Lao People's Democratic Republic

Peace Independence Democracy Unity Prosperity

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Ministry of Health

Health and Nutrition Service Access Project

Social Assessment

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I. Introduction and Objectives

1. Project description

Project Development Objective

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

Description of Project Components

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

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

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

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

Component 4: Contingency Emergency Response Component (CREC): The objective of the contingency emergency response component, with a provisional zero allocation, is to allow for the reallocation of financing in accordance with the IDA Immediate Response Mechanism in order to provide an immediate response to an eligible crisis or emergency (natural disaster, disease outbreak or pandemic, etc), as needed. This component will finance expenditures on a positive list* of goods and/or specific works, goods, services and emergency operation costs required for emergency recovery. An Operational Manual for this

component will detail the eligible situation when the CERC can be triggered, financial management, procurement, safeguard and any other necessary implementation arrangements, to be submitted to and accepted by the WBG prior to the disbursement for this component of IDA funds.

Project Location

For component 1, the initial roll out of this performance-based payment to health centers will take place in the four northern priority provinces: Oudomxay, Phongsaly, Huaphan and Xiengkhuang. After then, the expectation is for this mechanism to be rolled out in other provinces with a perspective to cover nationwide, adding 2 to 4 provinces in each six-monthly cycle. An operational manual of this performance-based mechanism will be developed within one month after project effectiveness. It is expected that for the first roll out of the performance score cards, around 220 health centers in these four provinces will be assessed.

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

- Two DLIs (G and H) related to nutrition specific service will be focused on the 4 nutrition priority provinces.
- Other two DLIs (J and K) related to Global Fund (GF) funded will depend on discussion between CHAS[1] and GF which will be finalized during project appraisal in January 2020.
- For DLI A which directly linked to Project Component 1 on QPS will initial at 4 convergence provinces in year 1 and then will add more 4 provinces each year so that by year 4 will cover nationwide in which 90% of health center in the country will receive timely quality assessment and verification visits
- For DLI B on timely receipt of National Health Insurance Bureau (NHIB) payment at health center level and increase in the number of health centers received free maternal and child health (MCH) services will cover all provinces except Vientiane Capital
- For DLI C on availability of essential drugs and supplies at health center level improved the scope is similar to DLI A
- For DLI D on number of provinces in which the number of health centers without a clinical health worker has been reduced the scope is similar to DLI A and C
- For DLI E on financial management capacity at health center level improved the scope is similar to DLI A, C and D
- For DLI F on increase coverage and correctness of event capture report the scope is similar to DLI A, C, D, and E
- For DLI I on EPI the scope is focus on 50 priority districts of all provinces based on DHIS2 system to generate Penta 3 and SBA
- For DLI L on increase national readiness for health security in responding to pandemics and health emergency at international boundaries (airports and ground crossings) the scope is similar to DLI A, C, D, E and F

For Component 3, the scope of project is nationwide from effectiveness to closure of the project

For Component 4, the project will cover the areas where the CERC is triggered. The most likely situation to be triggered for emergency response would be the natural disaster e.g. flood and landslide or pandemic. The project is highly likely exposed to flooding in the four project provinces in the south and flashing flood or landslide in the four project provinces in the north in very near future. Extreme flooding may lead to damage of health facility, water supply system, and road which will directly impact the access of health

[1] CHAS requested to the project that will be the same 4 nutrition convergence provinces because these provinces despite low prevalence of HIV but received little support from development partners while GF want to focus on province in the south where GF has already supported just continue project activities.

and nutrition of the target beneficiaries. In addition, some kinds of pandemic of human influenza or zoonosis disease could spread through in the national disaster areas or cross border. The potential impact on component 2 is highly likely. The right kind of capacity building measures could increase preparedness and longer-term resilience to unexpected natural disaster risks. Understanding the climate and geophysical risks need to be explored.

2. Project Implementation agency

The Project will be implemented by the MOH through the Department of Planning and Cooperation (DPC), MOH technical departments and the provincial health offices (PHOs) and district health offices (DHOs). The DPC is expected to remain the main coordination body building upon the mechanism already in place under Health Governance and Nutrition Development Project (HGNDP). For sustainability and greater use of government systems, the preparation will explore the possibility of Department of Finance (DOF) in a larger fiduciary role, potentially taking on some of the procurement and financial management responsibilities that are currently carried out by National Project Coordination Office (NPCO).

At the national level, the existing NPCO in the DPC will be responsible for overall project management and administration, implementation of project activities and achievement of DLIs in close coordination with MOH technical departments and those PHOs and DHOs participating in the project and M&E. The NHIB and the Department of Health Care and Rehabilitation (DHR) will play a central role in the design and implementation of the component 1, in close coordination with other technical departments including Department of Foods and Drugs (DFD), Department of Communicable Diseases Control (DCDC), DPC and Department of Hygiene and Health Promotion (DHHP), as well, as centers under these departments who will likewise play a critical role in the implementation of activities in their respective key areas. Each department and centre will nominate a focal point supported by a core group from DPC for the preparation and implementation of the project.

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

II. Social Assessment Objectives and Methodologies

The overall objectives of the World Bank's safeguard policies is to help ensure the environmental and social soundness of investment projects, including enhancing project outcomes for local communities, including the poor, ethnic minorities, women and other vulnerable communities. Two of the Bank's policies apply to the project:

i. operational policy OP 4.01 on environmental assessment, which aims to assess the project's potential social and environmental risks and impacts in order to enhance positive impacts and to prevent, minimize, mitigate or compensate for adverse social and environmental impacts; and
ii. operational policy OP 4.10 on indigenous peoples (ethnic minorities) which aims to design and implement projects in such a way that ethnic minorities

- do not suffer adverse effects during the development process and
- Receive culturally compatible social and economic benefits.

1. The objectives of the social assessments
   i. to assess potential risks and social impacts of proposed project activities as per World Bank's operational policy on environmental assessment (OP 4.01)
   ii. to identify vulnerable and under-served population groups, to identify social and cultural issues relevant for the proposed project.
   iii. to inform the design of the project and an Ethnic Group Development Framework (EGDF) to enhance project outcomes and ensure equitable benefits for vulnerable social groups such as the poor, women and ethnic minorities.
   iv. to identify and assess particular issues and risks concerning ethnic minorities following the requirements of the World Bank's operational policy on indigenous peoples (OP 4.10) that aims to ensure that the project provides culturally appropriate benefits and do not have adverse social impacts on ethnic minorities.

2. Methodology of the Social Assessement

The SA mainly focuses on accessibility, inclusion, risks and impacts of NHI implementation, MNCH and nutrion services, and recommendations. The key result findings of the SA later will be used for preparing and developing the EGDF for HANSA project. The SA consists of some main sources including:

   i. NHI implementation such as Decress on NHI scheme (2012), and NHI assessemt report (2018); and
   ii. MNCH and Nutrition services such as EGDP 2017 of the HGNDP, Population and Household Census (PHC) 2015, and Lao Social Indicator Survey (LSIS) 2017.

III. Legal and Institutional Framework on Ethnic Groups in Lao PDR

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

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

The intention of the Constitution is to grant equal status to all ethnic groups, and to this end no reference is made to distinctions between highlanders (Lao Soung) and lowlanders (Lao Loum) and midlanders (Lao Theung). The official terminology, for describing the diverse population of

the Lao PDR is 'ethnic group' and was introduced in the 1991 Constitution. The term "indigenous people" is not used in Lao PDR. Article 75 of the Constitution specifically indicates that the Lao language and script are the official national language and script. The lead government agency in relation to ethnic minorities is the Lao Front for National Construction, Department of Ethnic Affairs. Therefore the Social Assessment and the Ethnic Group Development Framework (EGDF) will use the official terminology of the Government of Lao PDR.

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

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

The implementation of the Party's policy on ethnic minorities is tasked to the Lao Front for National Construction (known colloquially as Neo Hom).

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

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

Policy relating to the non-Lao Tai remains relatively unchanged from that announced by Party Central in 1992, which identifies three essential tasks for their development: (a) strengthening political foundations; (b) increased production and opening of channels of distribution in order to

convert subsistence based economics towards market-based economics; and (c) a focus on the expansion of education, health and other social benefits.

Despite the fact that the number of ethnic groups have changed over time, specialist agree on the ethno-linguistic classification of ethnic groups produced by the Lao Front for National Development (LFND) which contains 49 categories and over 160 subgroups.
According to the official categorization of the LFND, ethnic groups in Lao PDR can be categorized into four ethno-linguistic categories:

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

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

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

IV. Ethnic Groups in the project provinces

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

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

The population and ethnic origin group in the 12 nutrition districts of 4 project provinces of Xiengkhouang, Houaphan, Oudomxai and Phongsaly are retrieved from the Population Housing Census (2015), as are indicated in the table 1 below.

Table 1: Lao Population and Housing Census 2015

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

V. Socio-economic Context

1. Population Overview

The population comprises a diverse ethnicity with the last census identifying 47 distinct ethnic groups in the country. While the last census identified 47 ethnic groups, Government officially recognizes 49, which are separated into four ethno linguistic families. Lao-Tai is the official language, but many ethnic groups do not speak it. Based on the PHC (2015), the Lao-Tai groups make-up 62.4 percent of Lao's population, followed by the Mon-Khmer (23.7 percent), the

Hmong-Mien (9.7 percent) and the Chinese-Tibetan (2.9 percent). In addition, The Lao-Tai group comprises 52.5 percent of the population and live primarily in the lowlands, while the non-Lao Thai live predominantly in the highlands. This diversity poses challenges to the delivery of health care services, due to cultural and language barriers.

2. Social-economic Overview

Lao PDR is one of the poorest and least developed countries in East Asia. With a population of 6,492,228 (PHC 2015), and a GDP per capita of US$ 1,208 in 2010, it is classified as a lower middle income country (WDI 2010). Poverty in the country has been reduced significantly, with the poverty headcount declining from 46 percent in 1992 - 1993 to 34 percent in 2002- 2003 and to 28 percent by 2007 - 2008, and expected to reach the related Millennium Development Goals (MDGs) target of 25 percent by 2015 (Lao DoS 2010). However, in 2011–2012 Lao's economic growth rates have faced problems due to several natural disasters, which caused limiting economic growth and damage social infrastructures. Thus, the 7th Five Year National Social Economic Development Plan 2011 – 2015 has not achieved as planned, and government of Lao has given all efforts on rehabilitation in order to resulting in continuously economic growing (NSEDP, 2016 – 2020).

3. Health Sector Overview

The 2014 World Bank study on health workforce found substantial gaps in the clinical abilities of frontline health workers in the management of MDG-related clinical situations. It highlights a significant gap in the quality of health education, beginning at the pre-service stage (including entry regulations or requirements for health workers) and continuing throughout the professional life of the health worker. The study also suggests that there are opportunities to address the significant inefficiencies in health service delivery related underutilization of frontline human resources. The study suggests investment to reduce demand-side barriers such as physical access barriers, ethno-linguistic and gender barriers, to increase the utilization of essential health services. Finally, the study also notes the need for investment in improving service readiness of public health facilities to ensure the availability of essential health commodities, equipment, and infrastructure.

Shortage of qualified manpower is further compounded by an uneven distribution of health workers across provinces. The density of doctors to population in Vientiane is four times that of the rural areas. Similar but less pronounced differences exist for high-level nurses and midwives. The 2014 study conducted, however, found maldistribution of staff (by geography, level and type), substantial gaps in clinical knowledge, and a mismatch between the type of in-service training provided and the knowledge needed to perform the service required.

Financing for health sector in Lao PDR has long been challenged by the low level of government investment in health and correspondingly high reliance on out of pocket (OOP) health expenditure and external assistance for health. However, there has been significant increase in the

government budgetary spending on health from US$11 per capita in 2011 to US$30 per capita in 2016. The country currently spends US$60 per capita or about 2.4 percent of GDP in 2016, where government health spending including external sources accounted for a combined 52 percent of the total health expenditure. While overall government spending on health has increased, further evidence is needed to understand if the increase has translated into improved availability and delivery of health services.

VI. Key Findings of Social Assessment

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

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

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

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

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

NHI assessment report 2018 - After the NHI scheme has been introduced for a year, the NHI assessment was conducted (Apr – Jun 2018) in the five selected provinces of Luangnamtha,

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

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

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

2. At the supply side, due to the NHI implementation is recently launched nationwide in 2017, many health facilities, especially the health centers, can hardly handle the implementation in many circumstances. According to the NHI assessment (2018), many concerns are raised due to the NHI implementation that (1) increasing number of patients and workload with no incentive; (2) pending of the reimbursement at the subnational level; (3) irregular monitoring of supportive supervision; (4) requirements of improve the quality of services and health facility; and (5) limited of medical equipment and drugs.

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

Recommendations – Improvement of the NHI implementation are including: (1) provide refresher training on NHI related topics to the health staff at the subnational level; (2) conduct regular monitoring and focus on coaching at the health facility staff; (3) improve quality of health care

services for better services to meet the needs of population; (4) allocate enough of qualified staff to appropriate work at the health facilities; and (5) encourage and closely support village authorities to promote NHI at the community level.

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

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

MNCH Service Delivery issues

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

2) Both the internal and external reviews of the MNCH Strategy 2009-2015 argued that current MNCH program interventions are channeled through an existing health system that struggles to support universal basic health services. The capacity at the different levels and in various elements of the health system varies widely depending on two key dynamics: first, the level of facility (central level hospital, provincial hospital, district hospital or village-level Health Center), and second, the level and type of development partner assistance in supporting MoH staff in program implementation, supply of health equipment and consumables and support for infrastructure development. Generally, health services are better funded and supported at Central and Provincial level, with highly significant decreases in support (both funding and personnel deployment, training and supportive supervision) when District and Village level services are evaluated. More support for the health system aimed at strengthening capacity of staff to provide high quality basic health care at district and village levels could contribute significantly to engaging communities to seek health care from health facilities, including MNCH services.

3) Many fixed site health facilities are not adequately provisioned with MNCH related drugs, personnel and equipment, so encouraging women to deliver at facilities where the standard of care is inadequate will not necessarily improve MNCH outcomes, and is likely to discourage others in the community from delivering at the site in the future if one or more community members have a negative birthing experience while at a health facility. This finding is supported by the WB HSIP consultations, which was based on wide community consultations and stated that beneficiaries involved in the consultations reported that staff at Health Centers were rude to people accessing free services, staff did

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

4) The physical environment of the delivery rooms was another barrier to greater service utilization cited in the external evaluation. It was argued that the design of birthing rooms across the country, with stirrup beds that require women to give birth in a prone position is not in line with current international standards and is antithetical to many rural women's traditional birthing practices (which do actually reflect current, international best practice in birthing protocols, such as giving birth in a supported squatting position) (UNFPA 2005). For rural (and indeed urban) women to give birth in the prone position with their legs secured in the air is highly uncomfortable, both physically and culturally. Cost-effective, yet well designed alternatives to the current standard of stirrup beds can be readily developed and deployed, making the design of birthing rooms across the country more medically appropriate and in line with current international best practice standards, which aim to make the birthing space more welcoming for women and less medicalized, without compromising on standards of hygiene or medical care.

Traditional and Culture Practice

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

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

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

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

Language barriers and culture beliefs

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

Demand for MNCH Services by Individuals, Families and Communities

9) In terms of engaging communities with the health system, there are many excellent programs being implemented by MoH personnel, supported by development partners (based on the WHO, Individuals, Families and Communities model of community mobilization). In many sites there is evidence of increased knowledge around MNCH and the need for ANC, delivery at Health Centers, post-natal care and child nutrition (WHO 2014, Albone 2011, De Sa et al 2013, JICA 2015). Yet even in sites where increased knowledge is demonstrated, it does not necessarily equate to behavior change. The external MNCH evaluation found that, in a focus group discussions conducted in Hoay

Mong village, Bokeo Provence, both women and men clearly stated that they were aware of the importance of exclusive breastfeeding for the first six months of life, but participants said that they did not follow this proscribed behavior because women need to go back to work in the field very quickly after birth and therefore could not breastfeed while working. Because of the perceived need for women to return to work quickly, babies' diets were supplemented with foods such as pre-chewed sticky rice from as early as one week of age. This example illustrates that there more work to be done in initiating and sustaining behavior change in remote rural communities around health seeking, and MNCH in particular. As mentioned above, strengthening the health system in order to make making visits to health facilities more positive for service rights holders is a key aspect of ensuring sustained behavior change around health seeking behavior for remote community members.

10) It is widely documented (De Sa et al 2013, Albone 2011, Maloney 2011) that Lao PDR is a country with a culture where men hold significantly more power over decision making than women, particularly at community and household levels. These studies report that men hold decision-making power over whether or not members of the household seek medical care, including MNCH related services. This evidence is supported by a recent external evaluation of the MNCH Strategy 2009-2015, where it was strongly recommended that community engagement be done on the WHO Individuals, Families and Communities (IFC) model, and aim to actively engage men in improving MNCH and nutrition outcomes in their own families and communities.

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

12) The SIA for the HSIP (2005), and the more recent external evaluation of the MNCH Strategy completed in 2015, found that language (and by extension culture) are major obstacles to women's access to MNCH services. In several areas villagers reported they were not able to visit the clinic or the hospital without an interpreter. The interpreters are few, and

asking them to accompany a patient is a major financial problem as well as a social one of incurring debt according to the norms of reciprocity in the village, usually calculated in terms of labor. The result is that villagers rarely avail themselves of public health services.

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

14) Other than for the Hmong in Xaysomboun, however, non-Lao-Tai ethnic minority personnel in the health service system are rare. One reason for this is the high educational qualifications that are required for admittance. For the lowest level one must have completed lower secondary school and then study medicine for 3 years. The second level requires completion of upper secondary plus 5 years of medical study. And the highest level requires completion of upper secondary and 10 years of additional medical study. Thus the majority of the ethnic minority people are unqualified due to lack of educational opportunity. This lack of opportunity then leads directly to a lack of access to health services for the respective ethnic populations.

15) Moreover, some other additional information related on MNCH service delivery is mentioned in the Appendix A.

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

Recommendations - Improvement of the MNCH service delivery are including: (1) allocate ethnic health facility staffs to be based in the HC and district hospital; (2) strengthen knowledge and capacity building for the frontline health facility staffs in provision of standard and quality of the

basic health care services; (3) strengthen knowledge on the Infant Young Child Feeding (IYCF) SBCC to the village facilitators who will be the first contract for support ethnic groups at the village level; (4) ensure the IECs on IYCF SBCC in up to date and appropriately use with each ethnic group; (5) continue on promoting appropriate health and nutrition education and information to the target groups at the village level on social behaviour change campaigns in order to positive impacts of the health outcomes; and (6) apply convergence methods working in the target villages.

At the end the SA and the key findings of the Free, Prior, Informed Consultations (FPICs) with target villagers and health center staff at the target health centers in the 4 target project provinces, on Mar 10 – 23, 2019 has been used to develop the EGDF for HANSA. Please find the briefly summary of the FPICs in the Appendix B.

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

1. Health system and staffing

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

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

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

2. Health Information system

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

In addition, the current World Bank health project, HGNDP, has been supporting the Government strategy and plan on: (1) the development, implementation and maintenance of an improved HMIS of MoH through the DHIS2; and (2) technical support and capacity building for MoH staff at

all levels to use such system. Currently, several data platform and formats of malaria, tuberculosis and HIV/AIDS, Human Resources, the Expanded Immunization Program (EPI), and financial management information have been fully created and integrated into DHIS2. The Additional Financing have continued to support the MoH through implementation of the Health Information Strategic Plan, and integration of HMIS for all vertical programs into DHIS2. Such support process are provision and maintenance of IT equipment, technical assistance and training of staff at all levels to ensure data quality and use of information for planning and decision making purposes. It is also envisaged that the Village Health Information System will be integrated into DHIS2.

3. Maternal health issues

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

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

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

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

Adolescent birth rate aged between 15 – 19 years old is at 83 percent. Early childbearing is very high in the rural without road (136 percent), and none education mothers (176 percent). In addition, it is about eight times higher compared between the poorest and richest wealth quintile (156 percent and 20 percent respectively) (LSIS 2017).

4. Child health and nutrition issues

Child immunization for under- 2 years old vaccination who have been received fully immunized by the first years of life is at 48.1 percent compared to urban and rural without road areas (53.4

percent, and 40.7 percent respectively). However, the immunization coverage for all the vaccines is still below the target of 90 percent. Child immunized coverage for BCG is at 81.5 percent; Polio3 is at 69 percent; DTP-Hib-HepB is at 60.8 percent; and Measles and Rubella (MR1) is at 66 percent (LSIS 2017).

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

5. Maternal and child mortality

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

6. Clean and safe environment

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

Appendix B - Free, Prior, Informed Consultations (FPICs) at project provinces

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

The Free, Prior, Informed Consultations was conducted with the stakewholer and beneficaries in target villagers and health center staff at the target health centers in the 4 target project provinces, on Mar 10 – 23, 2019. The objectives of the consultations are:

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

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

The consultations held at the 6 selected health centers with commnunity people consist of 121 participants of 22 villages in 10 ethnic origin communities, including village chiefs, Lao Front Union, Lao women's union, village facilitators, pregnant women, and fathers and mothers of under- 5 years old as well as representatives from the poor and vulnerable groups, not limited to ethnic groups living in the areas participated. Representative from the NPCO lead the consultation in each area providing an overview of the project object, components, impacts gatherring from social assessment, and safeguard measures including feedback and resolution mechanism. After completing the consultation with community participants, the NPCO together with provincial and district health officers conducted a consultation meeting with the health center staff who are mainly responsible for the implementing on NHI, and provinding MNCH services - names of the traget villages, ethnic groups, health centers, and districts are indicated in the table 2, 3, and 4 respectively.

Table 2: Ethnic Origin in the target villages of the consultations from Mar 10 – 23, 2019

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

Table 3: Name of the target villages of the consultations from Mar 10 – 23, 2019

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

Table 4: Health centers interviewed during the consultations from Mar 10 – 23, 2019

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

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

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

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

A. Consultations with community participants can be summarized as below:

1. **Knowledge on NHI information and accessibility to NHI services** – Participats (including all ethnic groups) confirmed similar information to the NHI assessment report (2018) in term of that

    * Limited of NHI information and services, participants don't know about NHI services, but they know it as a service of "low co-payment and fee schedule, and free services.", and they cannot give explanation in details.
    * Knowing only family book as the eligible document for exemption. Participants added that currently many of the family books are with the district security office for the updated which would take some several months. Thus, they had to pay for full services cost.

2. **Challenges in NHI services** – Due to limitation of understanding of NHI services, lot of complains were gaven at the consultations such as

    * Not clearly understand about rational drug used for NHI services, participants complainted that "when first knowing about NHI services, we went for the services, and most of the time, we only got small amount of drugs. Thus, some of us decided

not to use NHI services anymore, and go back to the normal services, which we think that we get better services compared to the NHI services."

* Limited of IEC materials on NHI services either in Lao or ethnic languages, participants mentioned that they have never seen any kind of posters on NHI information either at the villages or health facilities. For example, NHI information in Lao language only found and displayed in 1 out the 6 selected health centers wall, and other ethnic groups won't be able to understand if they cannot read Lao.
* Not have had not good experiences utilizing of health care services, ethnic participants said that they don't feel confident visiting health facilities due to language barrier and culture beliefs. So, they don't like to visit health center where there is no their own ethnic health staff.
* Reluctant to go for the health care services, partipants mentioned that some of health facilities tend not to provide services during out of working hours or during the weekend, which is causing community people either waiting for longer times, or spend more money and go further to the district hospital, and pay extra money for transportation. The risk is that some patients decided to go home instead of not going to further health facility because they cannot afford it.

3. **Constrains of accessibility and affordability to MCHN services of the poor and ethnic minority women** – Participants mentioned that ethnic women are not only facing poverty and language barriers, but they also have to depend on tradition beliefs and decisions of the most influence members in the family. At the consultations, these women said that they are quite worries about their people, who are in the mid ages and older generation in their communities, especially husbands, parents and grandparents are not aware of risky inappropriate health behavior practices. The risk is that if there is no one who can speak Lao or offer to take pregnant women to a health facility, these women are hardly to manage it by themselves. Here are some of the reasons mentioned by the ethnic women for not able to accessibility and affordability to a health facility. For example,

    * Mostly Akha, Khamu, Hmong and Phong women don't like to access to the NHI and MNCH services because of their husband's beliefs. In addition, many of their husbands are drug addicted, no money, and no transportation.
    * Akha women said that they are too shy to let others know that they are pregnant, so as a result they don't go for the ANC at the early as possible, but they would go for the ANC almost at the late trimester of her pregnancy.
    * Khmu women do heavy works while getting pregnant due to fear to trouble the husbands and parent's husbands.
    * Hmong community, the husbands aged 30 and older tend not to take their pregnant wives for ANC, delivery at a health facility, or allow under- 5 years old to get vaccinated. These people think that get pregnant and give birth are natural process, and not getting child vaccinated also won't have any harm to their children.

* The risk is that many ethnic women said that they don't ride a motorbike, and must depend on the husbands taking theme to a health facility, and they are too shy for delivery at a health facility. In fact, their husbands don't like other to touch or see their wives' bodies.

4. **Maternal and child health related to gender issues** – At the consultations, participants mentioned that in rural and remote areas, teenagers get married as very young ages at 14 years old, and have babies soon after marriage. Difficulty in physical accessing health facility, no transportation and shy, Lue, Phong, Khmu, and Hmong pregnant women did not attend ANC, and delivered babies at home with assistance from husbands, parents, and relatives. Ethnic women said that during and after delivery babies, they usually practiced food taboos, and worked hard as usual with the beliefs that those practiced behaviors would help them deliver easily. The risks are that all ethnic women are not aware of benefit of the PNC at all, as well as get child vaccinated soon after delivery at home. Some women said that although they know what to do during pregnancy, their husbands, parents, and grandparents around her don't understand or consider as unnecessary to do such as take more rest, no food taboos, and not working overloaded. For example,

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

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

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

B. Consultations with health center staff can be summarized as below:

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

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

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

Appendix C - Registration form from each PFICs with both target community participants, and health center staff

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

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

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການ ສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	[illegible]	ຍິງ	20	ມົ້ງ	[illegible]	[illegible]	[illegible]	02097713955	[illegible]	[illegible]
2	[illegible]	ຍິງ	20	ມົ້ງ	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
3	[illegible]	ຍິງ	18	ມົ້ງ	[illegible]	[illegible]	[illegible]	02092116550	[illegible]	
4	[illegible]	ຍິງ	28.	ມົ້ງ	[illegible]	[illegible]	[illegible]	0304433637	[illegible]	[illegible]
5	[illegible]	ຍິງ	21	ລາວລຸ່ມ	[illegible]	[illegible]		0209155123	[illegible]	[illegible]
6	[illegible]	ຍິງ	26	[illegible]	[illegible]	[illegible]		0305765545	[illegible]	[illegible]
7	[illegible]	ຍິງ	27	ໄທດຳ	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]

8	ນ.ພັນ	ຍິງ	23	[illegible]	ມ.1	[illegible]	[illegible]	0209711?0 635.	ນ.ພັນ	[illegible] 5 ປີ
9	ນ.ນຸດ	ຍິງ	31	[illegible]	ປ.5	ບ.ເມືອງເຫົ້າ	[illegible]	030994123?4	[illegible]	
10	ນ. [illegible]	ຍິງ	25	[illegible]	ປ 5	ບ.ເມືອງເຫົ້າ	ປະ[illegible]	03045594 5551	ນ.[illegible]	[illegible]
11	ນ.[illegible]	ຍິງ	22	[illegible]	ມ 2	[illegible]	[illegible]	[illegible]09969586	[illegible]	
12	ນ.[illegible]	ຍິງ	23	[illegible]	ມ2	[illegible]	[illegible]	0209747079	[illegible]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[illegible]

ລາຍເຊັນພະນັກງານສຸກສາລາ

[illegible]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

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

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
01	[illegible]	ຊ.	42	[illegible]	ມ6.	ເມືອງເຫົ້າ.	ອະນະບ້ານ	020.99992442	[illegible]	
02.	ທ. [illegible]	ຊ.	62.	[illegible]	ປ.5	ເມືອງເຫົ້າ	ອສະ[illegible]	020.9952506	[illegible]	
03	ທ [illegible]	ຊ	25	[illegible]	ມ7	[illegible]	ອະນະບ້ານ	0309131913	[illegible]	
4.	ທ. [illegible]	ຊ	34	[illegible]	ມ1	[illegible]	ອ ສບ	02096768441	[illegible]	
5	ທ. ນຸດ	ຊ	23	[illegible]	ມ7	ເມືອງເຫົ້າ	ຄະນະ[illegible]	0305119907	[illegible]	

6	ທ. ໄຊທອງ	ຊ	27	ຂະມຸ	ມ3	ສາມສຸມ	ອ. ສ. ປ.	02049434391		
7	ທ. ໂຊທະນາ	ຊ	33	ຂະມຸ	ປ.ຊ.	ບ. ຫ້ວຍວັງ	ຣະບອບ	0309455834		
8.	ທ. ຈົ່ງລະສຸດ	ຊ.	31	ລາວ	ມ3.	ບ. ເມືອງເກົ່າ.	ຜຂ.ບ.	02055311350		
9	ທ. ສຸຂີ	ຊ	30	ລາວ	ມ6	ສາຍາເໜືອ	ອິນທາວ	0304912225		

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອິນພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ສຸພິດາ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

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

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ທ. ຊົ່ງ	ຍ	46	ຂະມຸ	ປ2	ກະບໍ່	ປ/ຊ		[signature]	
2	ນ. ດາວວັນ	ຍ	27	ຂະມຸ	ມ3	ກະບໍ່	ປ/ຊ		[signature]	
3	ນ. ລີ	ຍ	32	ກຶມມຸ	ມ1	ກະບໍ່	ປ/ຊ		ນາງ ລີ	ສົງໝາ.
4	ນ. ຄຳ	ຍ	28	ກຶມມຸ	ມ1	ກະບໍ່	ແມ່ຍິງບ້ານ		[signature]	
5	ນ. ແພງ	ຍ	47	ກຶມມຸ	ປໍ່ໄດ້	ກະບໍ່	ປ/ຊ		[fingerprint]	

1

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

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

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ທ. ຊົ່ງ	ຍ	46	ຂະມຸ	ປ2	ກະບໍ່	ປ/ຊ		[signature]	
2	ນ. ດາວວັນ	ຍ	27	ຂະມຸ	ມ3	ກະບໍ່	ປ/ຊ		[signature]	
3	ນ. ລີ	ຍ	32	ກຶມມຸ	ມ1	ກະບໍ່	ປ/ຊ		ນາງ ລີ	ສົງໝາ.
4	ນ. ຄຳ	ຍ	28	ກຶມມຸ	ມ1	ກະບໍ່	ແມ່ຍິງບ້ານ		[signature]	
5	ນ. ແພງ	ຍ	47	ກຶມມຸ	ປໍ່ໄດ້	ກະບໍ່	ປ/ຊ		[fingerprint]	

1

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

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

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການ ສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ທ. ບົວກາຍ	✓	43	ຂະມຸ	ຊັ້ນ[illegible]	ກະບໍ່	ນາຍບ້ານ	0305778888	[illegible]	
2	ທ. ທອງສີ	✓	43	ຂະມຸ	ມ2	ກະບໍ່	ຄະນະບ້ານ	0304724683	[illegible]	
3	ທ. ຄຳສຸກ	✓	55	ກຶມມຸ	ຊັ້ນສາມ	ກະບໍ່	ຄູສອນ	0302290 592	[illegible]	
4	ທ. ຄຳໜິວ	✓	50	ກຶມມຸ	ມ1	ກະບໍ່	ປ/ຊ.	0304703140	[illegible]	
5	ທ. ທອງບົວ	✓	52	ກຶມມຸ	ປ.3	ກະບໍ່		0305744865	[illegible]	
6	ທ. ບຸນທັນ	✓	59	ກຶມມຸ	ປ3.	ກະບໍ່	ປ/ຊ.	0305066030	[illegible]	
7	ທ. ສົມ	✓	37	ກຶມມຸ	ປ3.	ກະບໍ່	ປ.ກ.ຊ.	0304649340	[illegible]	
8	ທ. ຄຳພອນ	✓	49	ກຶມມຸ	ມ3	ກະບໍ່	ຮອງນບ້ານ	0305372 807	[illegible]	
9.	ຄຳສີ	✓	28	—	ມ3	ກະບໍ່	[illegible]	0304949 029.	[illegible]	
10	ທ. ໃຊ.	✓	44	ກຶມມຸ		ກະບໍ່	[illegible]	0305076498.	[illegible]	
11	ທ. ໃຈ	✓	35	ລື້	ມ4	ກົ່ວໃຈ	ບໍລິການ	99553661	[illegible]	
12	ນ. ຄຳແພງ	✓	36	ລາວ	ມ.6	ກົ່ວໃຈ	ທ/ສ.ສຸກສາ	0309701157	[illegible]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອໍາພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ສຸກສາລາ ຈ່າຂົ້ນ

[illegible]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໄພຂຸະນາການ (ຫັນສາ)

- ຄັ້ງວັນທີ:...../ 03 / 2019
- ສະຖານທີ: ສຸກສາສາ.....ລວນສຸກ.....,ບ້ານ:.....ລວນສຸກ.....ເມືອງ:.....ຫົວເມືອ.....ແຂວງ:.....ຫົວພັນ.....

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
01	ວັນພອນ	ຊ	24	ລ:ຫ	ຫ5	ບ. ລວນສຸກ	ໝໍບ້ານ ຄູ່ມ	020937446[illegible]		
02	ທອງ[illegible]	ຊ	48	ຫ[illegible]	ປ[illegible]	ບ[illegible]	[illegible]	020[illegible]	ອ[illegible]	
03	ທ[illegible]	ຊ	42	ລ:ມ	ປ.5	ບ[illegible]	[illegible]	020[illegible]		
04	ທ. ພັດ	ຊ	35	ຫ	ປ.2	ບ[illegible] ຊ[illegible]	ບ: ນ[illegible]	030[illegible]	[illegible]	[illegible]
05	ກ[illegible]	ຊ	36	ລ:ຫ	ມ6	ບ[illegible]	ບ: ນ[illegible]	02055441[illegible]	[illegible]	
06	ນ. ນ[illegible]	ຍ	33	ລ[illegible]	ມ6	ສ[illegible] ຫ[illegible]	ວິຊາການ	28608432		

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອ[illegible]

ລາຍເຊັນພະນັກງານສຸກສາລາ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...18.../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ.........ລາວຊຽງ.................,ບ້ານ:.......ລາວຊຽງ..................ເມືອງ:...ຫົວເມືອງ...............ແຂວງ:.......ຫົວພັນ.............

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
	ນ. ເພັງ	ຍ	20	ຂະມຸ	ປ.2	ລາວຊຽງ	ປ/ຊ		ນ. ເພັງ	ແມ່ລູກອ່ອນ
	ນ. ໄຊອາຍ	ຍ	18	ຂະມຸ	ປ3.	ລາວຊຽງ	ປ/ຊ	.	ນ. ອາຍ	ແມ່ຍິງກໍາພາ
	ນ. ກຽງ	ຍ.	20	ຂະມຸ	ປ3	ລາວຊຽງ	ປ/ຊ		ນ. ກຽງ	ແມ່ຍິງກໍາພາ
	ນ. ອຸ້ຍ	ຍ	18	ລາວລຸ່ມ	ມ3.	ລາວຊຽງ	ປ/ຊ	0304938719	ນ. ອຸ້ຍ	ແມ່ຍິງກໍາພາ
	ນ. ຕ້ອນ	ຍ	25	ລາວ	ມ1	ລາວຊຽງ	ປ/ຊ	0304794701	ນ. ຕ້ອນ	ກໍາພາ

	ນ. ລຸນ	ຍ	19	ມົ່ງ	ປ.4	ນາຂວາງ	ປ/ຊ	0305155 839	ນ.ລຸນ	ກີ້ພາ
	ນ. ມົງ	ຍ	16	ມົ່ງ	ມ.1	ນາຂວາງ	ປ/ຊ		ນາງ ມົງ	ກີ້ພາ
	ນ. ແພັດ	ຍ	18	ມົ້ງ	ມ.2	ນາຂວາງ	ປ/ຊ	0304797 163	ນ.ແພັດ	ກີ້ພາ
	ນ. ເຕົ່ງ	ຍ	28	ມົ້ງ		ນາຂວາງ	ປ/ຊ			ກີ້ພາ
	ນ. ຊົ	ຍ	20	ມົ້ງ	ປ3	ນາຂວາງ	ປ/ຊ	0709196 317	ນາງຊົ	ກີ້ພາ

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ທຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ທາພອນ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:..18...../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ....[illegible]...................,ບ້ານ:.......ຂວາງ.........................ເມືອງ:.....[illegible]..................ແຂວງ:.....ອຸດົມໄຊ.................

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
01	[illegible]	✓	51	ລື້	ປ.5	[illegible]	[illegible]	23959220	[illegible]	
02	[illegible]	✓	36	[illegible]	[illegible]	[illegible]	[illegible]	0305995696	[illegible]	
03	[illegible]		53	ລື້	ປ5	[illegible]	[illegible]	0305447475		
04	[illegible]		48.	ລື້	[illegible]	[illegible]	[illegible]	54933806	[illegible]	
05	[illegible]		33	[illegible]	[illegible]	[illegible]	[illegible]	02058843433	[illegible]	

1

6	ທ. [illegible]		36.	[illegible]	1	[illegible]	[illegible]	0304286570	[illegible]	
7	ທ. [illegible]		45	[illegible]	ປ3	[illegible]	[illegible]	0305730847	[illegible]	
8	ທ. [illegible]		26	[illegible]	ປ5	[illegible]	ພ.ອ.ຍ	020590[illegible]	[illegible]	
9	ທ. ໄພ		27	ລາວ	ມ7	[illegible]	[illegible]	5444 38997	[illegible]	
10.	ທ. [illegible]		19.	[illegible]		ບ. [illegible]	ປ/ຊ.	56296998.	Aountane.	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[illegible]

ລາຍເຊັນພະນັກງານສຸກສາລາ

[illegible]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:....18../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ.......[illegible].........................,ບ້ານ:.......[illegible].........................ເມືອງ:.......[illegible].................ແຂວງ:......[illegible]..............

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1.	ນ. [illegible]	ຍ	31	[illegible]	ມ6.	ບ. [illegible]	[illegible]	0305841037	[illegible]	
2	ນ. [illegible]	ຍ	35	[illegible]	ມ.3	ບ. [illegible]	[illegible]	0305646236	[illegible]	
3.	ນ. [illegible]	ຍ	17	[illegible]	ມ5	ບ. [illegible]	ມ/ສ.	02052317260	[illegible]	
4	ນ. [illegible]	ຍ	25	[illegible]	ປ2	[illegible]	[illegible]		ນ. [illegible]	
5	ນ. [illegible]	ຍ	20	[illegible]	ມ.7	ບ. [illegible]	ປ/ຊ	020 5294808[illegible]	ນ. [illegible]	

1	ນ.ແກ້ວ	ຍ	24	ຊະນູ	ມ4	ພູຫຼີ	ປະຊາຊົນ	0305703934	ນ.ແກ້ວ	
2	ບ.ສີທອງ	ຍ	18	ກໍ່	ມ4	ພູຫີນ	ນັກຮຽນ	02058966213	ບ.ສີທອງ	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[illegible]

ລາຍເຊັນພະນັກງານສຸກສາລາ

[illegible]

Activat

2

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ຕົ້ນສາ)

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

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1.	[illegible]	[illegible]	29.	[illegible]	[illegible]	[illegible]	[illegible]	02082230418	[illegible]	
2.	[illegible]	–	34	[illegible]	[illegible]	[illegible]	[illegible]	0304899165	[illegible]	
3	[illegible]	[illegible]	37	[illegible]	[illegible]	[illegible]	[illegible]	0305433132	[illegible]	[illegible]
4	[illegible]	–	42	[illegible]	[illegible]	[illegible]	[illegible]	02052895879	[illegible]	
5	[illegible]	[illegible]	32	[illegible]	[illegible]	[illegible]	[illegible]	0305688943	[illegible]	

6	[illegible]	✓	36	[illegible]	[illegible]	[illegible]	[illegible]	02055625979	[illegible]	
7	[illegible]	✓	28.	[illegible]	[illegible]	[illegible]	[illegible]	0309346461	[illegible]	
8	[illegible]	✓	45	[illegible]	[illegible]	[illegible]	[illegible]	0309450288	[illegible]	
9	[illegible]	,	33	[illegible]	[illegible]	[illegible]	[illegible]	0305978986	[illegible]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[illegible]

ລາຍເຊັນພະນັກງານສຸກສາລາ

[illegible]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...19..../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ......ນວມພັນ.................,ບ້ານ:.....ນວມພັນ.............ເມືອງ:......ຂວາ.....................ແຂວງ:......ຜົ້ງສາລີ..........

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ.ແປງ	ຍ	29	ໄທດຳ	ປ.4	ວັດພ້າວ	ພ.ອ.ບ	030 5933752	ນແປງ	
2	ນ.ອັນມົວຍ	ຍ	24	ອາຄາ	ປ5	ຫ້ວຍລາ	ພ.ອ.ບ		ນ.ອັນພັຍ	
3	ນ.ອາຄົມ	ຍ	22	ອາຄາ	ມ.1	ແພເຈົ້າໄທ	ພ.ອ.ບ		ນາງອາຄົມ	
4	ນ.ກວັງ	ຍ	28	ອາຄາ	-	ພະເຈົ້າໄທ	ພ.ອ.ບ			
5	ນ.ອາບູ	ຍ	25	ອາຄາ	ປ2	ຫ້ວຍລາ	ພ.ອ.ບ		ນາອູບ	

6	ນ. ມອນ	ຍ	21	ກຶມມຸ	ມ.4	ບອນພັນ	ແມ່ບ້ານ	.	ນ.ມອນ	
7	ນ. ລີ	ຍ	29	ກຶມມຸ	ມ.1 (ຮຽນສຶກສານອກໂຮງຮຽນ)	ບອນພັນ	ແມ່ບ້ານ		ນາງລີ	
8	ນ. ຈິສໄລ	ຍ	31	ລາວ	ມ.6	ບອນພັນ	ແມ່ຮົວ ນາຍບ້ານ	.	ຈິສໄລ	
9	ນ. ຄຳວີ	ຍ	30	ອາຄາ	ບໍ່ໄດ້ຮຽນ	ກົກເພົາ	ແມ່ບ້ານ		[illegible]	
10	ນ. ຄຳເພົາ	ຍ	33	ລາວ	ປ.5	ກົກເພົາ	ແມ່ບ້ານ.		ຄຳເພົາ	
11	ນ. ລີ	ຍ	25	ໄທເໜືອ	ປ.4	ກົກເພົາ	ແມ່ບ.		ນ.ລີ	
12	ນ. ລັບ	ຍ	45	ລາວ	ປ.4	ກົກເພົາໃຫ່	ແມ່ບ		ນ.ລັບ	
13	ນ. ນຳເພີ	ຍ	39	ອາຄາ	ປ.2	ກົກເພົາໃຫ່	ແມ່ບ		ນ ນຳເພີ	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

[illegible]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກຸ່ມຍ່ອຍ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...20.../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ...ລືວກະຈຳ...,ບ້ານ:...,ເມືອງ:...ລອງ...,ແຂວງ:...ພົ້ງສາລີ...

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ. ລູຈະ	ຍ	22	ອາຄາ (ຊີລາ)	ບໍ່ (ຮຽນ)	ລືວກະຈຳ	ປະຊາຊົນ			ກຳພາ
2	ນ. ປີປະ	ຍ	24	ອາຄາ (ຊີລາ)		ລືວກະຈຳ	ປະຊາຊົນ			ກຳພາ
3	ນ. ລໍ່	ຍ	20	ອາຄາ (ຊີລາ)		ລືວກະຈຳ	ປະຊາຊົນ			ຖືພາ
4	ນ. ບໍ່ເຢີ	ຍ	24	ອາຄາ (ຊີລາ)		ລືວກະຈຳ	ປະຊາຊົນ			ຖືພາ
5	ນ.ເຈົ່າເປຍ	ຍ	37	ອາຄາ (ຊີລາ)		ແສງຫລວງ	ປະຊາຊົນ			

6	ນ. ບົວສອນ	ຍ	30	ກືມມຸ	ມ.3	ປ/ສ ນ້ອຍແສງ	ເພອນ	0309669070	ນ. ບົວສອນ	
7	ນ. ບຸນ	ຍ	23	ກືມມຸ	ມ.5	ປ/ສ ນ້ອຍແດງ	ເພອນ	0309665086	ນ. ບຸນ.	
8	ນ. ບົວວັນ	ຍ	33	ກືມມຸ	ມ.3	ບ.ຫຼວງລາ	ເພອນ	0309295961	ນ.ບົວວັນ	
9	ນ. ເພັງ	ຍ	40	ກືມມຸ	ປ.5	ນ. ຫຼວງລາ	ລ:ທ:ພັນແມ່ ຍິງບ້ານ	0305357821	ນ: ເພັງ	
10	ນ. ເວັນ	ຍ	22	ກືມມຸ	ມ.7	ບ. ທາທາດ	ເພອນ	0309302731	[illegible]	
11	ນ. ໄຂ	ຍ	37	ກືມມຸ	ປ.5	ບ້ານທາດລາ	ແມ່ຍິງ ບ້ານ	0304738512	ນາໄຂ	
12	ນ. ບຫຼ	ຍ	25	ກືມມຸ	ມ.4	ເພຍ	ບ/ວ		ນ. ແບັຽ	
13	ນ. ແພັດ	ຍ	36	ກືມມຸ	ປ.5	ເພຍ	ລ:ທ:ພັນແມ່ຍິງ ບ້ານ	0304657134	ນ. ແພັດ	
~~13~~										

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

ອໍາພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

ບຸນທອງ

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັນສາ)

- ຄັ້ງວັນທີ:...26..../ 03 / 2019
- ສະຖານທີ່: ສຸກສາລາ.......ກົວລະສັ່ງ..................,ບ້ານ:......................................,ເມືອງ:.................................,ແຂວງ:......................................

ລຳດັບ ລະຫັດ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
04	ທ. ຄຳເພົ້ອ	ຊາຍ	21	ກຶມມຸ	ພ.6	ບ. ຫ້ວຍແລງ	ອ.ພ.ບ	02097699 035	ທ. ຄຳເພົ້ອ	
09.	ທ. ຣະຫາວົ	ຊາຍ	36	ກຶມມຸ	ພ2	[illegible]	ຮອງນາຍບ້ານ	55440364	ຣະຫາວົ	
07	ທ. [illegible]	ຊາຍ	45	ກໍ່	ພ1	ບ. ຫ້ວຍແລງ	ຊາວໜຸ່ມ		[signature]	
05	ທ. ແຫ່	ຊາຍ	36.	ກຶມມຸ	ປ4	[illegible]	ຮອງນາຍບ້ານ	0309300474	ແຫ່	
06	ທ. ເຫຼືອງ	ຊາຍ	52	ກຶມມຸ	ປ5	[illegible]	ອພບ	02052490714	ເຫຼືອງ	

1

08	ທ. ສີອຳໄພ	ຊາຍ	32	ກໍ່	ມ3	ບ. ແສນຫຼວງ	ນາຍບ້ານ	0309924403	[signature]	
03	ທ. ຕື້ແປະ	ຊາຍ	29	ກໍ່	ມ2	ບ. ແສນຫຼວງ	ອພບ	02092249683	ຕື້ແປະ	
02	ທ. ບຸນຈັນ	ຊາຍ	25	ກໍ່	ມ2	ບ. ແສນຫຼວງ	ອພບ	03049 22331	ບຸນຈັນ.	
01	ທ. ຄຳສີ	ຊາຍ	35	ກຶມມຸ	ປ.5	ບ. ເພຍ	ຮອງບ້ານ	0309785798	[signature]	
10	ທ. [illegible]	ຊາຍ	32	ກຶມມຸ	ປ.5	ບ. ເພຍ	ອພບ.	0309262766	[signature]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[signature] ຄຳພອນ

ລາຍເຊັນພະນັກງານສຸກສາລາ

[signature]

ລາຍຊື່ຜູ້ເຂົ້າຮ່ວມສົນທະນາປຶກສາຫາລືກ່ຽວກັບ ໂຄງການ ການເຂົ້າເຖິງການບໍລິການດ້ານສາທາລະນະສຸກ ແລະ ໂພຊະນາການ (ທັບສາ)

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

ລຳດັບ	ຊື່ ແລະ ນາມສະກຸນ	ເພດ	ອາຍຸ	ຊົນເຜົ່າ	ການສຶກສາ	ມາຈາກບ້ານ	ໜ້າທີ່ຮັບຜິດຊອບ	ເບີໂທລະສັບ	ລາຍເຊັນ	ໝາຍເຫດ
1	ນ. [illegible]	ຍ	25	[illegible]	[illegible]	[illegible]	ວິຊາການ	99944530	[signature]	
2	ນ. [illegible]	ຍ	25	[illegible]	[illegible]	[illegible]	ວິຊາການ	93334134	[signature]	
3	ນ. [illegible]	ຍ	26	ລາວລຸ່ມ	[illegible]	[illegible]	ວິຊາການ	0308843023	[signature]	
4	ນ. [illegible]	ຍ	27	[illegible]	[illegible]	[illegible]	ວິຊາການ	030 5089908	[signature]	
5	ທ. [illegible]	ຊ	28	ລາວລຸ່ມ	[illegible]	[illegible]	ວິຊາການ	96102000	[signature]	

6	ທ. [illegible]	ຊ	36	[illegible]	[illegible]	[illegible]	[illegible]	030 599 5696	[signature]	
7.	ທ. [illegible]	ຊ	34	[illegible]	[illegible]	[illegible]	[illegible]	59856444	[signature]	
8	ນ. [illegible]	ຍ.	25	[illegible]	[illegible]	[illegible]	[illegible]	59731159	[signature]	
9.	ນ. [illegible]	ຍ	25	[illegible]	[illegible]	[illegible]	ວິຊາການ	02096242939	[signature]	
10.	ນ. [illegible]	ຍ	25	[illegible]	[illegible]	[illegible]	ວິຊາການ	02095115910	[signature]	

ລາຍເຊັນຫົວໜ້າທີມງານເກັບຂໍ້ມູນ

[signature]

ລາຍເຊັນພະນັກງານສຸກສາລາ