3-4 times a year and preparing the report submitting to MOH at the central level; ▪ The main challenge that they face is i. the information in the paper is not yet properly recorded by the health officers, so they need to spend time for reviewing; ii. The	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							internet connection is slow, it causes the figure may be incorrect; iii. No admin budget (telephone, ink, printing and paper), so the PHO has to use their own admin budget; another the issue they found is some sectors do not know how to check the information in DLI system, so the refresher training is needed; ▪ In the project phase II, PH propose the project to provide the training on the use of the system twice a year as well as during the preparation/planning of project activities is needed to involve the local level (provincial level) in order to allocate the activities to suit the reality, In addition, they requested the project to allocate some budget for admin works and providing of vehicle for provincial coordinators and books to record no. of patients receiving service at provincial, district and HCs because they have not been received for 2 years	
28/02/23	10:30 – 11: 00 AM Sekong provincial hospital, SK province	▪ 3 TUBERCULOSIS PATIENTS (1 out 3 is female)	2	1	Lao and Trieng	TB patients who are direct beneficiary of the Project activities on HIV/AIDS	▪ The interviewees shared that the project helps patients to recover and become healthier at no cost, which helps to reduce the family's expense on the treatment; ▪ The project also provided knowledge on how to take care of themselves and prevent themselves and others from getting infected, maintaining cleanliness; knowing how to isolate, keep clean, eat healthy food and take medicine on time; isolating themselves during the treatment period, some people may be a bit difficult because they're staying at the farm, sometimes do not take medicine on time, so they may need to pay more attention; ▪ They also concern about the stigma by the society, because the people is afraid to get affected from them (even the truth is that if they already take the medicine	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							for 2 weeks, the decease will not be able to communicate to others), therefore, they decided to stop working for 2 months or going to work not regularly, fortunately, the office also understands them; ▪ The hospital provides regular advice and has shared with them the contact numbers for doctors who they can seek for additional support or advice at any time; ▪ Their family members also help to support them such as cooking, boiling water, reminding to take medicine, giving encouragement, etc. ▪ Most common impact they face is about unable to stay in the society like normal, also affecting to their work and business, farmers are getting tired and can't do much, lack of income from farming. ▪ For the project in Phase II, they recommended that the project should raise awareness on TB to the public (such as dangers, treatment methods, self-care to preventing from TB and when treated well, it will not be able to communicate to others and etc.). They also requested the project to consider supporting the TB patients esp. the poor family with the nutritional food (milk, meat, fish and fruit) during 2 months of treatment, because this is really help them to recovery from the illness; they also willing to see the hospital to have particular TB center (isolation center) to follow-up the patients and providing of treatment especially first 2 weeks/2 months, because if there is the drug resistant patients, they will be sent to the TB treatment center in VTE capital.	
28/02/23	2:30- 3:00 P.M	▪ 3 Female Service women	0	3	Lao	Female Service women who are	▪ The Service women shared that the health officers come to provide knowledge on HIV/AIDs as well as other	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
	Lamam district, Sekong province					direct beneficiary of the Project activities on HIV/AIDS	sexually transmitted disease (STD) every 2-3 months, they can also go to a hospital for blood test with no cost, there is also mobile test available, they restaurant owner support them to have blood test at the hospital as well ; ▪ They also said that the best approach for gathering information is to come and meet them at their accommodation where they feel comfortable to provide such required information; ▪ During the awareness raising, the health officer has provided demonstration on how to use condoms properly, self-practice for safety and knowing of the dangers of HIV/AIDs and other STD such as gonorrhea Papilloma Virus or HPV, etc. and their signs and symptoms; ▪ For project in phase II, they expect the project to provide health education to all Service women twice a year with the leaflets for the preventing of HIV/AIDs and STD, providing of on-site blood test once a year, distributing of condom and gel; ▪ The condom that was distributed by the project "Hak Der" brand is often rip.	
II.	Bolikhamxay province							
2/03/23	9:00 – 10:00 A.M Namsang village, Pakkading district, **BLKX**	▪ **Group 1:** 7 pregnant woman and mothers with children under 5 years old) ▪ **Group 2:** 5 father who have children under 5 years old	5	7	Lao	Health and nutrition services for mothers and child under HANSA Project and	▪ The pregnant women go for an antenatal care, taking medicine and young mother take their babies to get vaccinated, weighing, arm circumference measurement. They also said that they gain knowledge about health care and when their baby got sick, they receive appropriate treatment which make them feel safe. ▪ The father also added that once the pregnant women receive vaccination and check-up are really good for the	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
						recommendation for HANSA II	health of the child. In addition, they also receive advice from doctors and have chance to read about the handout about maternal health dare. ▪ The HC is easy to access because it is located nearby the main road, but during this time the road is being repaired, it may be difficult and for some families, those who work in the rubber tree farm have to travel a long way to receive the treatment at HC and concerning about accident during the travel. ▪ Those who are husbands, fathers and relatives also support and take them to the hospital, the village authority and health volunteer also has regularly followed up and support. ▪ Most of health officers at the HC have provided a good service with smile, but some of them are not friendly (Not paying attention), sometimes the appointment is scheduled on Saturday, but when they come, it is postponed to Monday. The villagers also shared that they do not dare to make a complaint neither do not know who should report to. ▪ Some medicine is likely to run-out such as medicine for fever, cough, birth control pills for young mothers, therefor they have to buy at the clinic. The abdominal examination with an echo machine is required because they have to go to the clinic for such service which cost around LAK 50,000 – 70,000 each time due to the district hospital is fare away to the village.	
2/3/23	10:00 – 12:00 A.M	▪ 1 Village Facilitator and 2	1	2	Lao	Health and nutrition services for	▪ Why asking about which extent that they find the project activities implementation effective? The interviewees reported that the mother and child work of the project	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
	Namsang Health Center, **Bolikhamxay** province	Health Center officers				mothers and child under HANSA Project and recommendation for HANSA II	was effectively implemented (vaccination of children), since the project has started, there are not many people's illnesses, health services are accessible to the people and people receive medicine, there is advice on nutrition 2-3 times a year, children are assessed on weighting, height measurement, etc.; ▪ The convergence project helped to purchase equipment that was missing such as heart rate measure, autoclave, computers and etc. ▪ The family planning is also well implemented. ▪ The constraint/areas that they think the project may consider to support children below the standard of nutrition (poor families) with special support such as food supplements, etc.; ▪ They want to separate the activities in the program because there are too many activities such as: weighting, injections, family planning, nutrition, antenatal care, because people will not wait if they are going to the farm, however they think the SBCC is quite effective, because the project has posters, advertising on village loudspeaker and awareness raising every month (half day), and the use of Lao language is not a problem; ▪ What the key challenges that they often face is the project beneficiaries are not at home, they have to call for following up, some families do not pay attention to come and receive the services, some has no vehicle to come to HC, therefor the HC has to regularly proving of awareness to these families, however the work coordination between the HC, VF and village authority is good, even there is only VF in the village.	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							▪ The capacity that they require is to increase the knowledge on nutrition, communication and management skills; ▪ In the phase II of the project, the VF required the project to set up a village medicine cabinet (basic medicine such as paracetamol, medicine for stomach ache, etc. and First Aid Kit) because the health center is located far away from the village, as well as, they required the training on medicine and first aid; while the HC officer requested the project to increase the incentive (LAK30,000) against the inflation rate, they also required a support on the equipment to be used at HC such as echo machine, blood test equipment, urine test for pregnant women, the medicine supply is also need to be improved, because the HC has prepared the medicine request plan for 2-3 times but it is not responded.	
3/3/23	10:00 - 10:00 A.M Hongxay health center, Paksan district, BLKX province	▪ 2 TB patients	1	1	Lao	TB patients who are direct beneficiary of the Project activities	▪ The TB patients shared that they receive the treatment with free of charge, this is helping to reduce the cost of buying medicine and reducing the burden on the family and helping the sick people to recover from the disease, compared to the previous time, many people died due to lack of access to medicine; ▪ During the treatment, Doctors has advised on self-protection and self-care, socializing and cleanliness, however, they still concern about others may be afraid of contracting the disease from them, therefore, they must take care of themselves and follow the doctor's advice. Doctor also calls them regularly to provide advice on self-care and medication;	

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							▪ Their relatives also support and help in preparing food and helping with finances; ▪ For HANSA II, they expect the project providing health education to the public, hospital will be maintaining patient confidentiality and hoping the project to reach the people who are still sick as much as possible, because the program is very useful and the medicine is really good.	
2/3/23	2;00 – 3:15 P.M Pakkading district hospital, BLKX province	▪ 10 DHO and DH officers	2	8	Lao	Consultation with district hospital and district heath office under HANSA Project and recommendatio n for HANSA II	▪ The DH shared that they have 3 officers working under the project to conduct the monitoring and assessment works, data entry and planning for budget allocation, checking report of HC to further reporting to the province, while DHP is monitoring the data entry of HC (vaccination, births and etc.), they also provide on-site monitoring and support at HC for completing report summaries and DHIS 2 data entry; ▪ While asking about what key achievements of their organizations have made under the Project activities, they responded that the QPS is implementing well showing that the HC has a regular doctor and they receive good scoring on QPS, on the other hand, the mother and child and convergence work at village-level is also well implemented and having a supporting budget. the health officer at HC is capable to fill in information (birth, vaccination, mother and child), the incentive money is provided to village health volunteer and health officer. The quality of data is improved, there is daily monitoring, and the capacity building is provided to HC in improving of health service as well as the provision of equipment (computers, autoclaves, medical equipment, etc.)	

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							▪ The key challenges that they face while facilitating project activities include i. the standards/facility of HCs do not yet meet the standards of the HANSA, so this makes some HCs has low scoring on QPS; ii. The no. of injection has not reached the target, due to the people are not at home, so the village head must follow; iii. the BCG vaccine for tuberculosis cannot be given to only one person, it has to wait for 4 people when that patient go back home, they don't come at the appointment date, this cause the vaccination statistics fall), To address this situation the nurse must to give injections to 2-3 people only to meet the target (the rest of the medicine must be thrown away); iv. The statistic unit is facing computers at work are not enough, due to many works require the use of computers, causing the data entering to be delayed, so the DH has prepared the budget plan to purchase computers under HANSA project. v. TB section is facing issue with people who are at risk or have TB are not yet conscious to be tested, according to the monitoring found that many HCs does not have the budget to go and collect samplings in all villages, so the officers has collected sample once a year only while implementing health education works. On the other hand, the budget for sending test results to provincial hospitals is still limited. What best they can be to keep the test results in the refrigerator and let the patient wait, sometimes they send it with the ambulance to the PH. ▪ For the project in phase II, they suggested the project considering to reduce the criteria/no. of question for QPS of HCs, because the standards are too high, but HCs are	

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							not yet ready to do it (according to the indicators) such as HIV testing and so on. They also requested the budget allocation need to be matched with the current situation, for example the price of fuel and so on, due to inflation rate; and If the village is large , the project should add specific health education activities such as ANC, childbirth, mother and child and etc. lastly, to provide enough computers to HCs for data entry (>4 units)	
3/3/23	8:30 – 9:00 A.M At house of HIV/AIDS patient	▪ 1 HIV/Aids patient	1	0	Lao	MSM who are direct beneficiary of the Project activities on HIV/AIDS	▪ The HIV/AIDS patient reported that he receives the free of charge treatment from the hospital as well as getting medicine and vitamin for free, he collects the medicine every six months and having health check-up once a year, the health officers provide knowledge on self-care, being with others safely, he also recommend his friends to protect themselves (wearing a condom), he follows the guide dance of doctors to eat good food and doing exercise, however, he is concerning about on the stigma of the society, some people don't socialize, he shared the case of his friend's that working as a chief , but when the employer found-out he is HIV patient, he got fire, what best they can do is only explaining to their friends that it is not easy to get affected, however they receive a good support from hospital as well as their family which is advising them to maintain health, taking medicine on time and so on. ▪ He also added that it is really impact to their career as no one accepted them to work for, some of them have worked because they keep it as confidential ▪ In project phase II, he requested if any possibility that the project will be supporting on any occupation to the	

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							HIV/AIDS patients such as: raising ducks and chickens, opening small shops (grocery stores, restaurants) , in addition, he suggested the project to provide health education about HIV/AIDS to reach out various communities, training on HIV/AIDS to the VFs and Doctors should keep the confidentiality of people with HIV/AIDS well.	
3/03/23	10:30 to 11:30 A.M Provincial Health Office, Paksan district, BLKX province	▪ 5 PH officers and 3 PHO officers	3	5	Lao	Consultation with provincial hospital and provincial heath office under HANSA Project and recommendation for HANSA II	▪ Each section of the PH reported that: i. Mother & child sector: Collect statistics and enter individual data into DHIS 2; ii. Healthcare & Hygiene Promotion sector: Prepare implementing plan at the provincial level and follow up on the implementation and summary; iii. CDC (HIVs): planning on MSM activities, supporting and monitoring at the district level, reviewing of data entry and records by DHs. iv. Health and Rehabilitation sector is responsible for the overall budgeting and distribute to the district level as well as assessing HCs and technical monitoring; v. Financial sector: after receiving the money, they provide the training on financial management for HCs officers, to monitor the financial (income-expenditure) according to the form; vi. TB sector: monitor and promote tuberculosis work at the district level, HCs, collect samples (at provincial hospitals), manage patients, monitor data input, deliver drugs to the district and prepare quarterly drug plans for tuberculosis centers (in the HANSA project, they support sample delivery, monitor and support works of PH, DHs and HCs); vii. Provincial coordination sector plays role to review the summary report of the various activities implemented by sectors, and monitor the implementation of the activities of each	

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							sector, allocating budget for each sector at PHs, DHs and HCs. ▪ The challenges that PHO & PH faced with provided solutions can summarize as follow: i. Compilation of reports may be delayed at the district level, it needs to encourage and provide support from the provincial level, so they propose to hand it over to the district to manage such works; ii. Health officers at HCs have never learned about finance, on the other hand they have workload (so they don't have a good understanding of accounting). The finance sector must to call to provide advice, therefor, they required to conduct the refresher training on financial management and accounting and budget for monitoring and counseling at HCs at least once a year; iii. Volunteer Incentives (AIDs) are still low compared to the increasing indicators, currently the salary is 2,200,000; iv. TB: small amount allocated (7 million)/year for sampling delivery which need to cover 7 districts (money allocated for monitoring) with 319 cases, now they use some budget from PP project to cover this cost, but the project will be end by this May 2023 ▪ For the project in phase II: they suggested that Activities and budget planning should be done locally, which the MOH which may outline a framework for the local PHO & DHO to follow or it should be joint planning between local and central. Some capacity building is still required for health officers such HIVs and TB strengthening the coordination & having the monitoring activities of the coordination focal point; enhancing SBBC works on TB, HIVs through the support of media such radio	

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							broadcasting, FB and other channels, Increasing the budget for TB sample collection and sample delivery, lastly DHR required some budget to follow up and support the QPS work, even that the related sector has already planned, but it has not received any response.	
3/03/23	4:00 – 4:30 Restaurant in Pakkading district, BLKX province	▪ 2 Female Service women	0	2	Lao	Female Service women who are direct beneficiary of the Project activities on HIV/AIDS	▪ The mentioned that they receive information on HIV/AIDS and STD from the health officers who come to their place as well as the hospital provide free of charge blood testing. they have learnt on how to use condom properly, self-protection and receiving condoms from the health officers (twice a year); ▪ For the project in phase II, they are also willing to receive such information on STD, HIVs, etc. and receiving of condoms	
III.	**Oudomxay province**							
06/03/23	10:00 to 10:45 A.M Mu Teun Village Hall, Namor District, **Oudomxay** province	▪ **Group 1:** 2 female Village Facilitators, 1 Deputy Village Chief and 10 interviewees (3 pregnant women and 7 women with young children less than 5 years old) ▪ **Group 2:** 2 Father with young children less than 5 years old)	2	10	Akha	Health and nutrition services for mothers and child under HANSA Project and recommendatio n for HANSA II	▪ Two out of three pregnant mothers used the services of antenatal care and birth delivery of their first child at the Health Centre (HC)/Small Hospital representing 20% of the total interviewees. Another pregnant woman (3 months) only used the mobile service for antenatal care provided by the HC. The remaining participants are females with young children of less than 5 years old who gave birth to their children at home with the help of their family members, i.e. their mothers and husbands. ▪ For those mothers who used the service, they said that their husbands were with them, the delivery service at the HC was free and safe for them and babies. The nurses and doctors look after them well and gave advice on how to look after themselves and babies after going back home.	

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							▪ They wanted to use the delivery service at the HC for their second child. However, there are a few reasons why they could not attend the service after the first child: i) a distance from their village to Khuang HC is about 18 km away and this road is very difficult to travel by motorbikes during the wet season; ii) they did not have their families (especially husband) who could take them to the HC on the expected delivery date and when the baby was due to be born, it was not possible for them to travel; iii) the expected delivery date was uncertain and kept changing so it was not possible for them to wait at the HC for a few days. ▪ It was informed during the interview that there were monthly mobile services provided by the HC staff facilitated by the Village Facilitators at the village to provide vaccination, drugs, education on nutrition and antenatal care. Therefore, they can easily access to these mobile services provided to their children for vaccination and health or nutrition advice. No negative feedback from them, their families and authority. ▪ For the Phase 2 Project activities, they requested to have services for picking up/delivery from their homes to the HC or sending HC staff to their homes to help giving birth since there is no village traditional birth attendant, their families do not own cars (only a few well-off families in the village have cars) and in case their husbands are not at home to take them to the HC. ▪ The father added that the HANSA 2 should improve the cooking area at HC due to it is too small and inconvenience, because during their wife gave birth, they	

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							will need to sleep at the HC for several days to look after their wives. In addition, the health education should also provide to the father as well not only the women.	
06/03/23	10:00 to 10:45 A.M Xay district, **Oudomxay** province	▪ 2 pregnant woman and 5 mothers who have children under 5 years old)	0	7	Hmong , Khmu, Lao and Lamed	Health and nutrition services for mothers and child under HANSA Project and recommendation for HANSA II	▪ The pregnant women have received antenatal care and injection which make them feel confidence and safe. They're knowing how to keep themselves and their child healthy, the service at the provincial hospital is free, but the service is still pretty slow this make many people choose to use the service at the clinic instead. Some pregnant women choose to receive the service of antenatal care once they got big belly (7-8 months) because they live far way to the hospital. Some family chose to give birth at home because they do not have vehicle and person to take them to hospital (esp. Khmu ethic, they rarely going to hospital and their husband do not even much care) ▪ The participant also shared that they received the poor service by the health officers during there are a lot of visitors, the staff like to speak impolitely (loudly) especial to those who come from rural area. But to a person who wears good clothes, they behave well with (speak nicely), so this make them feel they're being treated in different standard. ▪ Lastly, in project phase II they expect to see the service at the hospital to be improved, the doctors should treat everyone equally because everyone has the same rights. The service time also need to be improved, they start work late but also finish early. For example, the service receiver wait since 9-11 o'clock, then the officers said you	

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							need to come back again in the afternoon, therefor this is disappointment and wasting time.	
06/03/23	13:30 – 15:00 Khuang Health Centre, Namor District, Oudomxay Province	5 medical staff and 2 District/Provincial Health Office staff	2	3	4 Lao (Taileu) , one is Akha	General project activities implemented by medical doctors and nurses (as direct beneficiaries)	▪ The most effective activities financed by the HANSA I Project are the vaccination program for children under 2 years old that can be achieved 100% and the target for COVID-19 vaccination can be achieved 80% as per Government's policy regardless of ethnicity. The provision of nutrition advice was successfully delivered by giving to the husband if the ethnic female cannot understand the Lao language provided by nurses. Regarding the convergence program, this HC staff provide mobile services by visiting individual household at least 4 times a year that include vaccination, providing birth control pills and health related information. ▪ The most common challenge experienced by the HC staff is that some villagers are not at home; they either travel to work very early morning and/or stay overnight in their upland fields. The HC staff overcome this common issue by making a follow-up appointment with their village heads or requesting them to visit the HC for follow-ups. Another common challenge found is related to the high turn-over of the Village Facilitators (VF) whereby the trained VF cannot participate fully in the activities and other untrained villagers have to replace them because the trained VF's husbands do not want them to work, or they do not have time after getting married. Normally, the VF will be selected by the Village Chiefs according to the criteria provided by the Project. However, after changing their marital status, most VF who are female have limitation to continue with the service. There is a need in	

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							the Phase II to update the list of the trained VF and provide necessary training to the new selected VF. Last, they reported that the equipment provided by the Project to each village is adequate but the electric infant scales are found to be 60-70% malfunctioned in Na Mor District. They said that most of these scales use 2 pairs of AA batteries that will run out quickly if there are about 50-100 children per day (during the nutrition monitoring time). ▪ The tools used for the outreach activity shall incorporate more pictures and if possible, show in the form of cartoons and making short movie for communicating with villagers, especially the none-Lao ethnic groups. It will be very helpful if the staff can receive training on how to improve their communication with villagers in a simpler language using tools provided. ▪ Although the Government encourages the local people to use provided services at the hospitals and HC, given the conditions of the access roads, HC staff suggest that the VF can be trained with basic skills to handle emergency cases related to birth delivery in the village in coordination with the HC staff. In case of complications, the HC staff will make the best effort to attend the case by themselves in the village. They also suggested that the monthly stipend is increased from LAK 80,000 to reflect additional tasks and higher living costs. The duration for HC/Small Hospital staff to conduct mobile services shall increase from 1 day to 2 days depending on the size of the village and population number to be served. If possible, additional motorbikes are requested for medical staff mobile service	

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							as they have only 3 motorbikes (1 is broken) for 6 staff to do mobile service in the village. ▪ In terms of equipment, they requested that the new Project support additional needed equipment such as 2 new patient's beds to replace the old wooden bed, an incubator for newborn baby (still do not have now) and spotlight for operation or birth delivery service (now they use small headlight/mobile phone's light). ▪ Regarding infectious waste management, the medical staff separate infectious waste from general wastes using color coded bins provided. There are paper boxes for them to dispose syringes safely which they transfer a full box to a storage area with fencing and roof located behind the new mother and child building. An average of 2 boxes a month and there are 8 boxes stored in the storage area. Once reaching about 20 boxes, they will be transferred for disposal in the provincial hospital when there are office cars visiting their HC. The other small amount of infectious wastes will be burned on site together with other general waste in a dug pit located behind the building. Since this HC is located on the hill and no houses located in near vicinity of the HC, the small burning does not create significant impact on the surrounding environment and local people. Staff try to re-use the drinking water bottles and plastic bags to reduce non-hazardous waste since there is no recyclable facility in the village. A small incinerator provided some 20-30 years ago by the Province has no longer usable. HC staff received one training on environmental management including infectious waste separation and disposal during 25-27 July	

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							2022. It will be helpful if the new Project can provide additional training on safe handling and disposal of infectious waste as well as providing an incinerator for them to handle on site.	
07/03/23	9:00 – 10:00	3 DHO officers and 1 DO officer	0	4	Lao & Khmu	General project activities implemented by DHOs and recommendation for HANSA II	▪ Each section of DHO and DH has shared their role as follow: 1. Mothers and children: support prenatal maternal health screening, child vaccination, health assessment, family planning (on-site and mobile), 2. Food and drug section: Monitor HCs in summarizing and making monthly reports on medicine (48 items is enough within a month?), checking on daily data entry on DIH2 and making approval. 3. Hygiene and health promotion: promoting on maternal and child health and convergence works (such as primary health care, supporting HCs for mothers and children works, vaccinations, etc.), 4. Social security: Summarizing the report of health service facilities, verifying accuracy, financing and reporting to the province, as well as monitoring and promoting health services of HCs and PH, calculating the reimbursement of medical expenses (OPP); ▪ While asking about key achievements within their organizations they reported on activities that has been well implemented under HANSA include i. child check-up, vaccinations, pre-natal and post-natal can be done better if there is enough budget and more villages can be covered (before there is only 4 village coverage, now the no. of coverage village is up to 16 villages), iii. The QPS is also well implemented, because having a budget to evaluate and build technical strength for HC which showing that the reporting of HC is better (before using	

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							Excel), now they can check it on the computer, making it easier and more convenient (if it is correct, it will be green, if it is not, it will be red). ▪ However, there are some challenges that they are facing which is: i. the target group (pregnant women and young mother) do not come to receive health care regularly, because they are busy with farming works, the health officers have to wait and postpone the appointment to another week, ii. The supply of medicine is still lacking (it has been missing for 2 months now) such as birth control pills, injections, nutritional supplements (vitamin A, deworming and zinc have expired), so the health officers have to postpose the mediation, iii. The assessing of QPS is difficult to be implemented during the wet season or when it rains, there is landslides, but when the team needs information quickly, they may not be able to provide such information on time. Some HCs is also facing the problem on Internet connection, they had to walk to find an internet signal, some HC has insufficient water use, they must to take water from the river which make score dropping either, moreover, the staff in charge of medicine does not know how to use computer. ▪ In the phase II of the project, DHO suggested that the project should provide the training on health work and convergence to the VF and community leaders, so they can support enhancing this knowledge to the community members; for SBCC, the project should create an educational VDO on mother and child, health promotion and sanitation, improving of equipment supply for mobile clinic such as cardiac stethoscope, blood pressure monitor	

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							(when taken to the mobile clinic, the service center will be missing), they also required the project to provide sufficient computers for HCs to use for data entry and improving of medicine supply sufficiently and being on time. ▪ To improve the HCs according to the criteria of QPS by using $3,000 budget seems insufficient. ▪ Lastly, they require the project to provide training on IT, computer and data entry for HC and DHO officers 2-3 times per year, because there is staff rotating, and the knowledge on environmental management and waste segregation is also needed.	
07/03/23	09:00 – 09:45 Oudomxay Provincial Health Department	1 female TB patient, and 2 GOL staff (Provincial Health Department)	2	1	Lao and Hmong	Tuberculosis (TB) patients who are direct Project beneficiary	▪ The free service provided by the Project has helped them financially. They are also more aware of the TB, know how to protect themselves and their family members. ▪ There are support from their families however one female elder sleep separately from her life partner in the same house which is difficult for her to look after herself. All of them live separately from their children because they do not want them to have risks of infection. ▪ Overall, the infection has somewhat affected their well-being and finances. This is because they feel tired easily and can no longer perform work as they used to. Their children also want them to look after themselves and take rest. So, they only spend their times growing vegetables for sale at the market (female elder), raising livestock and driving the car around the village (for remaining two male interviewees). ▪ They are very concern that their family members will be infected especially children and life partners. They are	One male interviewee is Hmong ethnic group who practices livestock raising

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							worried whether they can completely treat TB. Otherwise, they will have to live on their own. They have overcome these concerns and challenges by taking medication as prescribed by the doctors and suggest their family members to do a check-up if they have any symptoms. ▪ The female elder suggested that the relevant building in the hospital shall have signage and information on the treatment hours and days to help her and other patients from rural areas.	
07/03/23	09:30 – 10:35 Rented accommodation in Xay District, Oudomxay Province	5 interviewees, 1 male PH Department staff and 1 male owner of accommodation	1	5	Lao (1 person) and Lao (Hmong)- 4 persons	Female Service women who are direct beneficiary of the Project activities on HIV/AIDS	▪ One person has stayed in this rented accommodation for more than 1 year and the rest has just moved in for less than 1 month. Thus, only one female has received 5 pieces of condoms provided by the male District Health staff twice this year. There is no data collection or other information provided to her regarding the free blood test or counselling services, awareness raising on how to safely protect themselves. Other female workers have not seen any Government staff visiting since they moved in. ▪ There is no discrimination against them by the owner of the rented accommodation and people outside. Most of these workers' family members do not know about their work. Only one person's family is aware but do not have any objection for her to continue. ▪ These female Service women do not have any recommendations provided. However, the male owner of the accommodation made good suggestions which he requested that the Project provides more information to them on the free available services including blood testing and treatment in order to stop the disease from infecting other people if they are found infected. It will be best if	These workers come from other provinces outside Oudomxay and 4/5 are Hmong who can understand Lao language well. The Provincial Health Department delegated this activity to the District Health Office. The GOL staff

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							the mobile service can be done in his compound and other high risk areas.	who conducts this activity is male and may not be suitable to work on this outreach activity with female Service women.
07/03/23	10:05-11:00	1 medical doctor from the hospital and 3 interviewees	4	0	Lao	Male having sex with male (MSM) and a male who are HIV/AIDS patients and direct beneficiary of the Project activities on HIV/AIDS	▪ Two MSM got infection from their partners and one male got infection from using a sex worker service. ▪ There is another Project called Action Education that entered the upper ethnic secondary school last month to disseminate information on safe sex and provide training targeting MSM. They only heard about the HANSA Project through the local news broadcasting via loudspeakers in the evening every day but did not pay much attention. ▪ They received blood testing and treatment for free of charge at the Provincial Hospital and were confident with the doctor therefore do not feel hesitant to provide their private information. The provided services helped them financially and mentally by giving advice on how to protect themselves and their partners as well as the necessary cares to be taken during the treatment. ▪ They would like to suggest that the new Project improves the information dissemination using posters, and leaflets to be attached to walls or news board in the public areas such as schools, village, etc. and provides mobile services	

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							to collect information and identifies infected persons at the village level because many of them feel reluctant to come to the hospital for blood tests. The type of information that the Project should emphasize in posters/leaflets or outreach shall be related to having safe sex with their partners who cannot be trusted, self-monitoring for signs of infection and treatment procedures. ▪ Also, they request that the Project continues to support all the services related to HIV/AIDs as they do now for free of charge.	
07/03/23	11:30 A.M – 12:30 P.M	4 PHO officers	3	1	Khmu, Hmong and Lao	General project activities implemented by PHOs and recommendation for HANSA II	▪ DHR section is responsible for monitoring of the district's QPS assessment; Statistics section is responsible for tracking of indicators in DLI data entry/DHIS 2 (DLIH) (District hospital, HCs and convergence works at village level) 4 times in a year; Evaluation sector is assessing QHIS works on mother and child, and Health insurance sector plays role in monitoring of indicators under the HANSA project, monitoring of QPS funds, ▪ Since the project begun, they found that the project has assisted the heath facilities to report better and faster, the quality of the report is improved and achieving the standard indicators (childbirth, postpartum and others) ▪ The most common challenges faced by PHO is that i. the reporting of the health facilities are yet not consistent (for example: in the report there is information on patients use the service, but such info is not shown in the logbook), therefor, they required the project to provide refresher training and lesion learned exchange meeting on DLI, on the other hand, the officer in charge for data entry does	

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			Male	Female	Ethnic Group			
							not understand properly, causing the number to be inconsistent (e.g. 5 patients received services, but the number is 8), this make the assessor have to check the logbooks and reports for confirmation of the data; iii. While implementing QPS, if there is no patient at HCs, the score is not given, so they propose whether the health officers can do the demonstration instead? iv. HC still does not comply with the standards of QPS, because Those who received the training do not do the works but practitioners is not trained due to staff turnover, iv. Number of pregnant woman receiving ANC is still low, giving birth with low number of medical assistants (SBA) causing 10 people died last year) because of the long distance, no one to deliver them to the hospital, and there are still existing traditional beliefs, So more health education is needed and to reach out the most people in the community, ▪ Other challenge facing by HCs is that the staff of HCs still do not well understanding about indicators of the project, so they do not know how to plan to improve their HCs in accordance with those indicators. Some HCs may only have women, so there are challenges in achieving certain indicators such as plumbing work, organizational chart signs are available but not attaching to the wall because there is no one to put up the signs and so on). Therefore, PHO suggested that there should be training for DHO and HCs on how to achieve the indicators, the implementation planning and assigning specific responsibilities as technically appropriate.	

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							▪ While asking about which area need for improvement, they shared that the assessors/evaluators should give detailed instructions for improvement as well and they must understand all aspects of the evaluation criteria, ▪ One of another challenge and commonly complaint by the project beneficiaries is the shortage of medicine at HCs.	
IV.	**Savannakhet province**							
10/03/23	09:22 – 10:10 Savannakhet Provincial Hospital	2 interviewees	2	0	Lao	Male having sex with male (MSM) who are HIV/AIDS patients and direct beneficiary of the Project activities on HIV/AIDS	▪ Suggest the new Project to ensure more accessibility to wider group of affected people with HIV/AIDs by the following: ▪ Provision of mobile services to the targeted districts or patients can use services at the nearest Health Centers or District hospitals closest to their homes. ▪ Home medication extension from 4 months to 6 months in order to reduce travel frequencies and save costs. It will be very helpful if there is a delivery service of medicines free of charge by Lao Post or private logistic companies that are closer to their villages. ▪ Financial support provision to the low-income patients who live further away from the hospital to pay for public transport or meals and accommodation. ▪ Following the practice of another similar Project targeting MSM for identifying high risk groups and conducting mobile blood testing. ▪ Provision of supplements and vitamins for patients with high deficiency. ▪ Improvement of communication and services by the medical staff.	The similar Project mentioned was not remembered by the interviewees, but this was followed-up with the Provincial Health Department staff and Website which is known to be a USAID funded project called "Meeting Targets and

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
								Maintaining Epidemic Control Project"
10/03/23	10:50 – 11:30 Kaysone Phomvihane District, Savannakhet Province	3 interviewees and a Project female volunteer	0	3	Lao	Female Service women who are direct beneficiary of the Project activities on HIV/AIDS	▪ There is a What's App group created for each group of female Service women administered by a female volunteer to make appointment for blood testing, training and briefing for new workers. The working hours with them is from 10:00 – 12:00 noon. The members can also chat in the group to ask questions and consult the volunteer, obtain tips to check the guests and themselves for any symptoms of STD and protect themselves, etc. ▪ They are not hesitant to share their private information with the Project and feel good that there is someone is supporting them. They do not have friends outside the workplace because of the stigma and competition (for workers in other shops). One worker's family is aware of her job, but her family members do not stop her or look down on her. These workers just keep the distance from the people who do not want to be friends with them and be positive. ▪ They appreciate the help of the female volunteer who has worked closely with them and advised them in a way that is easily understood as well as the provision of free distribution of condoms (6 pieces each person/time and another box for the shop), blood testing services. ▪ They would like the Project to do blood testing every month if possible due to their concerns. Currently, it is done every 3 months.	It can be observed that there is a very close relationship between the female volunteer and these female Service women making the discussions opened and relaxed. These workers are well aware of the risks and have done best to protect themselves from the infection. This is a very good

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							▪ There is no other project providing similar services so they hope that this project can continue.	example found amongst many Provinces.
10/03/23	10:15 – 10: 40	A female Project consultant and 2 medical doctor and nurse at the Savannaket Provincial Hospital	0	2	Lao	Infectious waste management practices at the hospital	▪ There is a private company providing waste collection and disposal services at this Provincial hospital. Each building will be under the responsibility of a designated staff who is part of a committee called IC. They were trained on how to separate waste and safe waste handling/disposal. ▪ There is a waste separation between general and infectious wastes, especially syringes that will be separated in a designated metal bin and emptied in a concrete tank located outside the buildings far away from the public. A total of 10 concrete cylinder type tanks were constructed since 10 years ago. It is unknown by the attended nurse responsible for the Infectious Disease building on the specifications of each tank. Currently the last 2 tanks are being used and the full tanks were already sealed off. In average, 2-3 bins of syringes would be emptied each day regardless of they are full or not in order to avoid risk for staff. ▪ The consultant was taken to an emergency building located near the entrance of the hospital to see a needle crusher. It was informed by the attended nurses in that section that there are a total of 4 crushers provided to the hospital some years ago (they cannot remember the name of the Project) to pilot the disposal of the syringes. The crushers will destroy the needle to be find materials which will be emptied in a metal box for further disposal in the	The consultant informed the interviewees that the Ministry is considering the best option for the disposal of sharps and infectious waste similarly with the cement tanks that they have at the hospital now. An incinerator is not a preferred option due to potential harmful gases

Date	Time/ Location	Composition of Participants	Total local participants			Consultation Purposes/ Content	Feedback from participants	Notes (e.g. Name of EG, Response from Team
			Male	Female	Ethnic Group			
							cement tank outside the building. They said that it will be helpful if there are similar crusher for them to use in the future to reduce the amount of sharps being disposed in the cement tank. ▪ Other infectious waste will be disinfected in an oven and discarded as other general waste for disposal by municipality. The head of infected disease building said that it would be very helpful if the Project can provide an incinerator so that they can manage the infectious waste at the hospital.	(dioxins) to be released from the burning of plastics and other wastes.

Annex 2 –Key Ethnic Groups in Project Area

Lao PDR is made up of 49 ethnic groups, with the Lao Tai comprising about 65 percent of the population while the other three ethnic families (Mon-Khmer, Hmong-Mien and Chino-Tibet) make up the remaining 35 percent. These ethnic communities are particularly vulnerable and poor as most of them are located in rural and remote upland areas. Often due to their geographical location, these populations have comparatively less access to public services, productive land and markets. In addition, cultural and linguistic differences may contribute further to their isolation. As such, the higher incidence of poverty makes upland, remote, ethnic populations particularly vulnerable socially and economically.

The low levels of education in remote communities, particularly some ethnic groups, as well as language barriers, could also pose a challenge in terms of having in place effective communication messages that are followed and understood about the healthcare for pregnant women and mothers such as antenatal care, birth delivery and nutrition, It is likely that ethnic groups will have their own beliefs about the birth delivery and antenatal care, which may be at odds with WHO recommendations. It will therefore be important to get the buy-in and support of influential leaders in communities and helping them spread factual information about healthcare, antenatal care, birth delivery and nutrition. It is noted that for some ethnic groups, pregnant and lactating women, for instance, are not allowed and discouraged to participate in project activities, SBCC session and adopt or follow health care and nutrition guidelines and practice introduced under the project due to their cultural belief and practice.

Of the ten ethnic groups who are currently beneficiaries, Hmong, Khmu, Akha, Phong, Phounoi, Lao are the major beneficiary groups. General characteristics of these groups are described below:

Hmong

Typically, Hmong have settled in the highest areas of the upland, even preferring to be buried on mountain tops. They have a reputation of being both hard working and more recently, assertive in Oudomxay Province over acquiring land and property. Hmong Khao are also structured by clans, or seng (e.g., Toe, Veu, Tsiong, Moa, Lee, Va, Ya, Ha, Ja, and Keu). The seng determines the boundaries of land and property rights, and protects the role of men as transmitters of those rights by constraining women's choices, particularly as to who and when a woman may marry.

The Hmong are an Asian ethnic group from the mountainous regions of China, Vietnam, Laos, and Thailand. Hmong are also one of the sub-groups of the Miao ethnicity in Southern China. Historically, Hmong society is patriarchal. The Hmong culture usually consists of a dominant hierarchy within the family. Males hold dominance over females and thus, a father is considered the head in each household. Hmong are generally group oriented, so the interests of the group come before the interests of individuals. They belong to the Hmong-IuMien ethno-linguistic group and either speak the "Hmong Der" (White Hmong) or "Mong Leng" (Green Hmong) dialect. Hmong are skilled at hunting, mixing herbal medicines and raising animals, particularly horses. Hmong believe in a variety of natural, ancestral and supernatural spirits and their religious practices incorporate elements of ancestor worship. Intricate embroidery and heavy silver jewelry adorn their clothes. The Hmong constitute about 8% of the Lao PDR population. In the past, the Hmong used to be called the Miao which means "Lao of the mountaintops". The expression refers to where the Hmong traditionally liked to live. These names are no longer considered appropriate, and the Hmong prefer to be called

by their ethnic group name. The Hmong are a proud ethnic group, maintaining their distinctive culture and traditions. They cannot marry within their clan, or even a person of their own family name. This means that men and women often have to find a spouse from outside of their village. Traditionally after marriage, a woman will then follow her husband and severe ties with her parents. The Hmong practiced shifting cultivation of unirrigated upland crops; buckwheat, barley, and millet were grown at the highest altitudes, and rice and corn (maize) at lower elevations. Virgin forest was cleared and burnt off for the planting of new fields; when soil fertility declined (usually after several decades), the entire village would relocate. New villages could be a considerable distance away from a group's previous locale. In the late 19th century the opium poppy was introduced into the highlands by outside traders, and the Hmong began to cultivate it in an integrated cycle together with corn and dry rice. They sold opium to itinerant traders, usually Chinese, in return for silver. By the late 20th century, shifting cultivation had become impracticable except in a few remote areas. In response to government programs in Thailand, Laos, and Vietnam, the Hmong have now largely abandoned shifting cultivation and opium production. They have instead turned to the permanent-field cultivation of crops such as rice and corn or the gardening of flowers, fruits, and vegetables, which they sell in lowland markets.

Khmu

The Khmu people are the oldest inhabitants of northern Lao PDR, and are now settled throughout all Northern provinces and as far as Bolikhamxay Province. Next to the Lao Tai, they are numerically the largest ethnic group in the country. They have eight sub-groups which co-reside, for example Khmu-Rok, Khmu-Lue, Khmu-Ou, and Khmu-Khrong. Khmu are strongly governed by spirits, both benevolent and dangerous, which influence foundations of customary law. The world of the spirits consistently influences gender relations, land use and property rights, and change disturbs the relationship between the Khmu and the external world. Different levels of spirits govern different choices made by men and women – some spirits are territorial, associated with particular places or locations, others are associated with the village and under the authority of the territorial spirit. The belief in spirits can influence the choices made by men and women in their daily routine, seasonal activities, property rights and relationships between the sexes. Other spirits govern the structure of the household and are normally ancestral who continue to protect the well-being of families. Lastly, there are individual spirits, linked to the household.

Each sub-group may be composed of several patrilineal clans called "ta". Ta names are totemic, meaning they are taken from a natural object, or animal, or bird, to which the clan considers itself closely related and usually has prohibitions associated with the totem. Among Khmu Lue in Oudomxay, ta may include Teu Mong (a kind of civet cat), Teu va (a kind of fern), Teu Kok (a species of bird), etc. The totem is the household spirit, and membership of a "ta" depends in which house a child is born. Ta membership determines marriage choices and by association, property rights.

The Khmu are an ethnic group of Southeast Asia. The majority (88%) live in northern Laos where they constitute one of the largest ethnic groups, comprising eleven percent of the total population. The Khmu were the indigenous inhabitants of northern Laos. It is generally believed that the Khmu once inhabited a much larger area but after the influx of Thai/Lao peoples into the lowlands of Southeast Asia, the Khmu were forced to higher ground, above the rice-growing lowland Lao but below the Hmong/Mien groups (Lao Sung) that inhabit the highest regions, where they practiced swidden agriculture. The Khmu of Laos resides mainly in the North, ranging across 10 provinces including Luang Prabang, Phongsaly, Oudomxay, Bokeo and Lung Namtha Provinces. The Khmu language belongs to the Austro-Asiatic language family, in which several closely related languages are grouped

together forming the Khmuic branch. The Khmu are an agricultural society, although gathering, hunting, trapping and fishing are parts of the Khmu lifestyle. Khmu crops include rice (especially white and black sticky rice), corn, bananas, sugar cane, cucumbers, beans, sesame and a variety of vegetables. Most of the agricultural work in Khmu villages is done communally, so as to combine the strength and finish the work quickly. Harvesting of wild rice is generally performed by the village women. Rice is stored outside the village in elevated structures to protect from mice and rats. Khmu elders are traditionally the most important people of the village, and are responsible for resolving all village disputes. Village leaders included the shaman (knowledgeable in spiritual medicine), the medicine man (knowledgeable in herbal medicine), the priest (based on family lineage of priesthood), and the village headman (in modern times chosen by the Laotian government). Laotian Khmu communities generally have localized justice systems administered by the village elders. Although the Khmu is the second largest ethnic group in Laos, they are also the poorest. Throughout the history of Laos, the Khmu have lacked political power, education and a role in administration. The results of a study on Khmu women show that they experience barriers to participation in project activities. The barriers include language; education; cultural norms; health issues; workload; resettlement; poverty; low self-esteem; staff and project approach; the village administrative structure; fewer opportunities with development projects; and limited formal access and control over assets. To overcome these barriers and to participate in development projects Khmu women would benefit from greater support from project staff such as teacher/trainer; learner; follower; advisor; demonstrator/role model and advocate. To empower women to overcome barriers themselves and participate more fully in community development requires both men and community to provide support and acceptance.

Akha

The Akha consists of about 14-15 subgroups that share similar livelihoods, but then wear different clothing and have a distinct social structure. Akha women are easily recognizable by their traditional hat, covered with coins representing the wealth of the household. Their villages are situated in remote/isolated areas and up until very recently one would not have found two ethnic groups, including the Akha's subgroups, inhabiting the same village due to their remote location and limited access to government services. This factor is one of the main reasons why most of the Akha ethnic group often have very high illiteracy rates and are unable to understand the Lao language. The Akha subgroup called the Muchi in Phongsaly said in an interview that they don't understand the Language of the Akha subgroups called the Kor in Oudomxay and Luang Namtha. Akha language is part of the Tibeto-Burmese linguistic family.

Phong

The Phong only presence in Houaphan, Vientiane and Xiengkhouang provinces and made up only about 0.5% of Lao population, but it's one of the main targeted ethnic groups covered by the project in Houaphan province. There are four subgroups: Phong-Phane, Phong-Lan, Phong-Pieng and Phong-Poung. They live in isolation and have their own language. Due to living in isolation for many years, and despite being a small group, each subgroup has slightly different dialects. Like the Khmu and other Mon-Khmer groups, the Phong still preserve their traditional social structure and distinct ethnic characteristics. It is interesting to note that while their livelihoods and the use of land and forest resources are similar to that of the ethnic groups belong to the Mon-Khmer, they share many characteristics with the Tai and the Lao instead of the Mon-Khmer groups. These include their housing designs, waving styles, religion (Buddhism), ritual ceremony and follow matrilineal clan/custom instead of the patrilineal clan.

Yao

The Yao ethnic group has two distinct subgroups within the Yao ethnic group in Lao PDR, which are known as Yao and Lanten respectively. The subgroups speak different languages, although some of the words are the same, but they may have slightly different meanings. The lowland living Yao speak Kim Mun (also known as Lanten) and the highland Yao speak Lumien. Lumien is very distantly related to the Hmong language. Together they form the Hmong-Mien language family. The Yao men and women cover their head with a black or red scarf. Instead of a scarf, some women wear a turban that may have different forms. The traditional suit of women is long and of bright colors. On their shirts they also wear decorations made of metal, copper and/or silver. Although some Yao have converted to Buddhism philosophy and Christian religion, many still remain practicing their traditional beliefs in seven principle spirits representing humans, animals, fields, forests, sky, water, and earth.

Annex 3 – Review of Gender Equality

The Lao People's Democratic Republic (Lao PDR) faces significant sustainability and environmental challenges that are amplified by climate change; Laos' female farmers are less resilient to climate change. Laos' limited economic resources create challenges for disaster management and climate change adaptation. Hydrological hazards such as flooding, droughts, and storms frequently impact rural areas, affecting the agricultural livelihoods on which most of the population relies. They also cause disease outbreaks, threaten food security, and force communities to migrate due to concerns for personal safety and the security of their livelihoods. Most of the land in the Lao PDR is degraded due to the impacts of droughts, flooding, and landslides, as well as the unsustainable use of natural resources, which has been accelerated by the marketization of agriculture. Female-headed households tend to have less diversified crop production, rendering them less resilient to the adverse effects of climate change and disasters. Also, their limited mobility and voice in community and household decision-making makes them more vulnerable than men to the effects of climate change.

According to the World Bank's 2022 Gender Analysis for Lao PDR's CLEAR project, Lao PDR achieved rapid growth and significant poverty reduction before the COVID-19 pandemic, though inequality widened. The national poverty rate fell from 24.6 percent in 2012 to 18.3 percent in 2018 and access to basic services, education, and health outcomes improved (World Bank 2022). However, poverty remains high by regional standards and concentrated among subsistence farmers and minority ethno-linguistic groups, who are among the targeted beneficiaries of CLEAR. The CLEAR project area covers Laos' Northern and Southern rural mountainous areas, which are home to many ethnic groups, whose socio-economic status is poorer than for those living in the lower Mekong Corridor. A combination of land tenure insecurity, lack of employment and livelihood opportunities (with additional pressures brought about by climate change), and increased investment by foreign-operated agribusinesses are believed to be additional risk factors in the CLEAR project provinces, particularly for women and girls.

Gender-based violence remains a significant risk in Laos, which is also perpetuated by child marriage, high adolescent birth rates, and harmful social norms—and further exacerbated by COVID-19 lockdowns. In Laos, it was shown that girls who marry before the age of 18 are at increased risk of experiencing violence, as they lack status and bargaining power within the household. They are more likely to be physically and mentally abused by family, their husbands, or in-laws, and more likely to be isolated from the community (World Bank Lao PDR CGAP 2017). Addressing Gender-Based Violence (GBV) is a priority for the Government of Lao PDR, as indicated in the Fourth Five Year Action Plan on Gender Equality 2021-2025 and the National Action Plan on Prevention and Elimination of Violence Against Women and Violence Against Children in for 2021-2025, but the challenge is

complex and new risks are increasing. Accelerated regional integration and cross-border movement has brought about increased risk of human trafficking for rural women and girls. The Lao PDR-Thailand is one of the main regional migration corridors. According to the US State Department 2018 Trafficking in Persons Report for Laos, the country "does not fully meet the minimum standards for the elimination of trafficking", and there was a lack of progress in the last reporting period. Communities in proximity to large-scale infrastructure projects are at elevated risk of forced labor in relation to the environment.

Education plays a significant role in protecting women and girls from EMAP risk, improving health and nutrition outcomes, and providing girls with better economic opportunities. Girls and boys are enrolled equally in early childhood education in the Lao PDR (34 percent female and 30 male) and the country has nearly achieved gender parity at the primary school level. However, a lower proportion of girls attend each stage of secondary school, with 91 girls attending upper secondary for every 100 boys. In 2017, 41.8 percent of girls aged 15–17 were in school . Girls—especially those from ethnic groups and poorer families—leave school early at higher rates than boys at every school level, and girls from the lowest wealth quintile are significantly underrepresented in upper secondary school. Adult literacy is also lower among women than men, with a 10.6 percentage points difference; the gap is more pronounced among ethnic groups and older age groups. These gender differences in educational attainment and literacy affect women's economic opportunities and participation in decision-making. A lack of off-farm employment opportunities drives young people to migrate to cities.

Women are active participants in Lao PDR's labor force; however, wage gaps and occupational segregation by gender persist. The labor force participation of women has improved but remains slightly lower than men's, with 76.5 percent among females and 79.8 percent among males. There is also a significant gender wage gap, with female employees earning an average of 20 percent less than men. The relatively high rate of female labor force participation is driven to a large extent by women's engagement in agriculture, often in subsistence farming. Women are more likely to work in the informal sector, engaged in subsistence-level activities working under precarious working conditions with little to no protection and representation (81.3 percent women and 67.5 percent men). Most of the unpaid workers are women; in 2015, 61 percent of unpaid workers were female compared to 26 percent of men . Men compose the majority of civil servants, professionals, technicians, and other positions that require higher education. Conversely, women are overrepresented in low-skill occupations, comprising 71.8 percent of the workforce in the service sector and 63.36 percent in the retail sector.

Women play a key role in the agriculture sector in Lao PDR; they comprise a little over half of the agricultural workforce and contribute to all parts of agricultural production. The majority of agricultural production in Laos is driven by smallholder farmers. In 2019, of all women in the labor force, 63.5 percent were employed in agriculture (versus 59.4 percent of working men). Traditionally, women work in the fields (planting, weeding, and harvesting crops) and look after livestock (mostly animals such as pigs, poultry, and goats, while men tend to larger livestock such as cattle). Lowland or upland, decision-making with regard to irrigation and water resource management is often considered men's work, even though in most cases women manage water at the household level. Division of labor is also apparent in fisheries: women engage in fishponds and fish culture in rice fields and play a key role in fish processing and marketing. Even though women play a significant role in agriculture, they have unequal access to micro-level agricultural investments. On average, female-headed households have less household labor and productive assets than male-headed households and have a less diversified crop base than male-headed households. An agricultural issue that has

emerged and which is most pressing for women is the level of toxic chemicals that are being used in commercial agriculture, with severe effects on women's health including reproductive health and on children. This is particularly problematic in highland provinces (for ethnic groups) due to poor soil quality and mountainous terrain (requiring fertilizers).
Laos is transitioning from subsistence farming to commercial agriculture, which has brought benefits for some but also exacerbated gender disparities and power imbalances in other communities. Many rural communities are benefitting, as new opportunities for women to undertake paid employment outside the family farm opened, particularly through participation in 'non-traditional export crop production', as contract farmers or direct wage employees. While some work has been done to ensure that local-level contracts between investors and communities are fair and transparent, efforts to ensure that women are meaningfully included in contract farming negotiations and benefit equally are still nascent. For women in poor rural areas, who have lost access to productive land and have not been able to find employment off-farm, commercialization has increased vulnerability. It has also disadvantaged women in non-Lao Tai ethnic groups, who may have limited Lao language skills and lack experience conducting business in a cash economy.

Under the law, women, men, boys, and girls have equal rights to own and inherit land, but in practice, unequal customary traditions prevail. Land titling remains limited to urban and peri-urban areas, leaving most rural land untitled and unregistered. Many rural land users, especially women, lack legal documentation for their tenure security. Women are usually not registered on land titles to marital property. While under Lao law men and women have equal status regarding land ownership and land-use rights, and women have the legal capacity to enter into contracts or sign legal documents, in practice it is often the head of household (usually a man) who signs the tenure document, whether a temporary certificate or a land title. In the 2003 National Land Law, there was a provision requiring both husband and wife to sign a land title or document. However, in 2019 women's land rights have been weakened in the new Land Law (2019) by the removal of dual names (wife and husband) on land titles (from the 2003 Land Law, Article 43) which is a setback for securing land rights for women. With the loss of land, there is the risk of creating unequal gender stereotypes, e.g. women given lower-valued tasks as a housewife and caregivers than in productive agriculture activities.

According to national policy, women and men have equal access to markets and finance, yet women face constraints in accessing loans and credit. In 2021, 36.75 percent of men and 37.85 of percent of women had an account; the lowest in the region. Women are deterred from accessing credit and loans due to reasons that are both self-imposed and external. Lack of education and literacy, and the lack of confidence and access to Banks and information, create constraints that limit women, particularly ethnic women, from accessing loans. Although 41 Banks operate in Laos, 83 percent of these banks only have branches in the Capital Vientiane . Local-level banking mechanisms remain difficult for those in rural areas to access, Bank processes are complex and burdensome, and women, therefore, do not engage. The challenges women face in attaining documentation for land ownership contribute to women's lower levels of access to credit, as they lack collateral and thus have more limited opportunities to invest in agricultural tools, technologies, and climate-smart agricultural practices.

COVID-19 has created new economic inequalities. The Lao National Chamber of Commerce and Industry (LNCCI) survey on the impact of COVID-19 found that women respondents are slightly more likely to perceive a high risk of ceasing business operations (52 percent versus 48 percent for men). A World Bank survey from July 2020 suggests 8.4 percent of household businesses (and 15.4 percent of small household businesses) are temporarily or permanently closed and many are experiencing a

fall in revenue. The same survey found fewer women are remaining with the same job as compared to men, with more women changing their jobs (4.5 percent versus 3.2 percent for men) or currently not working (12.6 percent versus 9.7 percent for men). Of those who stayed employed (non-farm employees and own account workers), more women had a lower income (35.7 percent versus 26.3 percent men).

Women in Lao PDR remain underrepresented in decision-making institutions, particularly at the local level and in rural areas. In terms of women's political representation, Lao PDR ranked 102nd out of 188 countries with a 27.5 percent representation of women in Sapha Heng Xat, its national Parliament, in 2020. Women accounted for 31.5 percent of provincial assemblies in 2018. In 2021, Lao PDR had the first female Vice President in its history and the share of women in the civil service reached 46 percent in 2018. Female civil servants work mainly for the Ministry of Public Health (65 percent of its employees are women) or for the Ministry of Education and Sports (51 percent). Taken together, these ministries make up about half of all civil servant positions for women, suggesting large inequalities in other areas, including the sub-commissions for the Advancement of Women across all ministries.

Women's engagement in political decision-making on issues of rural development, natural resource management, and livelihoods has been limited. In rural areas, decisions are taken through a village committee comprising the Nai Ban and elected representatives from the village. In 2013, only 1.7 percent of Nai Ban and only five percent of deputy heads were women. The village chief and council hold the power to make decisions within the community, and fewer than three percent of village chiefs are women, and the remaining majority are men. Villages also have a variety of additional committees, focusing on issues such as trade, agriculture, health, education, and security. The Lao Women's Union (LWU) also has a village-level body, which is the main avenue through which village women participate in the village committees. With the exception of the LWU, other committees are almost exclusively composed of men. Within LWU, staff members who work directly on women's empowerment do not feel confident to speak up at meetings and hesitated to express their voices. In cases were women were elected to local community or project committees, they often just play a "quota role" but are not given the chance to actively advance rural women's concerns and aspirations.

Women's active participation in local decision-making is hindered by a range of constraints. First, legal and institutional constraints. Law on Local Administration provides that village meetings must be attended by household heads, who are traditionally men. Also, the land title may be considered a prerequisite for participation in community decision-making and resource management, limiting women's opportunities to participate and lead. While not universal, perceptions about land ownership rights also influences whether women have their names on a land title - women from ethnic groups are most likely to refuse to have their name on the land title, believing that land management is a man's role.

Annex 4 – Key Lessons Learned

LESSON LEARNED FROM REVIEW OF HANSA

Gender

The Project aims to achieve the universal health coverage by removing the disadvantage faced by vulnerable children, adolescents, women, men, remote populations, ethnic groups, and others to benefit equitably from the health system and achieve better health. This means there are needs to address gender and intersectional gaps in the health system on the demand and supply side.

During the national workshop for the preparation of HANSA II Project in November 2022, the representative of Division of Women and Mother-Child Advancement, Cabinet Office, Ministry of Health provide below observations on the lessons learned for the implementation of the HANSA I as below:

- There is a need for a clear plan to work with relevant technical departments responsible for GAP implementation to mainstream the gender and equity agenda into health policies and programs. Ideally, the gender and equity actions should be embedded as part of technical departments' work plan.
- Since gender and health equity are cross-cutting issues, collaboration, and close coordination between line ministries and MoH technical departments and centres, provinces and districts are required. It was recommended to update the Gender Assessment and Gender Action Plan (GAP) for the actual pace of implementation with relevant technical departments/centres as well as concerned provinces and districts. The involvement of CSOs in updating Gender Assessment and implementation of GAP shall be considered.
- Quality Performance Scorecard (QPS): It was suggested to revise through a Gender and Equity lens and dimension and ensure gender and equity gaps are measured and count.
- Strengthening the HC and PHC: Gender and Equity informed planning, budgeting and decision making are necessary to increase equitable access to health services and meet the needs of disadvantaged populations who are being left behind including adolescent girls, remote population, and non-Lao-Tai people.
    - ✓ Women face barriers to career progression which contributes to the limited number of women in leadership roles and women's perspective in leadership of the sector.
    - ✓ Language is a barrier to non-Lao speakers accessing health services and information. More effort is needed to overcome this barrier through more ethnic speaking health workers and ethnic language health communications.

Disbursement-linked Indicator (DLI)

The learning review on Disbursement-linked Indicator (DLI) approach for healthcare in Lao PDR was conducted under the HANSA I Project by Katalyst Partner[3] to document implementation bottlenecks and lessons learned so that inputs can be provided to the Ministry of Health (MOH), Ministry of Finance (MOF), World Bank (WB) and co-financing partners (Global Fund and DFAT) for timely adjustments during the HANSA I project and preparation of HANSA II Project. The results are briefly described as below:

- PHOs are well understood about the DLI at the management level – all the provincial teams who participated in the review have a deep understanding of how the DLIs work and are very committed to the approach.

[3] At the sub-national level, the review was done in Vientiane, Luangphabang, Xiengkhouang and Savannakhet Provinces. At the national level, it was undertaken in Vientiane Capital with participations of Government staff from MoH, PHO, DHO, Civil Society Organizations (CSOs), village heads and villagers from the selected districts in four mentioned provinces.

- They see them as not only a financial mechanism but an additional tool to help achieve key health care outcomes. They are not just focused on achieving the target – they care about the process to achieve the target.
- DLI payment mechanisms need to be strengthened so that payments are received at District and HC level much sooner after achieving the indicators. The current delays risk breaking the link between the incentive and the payment and place additional obstacles in the way of Districts and HCs achieving the next set of indicators.
- In addition, more thought needs to be given to payment structure, for example, whether achieving 50% of an indicator and 80% should be treated in the same way, and the impact it is likely to have on the motivation of District and HC staff if this continues to be the case.
- Stronger connection between HANSA and the projects of other Development Partners would ensure greater focus on results.
- Significantly more focus is needed on communication between levels, perhaps with a formal communication plan and implementation support, together with capacity building around planning and communication that shares success stories from DLI implementation to everyone involved in the project around the country.
- Better training and support, not only on technical issues, but also on customer service, counselling, communication, GEDSI and a range of other areas.
- More engagement and alignment are needed with Development Partners working on similar healthcare outcomes to avoid "overload" the staff.
- The current economic environment is placing strains on health care facilities, especially around the supply of drugs and equipment but also in staffing.
- There is a need for more support for HC staffing and staff skills development for both technical and non-technical skills with stronger focus on monitoring and evaluation (M&E) to clearly identify successful interventions, eliminate duplication, and ensure that short-cuts are not taken to achieving indicators such as testing all pregnant women to achieve DLI K indicators. A mechanism for sharing success stories should be introduced to accelerate progress in Provinces and Districts which continue to face challenges. This include a need for more exchange across teams working on different DLIs at the sub-national and national levels, as approaches taken to achieve certain DLIs are often replicable across others.
- Some indication that the DLI approach may be helping to address strategic gaps through problem-solving to improving the quality of patient services at health center level; provide free MCH services; overcome cultural barriers regarding women's health; Staffing - especially women and ethnic-language speaking; immunization (although challenges remain); identifying TB patients and finding ways to connect with and serve socially-excluded groups.
- Data collection and reporting has improved and is used in decision-making.
- More attention and support need to be given to monitoring and evaluation.
- Managerial/supervisory behaviors, service providers behaviors are changing but there is a clear need for capacity development around planning, an ongoing need to increase the quality of customer service at health facility level.
- In some locations, more work needs to be done on the attitudes of health care workers, especially towards marginalized populations, and gender equality in health care.
- There was a sense at the national and sub-national reviews that the DLI approach has resulted in an increase in ANC, birth delivery at health facilities, and PNC for ethnic women in particular.
- In Luangprabang, one district shared that the combination of CHWs from the same ethnic background, community outreach, and a focus on service quality has resulted in more ethnic

women using the service. They also indicated that their approach had meant that trust was increasing, and word of mouth was leading more people to use the service.

- Challenges are being experienced in most locations in engaging with socially-excluded groups, especially FSW and MSM
- Participants in the reviews from Provincial level suggested that reframing the DLIs to create indicators for gender and social inclusion would help draw more focus and effort to these areas.

HIV

The Community Rights and Gender Team of the Global Fund conducted community consultation workshops with the civil society and representatives of key population[4] in order to review and identify key achievements, insights, bottlenecks with regard to the quality and impact of services under the HANSA I project (including TB, HIV, MCH, nutrition programs) as perceived by clients and affected communities. Key results are presented below:

Availability of HIV Health Services:

- There is a need to bring testing as close as possible to the people who need it; scaling up outreach services to meet people where they are to reduce time, cost, and staff availability barriers by providing community-based HIV-Self Testing, index testing and prevention education, especially for Service women, their clients, MSM and their sexual partners.
- Scale up community ART delivery model for stable patients with maximum 6 monthly dispensing.
- Pilot a decentralised ART service at the district level in a high prevalence district.
- Track out of pocket expenses for all medical interventions required for the specific management of HIV for those affected.
- Ensure all HIV related medical interventions required by a PLHIV are covered under the NHIS.
- Provide gender affirming care for transgender people to increase reach and recruitment and reduce loss to follow up from treatment.
- Increase competency of health care providers on gender affirming and trans competent care provision.
- Increase condom promotion messaged alongside other prevention methods including PReP for both MSM and Service women.

Access to HIV Health Services:

- Scale up case management services that support home based care for PLHIV.
- Improve outreach and peer educator knowledge on HIV and STI's and their prevention and treatment for the implementation of targeted awareness raising campaigns.
- Cash vouchers to cover transport should support the cost of travel for all PLHIV to reduce loss to follow up.
- Improve outreach and peer educator knowledge on reproductive health to support better outcomes for women living with HIV interested in family planning and for Service women interested on contraception.
- Ensure all women living with HIV are provided with information on family planning within 3 months of diagnosis.
- Increase information and access to Pre-exposure prophylaxis (PrEP) for MSM and Service women.

[4] including men who have sex with men (MSM), transgender people (TG), sex workers (SW), people living with HIV (PLHIV) and people who use/inject drugs (PWUD/PWID)

- Increase awareness programs for trans people on the efficacy of PrEP when it is used in combination with hormones.

Acceptability of HIV Health Services:

- Greater privacy at government facilities is required during consultations.
- Confidentiality is an ethical requirement of all medical officers. It is essential that patients feel safe to disclose their status (HIV or as a key population) without breach.
- There is a need to increase innovative testing methods such as self-testing and index testing for hard-to-reach populations.
- Exploring options to provide further differentiated services to each of the key population groups to ensure targeted and relevant programs.

Quality of HIV Health Services:

- Greater investment is required in supporting health care providers to build skills in empathic and compassionate care to reduce stigma and discrimination.
- Increase capacity of health worker skill to provide accurate information to patients to ensure they are able to understand their diagnosis and treatment regime.
- Implement a confidential complaints mechanism with a clear pathway to support health care providers to review and improve their practice.
- Ensure that the private sector health providers have the required clinical skills in providing STI services and that positive results are reported for national prevalence indicators accordingly.

Tuberculosis (TB)

- Scale up CSO TRIO model, provide additional training and capacity building to TRIO support members to identify and manage TB patients and treatment adherence.
- In order to facilitate effective reach, provide training to CSO Field Officers to collect quality sputum samples and transport to nearest facility with GeneXpert machine to reduce multiple sample collection and delays in positive patients receiving diagnosis.
- Track out of pocket expenses for all related medical interventions, nutrition and transport related to TB management and consider ways to incorporate these costs into the NHIS.
- Consider incorporating conditional (on treatment adherence) cash transfers into the TB program to support out of pocket costs incurred by TB patients; transport, nutrition supplements.
- Ensure TB affected people are included under the key populations served within HANSA's nutrition programs.
- Inclusion of nutrition support for TB affected people and their families can increase positive outcomes.
- Sputum collection at village level can reduce out of pocket expenses incurred by travel.
- Income support or conditional cash transfers is required for those who are unable to work due to treatment side effects, to ensure greater adherence and to alleviate concerns of financial insecurity and poverty for families.
- Scaling up CSO and village level outreach programs can increase case detection, sample collection, treatment initiation and adherence.
- Health workers need increased training in informed consent practice for medical interventions, especially HIV testing.
- Greater investment is required in supporting health care providers to build skills in empathic and compassionate care to reduce stigma and discrimination.
- CSO's require additional investment in skills building including in mental health, STI information, SRH, confidence building.

- CSO's to design a community led model of HIV and TB package of services.
- Support for CSOs to develop an advocacy platform to influence greater fund allocation for the HIV/TB response based on their capacity to reach target populations and provide services that government continues to struggle with due to limitations of health workforce.

KEY FINDINGS FROM MID-TERM REVIEW OF CONVERGENCE PROGRAM

- ***Nutrition Status and Maternal Care***

This section is drawn from the key findings of the Mid-term Survey Report (2022) prepared by Indochina Research (Laos) Ltd for the Ministry of Planning and Investment, Ministry of Agriculture and Forestry, and the World Bank. This report covers the results of the Nutrition Convergence Program that is being carried out by the World Bank and IFAD in four Northern provinces that HANSA covers.

- ***Stunting levels***

Stunting among children under 2 (CU2) and children under 5 (CU5) have remained the same or deteriorated slightly with a total of 35.9% of CU2 and 43.7% of CU5 showing signs of stunting (compared to 31.8% and 42.5% at baseline, respectively). The increase in children with signs of stunting is highest in Phongsaly province where there was an increase of 7% in the proportion of CU2 stunted and of 3.8% in the proportion of CU5 stunted.
The proportion of stunted CU2 continues to be highest among the Hmong- Iu Mien ethnic group (42.2%) although the increase in the proportion of stunted children was the lowest since baseline (41.8%). The highest increase in the proportion of stunted CU2 was observed among the Lao-Tai ethnic group with an increase of 7.4% from 18.5% at baseline to 25.9% at mid-term. There was also a much higher increase in the proportion of boys under 2 with signs of stunting that among girls.
Among CU5 there was a slight increase in the proportion of children stunted in Xiengkhouang province (1.1%) and in Phongsaly province (3.8%). CU5 from the Lao Tai saw the highest increase in the proportion of stunted children with a 3.3% increase.
The causes for these increases in stunting are not clear and require further investigation, but could include the restrictions in movement imposed to control de spread of COVID-19 which limited the access to health care and markets in many parts of the country, as well as the recent spike in food prices.

- ***Child Growth***

Growth charts were available and up to date for over half (59%) of children under two years of age which is a considerable decrease from the almost 80% reported at baseline. All provinces saw a reduction in the proportion of CU2 with a growth chart, but this was particularly stark in Xiengkhouang (33% reduction) and in Phonsaly (21.4% reduction). Hmong-Iu Mien less frequently had a growth chart (45.4%) compared to Lao-Tai children (70.5%).
This could also be related to the restriction on movement and the more limited access to health care staff and health centers during COVID-19.

- ***Exclusive breast feeding***

Exclusive breast feeding is widely practiced, with 83% of mother of children aged 0-5 months of age indicating that they were not providing anything other than breastmilk to their child, but this is a decrease from the 87% reported at baseline. There was no difference observed between provinces, and there is still a lower rate of exclusive breast feeding seen amongst Lao-Tai mothers (80%)

compared to mothers from other ethnic groups. The reasons for this need to be further explored and addressed.

- ***Vitamin A supplementation***

Vitamin A supplementation in the past 6 months was done in over 67.5% of children aged 6-59 months ranging from a low of 57% of Chinese-Tibetan mothers, to a high of 77% of Lao-Tai mothers. Iron folic acid was taken for at least 90 days by 73% of pregnant women, which is an improvement from the 54.7% of mothers taking iron folic acid at baseline. Most Lao-Tai mothers (87.2%) compared to only 62.6% of Chinese-Tibetan mothers took adequate iron folate during their pregnancy, although the latter saw a notable increase from the 30% of mothers that had taken iron folic acid for at least 90 days at baseline.

- ***Antenatal Care***

Antenatal Care (ANC) attendance at least four times during pregnancy occurred for 79% of mothers of children under two, with a slight improvement from baseline. However, Chinese-Tibetan and Hmong-Iu Mien mothers were still less likely to attend (66%) than Lao-Tai mothers (93%).

- ***Minimum Dietary Diversity***

The minimum dietary diversity (MDD) score was met by 21% of children aged 6-23 months, which is a decrease from the 27% of children meeting MDD at baseline2. Children from Chinese-Tibetan and Hmong-Iu Mien groups had the lowest dietary diversity, with scores of 18% and 15%, respectively, but with significant improvements from baseline for the latter. Children routinely consumed rice, with dark green vegetables and occasional flesh meats. Few children ate eggs, fish or organ meats as protein sources and there was a decrease in the proportion of children that did so from baseline. Vitamin A-rich fruits and vegetables were rarely consumed. However, for most households in all provinces, except for those on the lowest wealth class, their diets were adequately diverse.

The causes for this deterioration in the dietary diversity of children under 2 years of age is not clear by the survey findings, especially as most other convergence indicators saw an improvement. Likely causes can include the recent spike in food prices or the restriction in movement imposed to control the spread of COVID-19, which limited access to health sector services where children at risk could have been identified and attended and to markets. In-depth research on the causes of this deterioration in dietary diversity is needed.

- ***Water and Sanitation***

Improved sanitation levels are still lower in Phongsaly where 62% of households have access to improved sanitation, compared to over 92% and 86% of households in Houaphanh and Xiengkhouang, respectively. However, there was an improvement from the 55% of households with access to improved sanitation in Phongsaly at baseline. Overall, almost 80% of households have access to improved sanitation. The differences between Chinese-Tibetan households where only 40% have improved sanitation to Lao-Tai household at 96% is still notable.

Access to clean water varies from province to province and between ethnic groups. Overall, there was an increase from 87% to 90% in the proportion of households with access to clean water. However, only 86% of households in Phongsaly, and 76% of Chinese-Tibetan households have access to water from a protected source. More households relied on a public tap in Phongsaly than in other provinces. Around 17% of households there continue to rely on surface water for drinking, which is an increase from the 10% seen at baseline.

The treatment of drinking water occurs every time in 79% of households, and sometimes in 12% of households. In Phongsaly, 18% of households do not treat their water, which is an increase from the

16.9% observed at baseline. The most commonly reported method of water treatment was boiling for 99% of households. Households rarely strain water through a cloth (3.2%), or use a ceramic or sand filter (1.3%).

- ***Hygiene***

Handwashing with soap is reported to be done frequently. However, upon inspection, only 32% of households actually had access to soap and a handwashing station, although this is an improvement from the 27% found at baseline. As observed in the baseline survey, Lao-Tai households more often (46%) had access than Chinese-Tibetan households where only 23% of households actually had soap available, despite the progress made. Handwashing before eating is reported by 77% of households, but less frequently before preparing food, after farming, and even more rarely after defecating or before feeding young children, or after touching an animal.

Access to bathing facilities has improved, with 56.2% of households having access to facilities at home. Xiengkhouang still has the highest proportion of homes with access to a bathing facility as part of their toilet with 53%, or more rarely as a separate room. Only 37% of households in Phongsaly have access to a bathing facility, although this is an improvement from the 31% found at baseline. Most households still bathe at community water sources, or in rivers and streams.

Disposal of children and animal feces occurred correctly in 37% of households, a small improvement over the 36% reported at baseline. Child feces disposal continues to result in open defecation, particularly in Phongsaly where 23% of mothers still leave child feces in the open, with no progress made in this area since baseline. About one third of children use the toilet or latrine and overall, less than half of the households appropriately dispose of children's feces, except in Houaphanh where 65% of households dispose of child feces appropriately.

- ***Household Diet and Food Security***

Household dietary diversity was high with 78% of households consuming foods from four or more food groups in the past 24 hours, which is the same proportion found at baseline. All ethnic groups and provinces show highly diverse diets. These rates contrast sharply with the dietary diversity of children aged 6-23 months which saw a clear deterioration between baseline and mid-term, and suggest that access to a diverse diet is not the limiting factor for child feeding.

Food availability was assessed based on the diversity of crops and livestock raised by farmers. Farmers who raised one type of animal, and one type of fruit or vegetable in addition to rice were considered to have food availability. In general, diverse nutritious food was available to 90% of households with no evident wealth gradient and very small differences by ethnic group.

- ***Consumption, Savings, Borrowing and Remittances***

Consumption of nutritious food (expenditure per capita) varies by province and ethnic group, and as would be expected, varied substantially by wealth category. Overall, the consumption of nutritious foods per capita increased by 91%, from 392,075LAK to 749,864LAK which could reflect the high inflation experienced by the country in recent years. The increase is most accentuated in households in Phongsaly where the expenditure on consumption of food doubled from 365,794LAK to 733,734LAK.

- ***Land and non-land assets***

Land and home ownership rates were high with 97% of families owning agricultural land, and 92% owning their home. Only 34.1% of households had title for all their land however, and most owned 2 hectares of land or less.

Most households (68.9%) own 3 plots of land or less with little difference between provinces. The average size of the land owned was 3.5 hectares. In Xiengkhouang, 26.7% of households had more

than 4 hectares, with farms as large as 50 hectares reported in Phongsaly, Huaphanh and Oudomxay. On average, each household cultivated 2.2 hectares in the past 12 months.

Livestock of some type were raised by most farming households, despite the decrease in livestock raising reported since baseline. Apart from rainfed rice grown by half of households, other common crops are sweet corn, maize and to a lesser degree cardamom and cassava.

- ***Women's Workload***

Women's Workload was assessed based on the time spent carrying water. Since most households have access to water very near, or inside their house, the time spent carrying water was very limited for most women. Most households rely on firewood for cooking, which must be collected in the forest, most often by women, so this aspect of women's work remains unchanged.

- ***Saving and Remittance***

Saving was possible for 23% of households, and decrease from the 26% of households that were reported to be able to save some money at baseline, with the highest proportion of households in Xiengkhouang, and in Lao-Tai households.

Borrowing among households increased from only 15.6% of households borrowing at baseline, to almost a fifth of households (19.8%) borrowing money in the last year. Families borrow mainly to buy food.

Remittances were received by 13% of households, and increase from the 9.2% of households that reported receiving remittances at baseline. Households in Xiengkhouang and Lao-Tai households were more likely to receive remittances than in Phongsaly or from Chinese-Tibetans ethnic groups Overall, the results of this mid-line survey suggest that despite the progress made in some areas, a multifaceted, convergent approach remains necessary. Special emphasis should be made on addressing the lack of improvement in dietary diversity of children and the limited progress made in some WASH indicators.