Social Assessment for The Laos Reducing Rural Poverty and Malnutrition Project

September 2018

Introduction

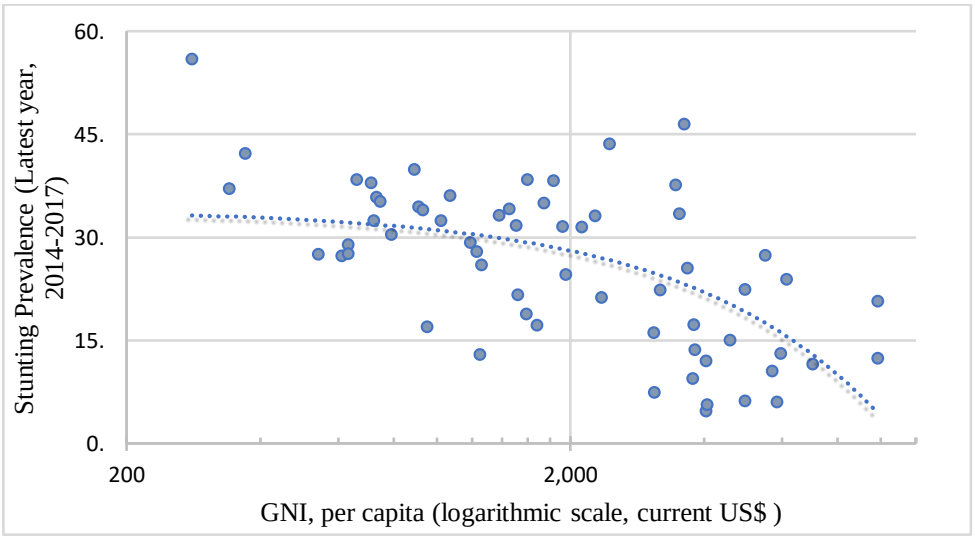
The following social assessment report has been prepared for the purposes of the Lao PDR Reducing Rural Poverty and Malnutrition Project to be financed by the World Bank. It is intended to highlight the differential impact of the project in addressing the unique nutritional challenges facing non-Lao Lum ethnic groups in the project areas of intervention. As such, it will serve as the social assessment required under the World Bank's policy on indigenous people, given that non-Lao Lum ethnic groups in the project areas of intervention can be considered as indigenous people according to the characteristics specified in this policy (language, collective attachment to land, self-identification, unique institutions). The report begins with a description of the background and context for the project followed by a brief description of the project components. Then, there is a description of the social assessment methodology, and the main findings and conclusions.

Background and Context

Levels, trends and determinants of undernutrition

In terms of childhood undernutrition, although there have been marked improvements in stunting over time, Lao PDR still performs poorly compared to other countries with similar levels of income and to other ASEAN countries (Figure 1). About 33 percent of children under five are still remain stunted, 21 percent are underweight, and 9 percent are wasted.

Figure 1. Persistence of undernutrition in Lao PDR is higher compared to other ASEAN countries



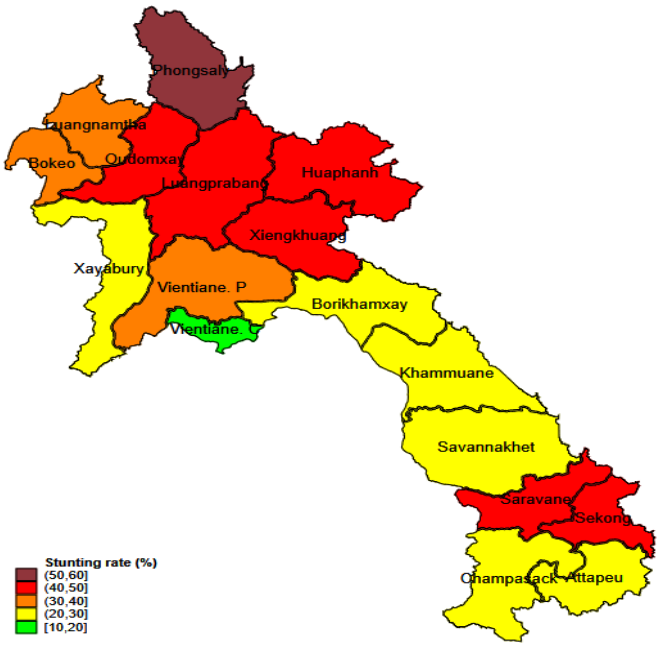
Source: WB Staff Calculation [1]

Moreover, the national aggregates of childhood undernutrition mask wide inequalities, with far worse outcomes in some provinces than in others. For example, stunting rates are higher in provinces like Huaphanh (40.7 %) and Phongsaly (54 %) and Xiengkhuang (48.3 %) and Sekong (49.9%)-(Figure 2). There is also significant variation across income levels; both stunting and underweight among children in the

[1] Nutrition in Lao PDR, Causes, Determinants and Bottlenecks, World Bank Group, June, 2016

poorest wealth quintile (48% stunted) are close to three times the rates for children in the richest quintile (14% stunted), and ethnic groups (i.e. among Hmong-Mien reaching 50 percent).

Figure 2: Stunting rates by province: 2017



Source: Laos Social Indicator Survey (LSIS), 2017

The multi-dimensional causes of childhood stunting in Lao-PDR underscore the diversity of actions that are needed across different sectors to address stunting and sub-optimal childhood development. Childhood undernutrition is an outcome of immediate, underlying, and basic causes[2]: at the *immediate level*, nutritional status is determined by nutrient intake to the body to meet its requirements, and the status of health (illness); *underlying causes* are related to food security (access, availability and utilization of food), maternal and child care practices, access to health services as well as clean water, appropriate sanitation and hygiene. Underlying these factors are *basic causes*: poverty is a basic cause of undernutrition, as are other economic constraints, women's status, etc.

Diet affordability and diversity and limited access to essential health and nutrition services are considerable issues in Lao PDR and are correlated with stunting prevalence. Only 55 percent of households in Lao PDR can afford a nutritious diet (WFP 2017) and affordability of a nutritious diet varies by province (83 percent in Vientiane versus 5 percent in Sekong, for example). These estimates can vary, where up to 61 percent of households reported unaffordability as a major constraint to diet diversity in the Laos Social Indicator Survey (LSIS) 2017. Household access to diverse diets is low. As the 2012-2013

[2] The UNICEF Conceptual Framework on Undernutrition, originally designed in 1990, identifies basic, underlying and immediate causes of malnutrition. The basic causes address systemic challenges including social, cultural, economic and political that contribute to an unequal distribution of resources.

Laos Expenditure and Consumption Survey (LECS V) demonstrated, this is especially acute in rural areas where most households consume only three of the nine recommended food groups. There is also a significant gender gap in terms of access to health and nutrition services. The LSIS 2017 found that only 52 percent of pregnant women from the poorest wealth quintile received ante-natal care (ANC) from a trained health professional and over 36 percent of pregnant women living in rural areas without roads received no ante-natal services. For the rural poor, many of whom live in remote areas, distance to health facilities is a major barrier to access.

Social and cultural norms are also closely correlated with stunting. Early marriage, for example, which is the primary cause of teenage pregnancy in Laos, is one (World Bank 2016). Early marriage remains widely accepted, particularly in rural areas, leading to high numbers of teenage pregnancies as evidenced by the fact that Laos has the highest adolescent birth-rates in the region. About 94 out of 1,000 births correspond to girls aged 15 to 19 (UNFPA 2016) compared to the regional East Asian average of 47 out of 1,000 births. Children born to mothers 18 years old and younger are ten percentage points more likely to be stunted compared to children to born to mothers over 18 years old. The low nutrition-related knowledge of caregivers is compounded by supply-side challenges, namely limited capacity of general health facilities and staff to provide health and nutrition-related services. Even without financial constraints, beliefs are usually promoted and at times enforced by influential family members, including grandmothers and husbands. Mothers have reported that they are encouraged to restrict food intake during pregnancy, so they can have smaller babies and easier deliveries, and that food restrictions often continue through the delivery and breastfeeding period.

Women's agency and empowerment have also been found to be determinants of stunting.[3] Three dimensions of women's autonomy— confidence in the ability to exert control over their own health care, self-esteem, and control over own spending or money, are associated with stunting in Laos. In other words, the likelihood of stunting is lower with women's increased access to health care, both in terms of distance and costs, and with their ability to use money as they wish. Two separate studies found that women's higher self-esteem, defined as their intolerance for domestic violence, is also associated with lower levels of stunting.[4]

Project Description

The proposed development objective is to: (i) develop the building blocks for social protection system in Lao PDR, (ii) improve key nutrition behaviors that are known to reduce childhood stunting in target areas in Lao PDR, and (iii) improve the coordination, monitoring and evaluation of a nutrition convergence approach in selected districts in Lao PRD[5].

The project will finance a nutrition-focused conditional cash transfer program and associated delivery systems/mechanisms. It will contribute to better nutritional outcomes by increasing the affordability of nutritious food as well as stimulating increased demand for and utilization of essential health and nutrition services known to improve nutritional outcomes and improving pro-nutrition knowledge,

[3] *See* Kamiya et al. Mothers' autonomy and childhood stunting: evidence from semi-urban communities in Lao PDR. BMC Women's Health 2018 18:70.

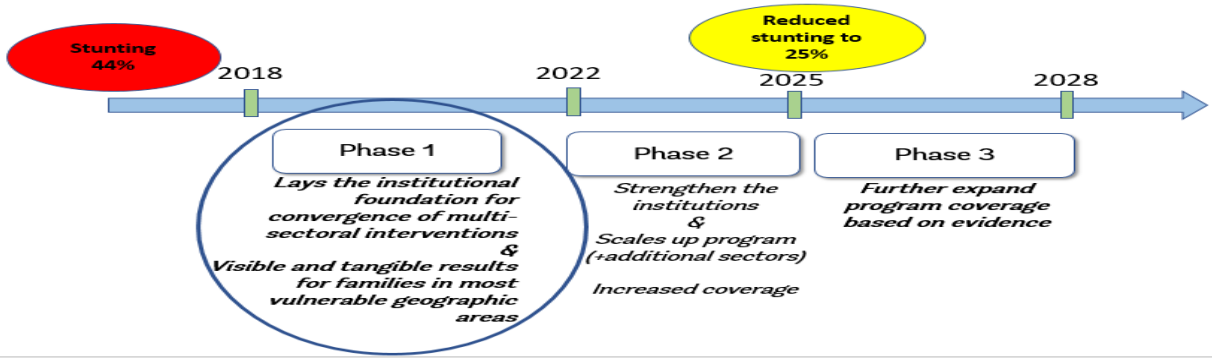
[4] Kamiya et al. Mothers' autonomy and childhood stunting: evidence from semi-urban communities in Lao PDR. BMC Women's Health 2018 18:70; and Kamiya, Yusuke. Socioeconomic Determinants of Nutritional Status of Children in Lao PDR: Effects of Household and Community Factors. Journal of Health, Population and Nutrition, [S.l.], v. 29, n. 4, p. 339-348, Aug. 2011.

[5] The overall formulation of the project development objective might still be rephrased during appraisal or before negotiations.

attitudes and practices. The cash transfer program will incorporate the following features: targeting the most vulnerable age group (i.e., first thousand days, geographic targeting and household poor and nearly poors) and directing transfers to women, with the ultimate goal of reducing poverty and improving child nutritional outcomes. The project will also finance the development of key building blocks for an effective social protection system, particularly the setting up of a targeting system and a social registry, which will enhance efficiency of spending, in particular for programs and projects targeted to the poor and most vulnerable.

For greater effectiveness, the Project will follow the principle of geographic convergence and its interventions will be coordinated with Health, Poverty Reduction Fund (PRF) and WASH projects that will focus on generating improvements in the supply of health, nutrition, and water and sanitation services, as well as the IFAD-funded Agriculture for Nutrition project (AFN). The Project will be implemented in 12 districts in the northern provinces of Oudomxai, Phongsaly, Xiengkhouang and Houaphan.[6] The proposed area of geographic convergence area covers a total population of approximately 400,000 people. The figure 3 below outlines the overall scope of phase 1-3 of the WB financed multi-sectoral nutrition convergence approach, with expected outcomes.

Figure 3. World Bank Lao PDR phased multi-sectoral approach to reduce stunting, 2018-2028[7]



The overall objective of the first phase of the proposed approach will beto lay the institutional and operational foundations for the multi-sector convergence approach before possible scale up in subsequent phases. Three active and four pipeline operations have been identified as nutrition-sensitive and, through simultaneous implementation in the same geographic regions and reaching the same households, would help maximize the reduction in stunting prevalence. Each of these interventions would address a key cause of undernutrition in Laos: poverty and vulnerability, limited access to quality health and nutrition services, limited access to water and sanitation, and limited knowledge of adequate maternal and child health and nutrition practices and early childhood development at the household level. In addition, these projects would help to address issues that cut across sectors, particularly gender

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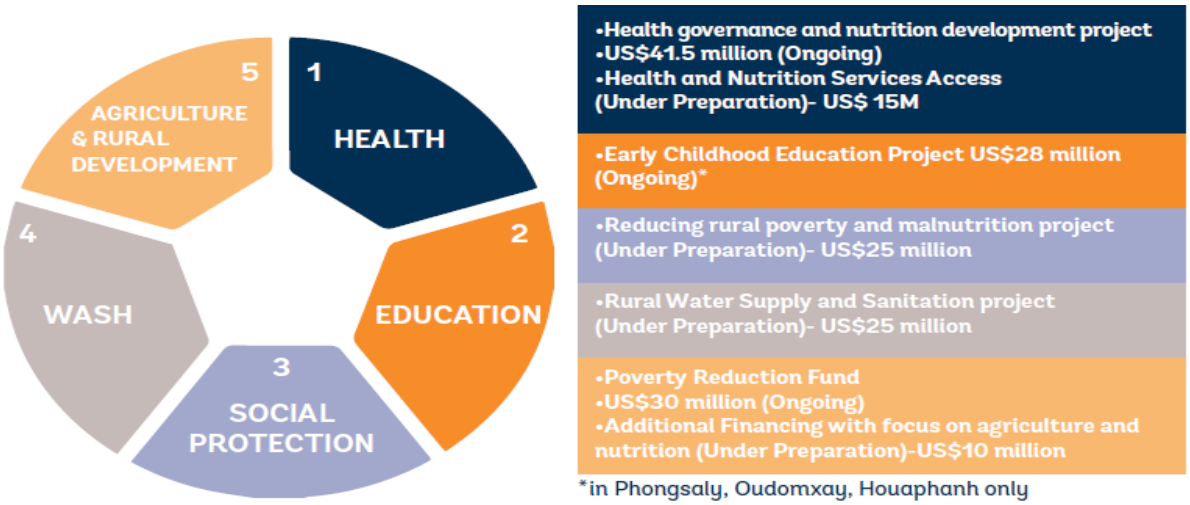
[7] The national target (reduction of stunting to 25 percent) pertain to national level objectives. The World Bank convergence approach will be centered on a subset of four provinces, and given that the operations noted above will converge in areas with a higher stunting prevalence (including some provinces with over 60 percent stunting), significantly contribute to the national goal of reduction of stunting. The common Monitoring and Evaluation Framework and expected reduction in stunting in the proposed area of intervention is presented in the Annexes.

dynamics that contribute to high levels of stunting. The specific projects include: Health Governance Nutrition Development (HGNDP);[8] a new health project which is currently in the early stages of preparation (Health and Nutrition Services Access Project); the Water Supply and Sanitation Project under preparation; the ongoing Early Childhood Education (ECE) project; the PRF project and its additional financing; and this proposed project. In the short term, the proposed four sectoral operations would jointly contribute (see Figure 4) to tackling the immediate and underlying causes of malnutrition in 12 priority districts in the provinces with the highest share and absolute numbers of stunted children[9].

Figure 4. World Bank programmatic approach portfolio in Phase 1



For greater effectiveness, the proposed Project will therefore follow the principle of geographic convergence and its interventions will be coordinated with other WB financed sectoral operation as well as the IFAD-funded Agriculture for Nutrition project (AFN). The Project will be implemented in 12 districts in the northern provinces of Oudomxai, Phongsaly, Xiengkhouang and Houaphan.[10] The proposed area of geographic convergence area covers a total population of approximately 400,000.

The proposed Project will comprise three components. **Component One** will focus on setting up the basic building blocks of a social protection system, namely: (i) a targeting system and a social registry for the country, which will be used by the proposed nutrition sensitive social safety net program financed under component two and by any other program targeted to the poor in the selected areas; and (ii) a beneficiary registry which will be critical jointly with the social registry to inform policy makers on gaps in the supply of programs and to report on the overlap of coverage in programs. **Component Two** will finance the set up and effective implementation of a nutrition-focused cash transfer program targeted

[8] The existing operation and its additional financing (approved in 2017) close in 2020.
[9] Phongsaly 54 percent, Oudomxay 42.7 percent, Huaphanh 40.7 percent and Xiengkhuang 46.3 percent (LSIS, 2017).
[10] The selected provinces present high level of stunting and poverty and have been selected by Government as priority districts for reducing poverty and malnutrition. Currently, the existing HDGNP is pilot testing a new model of SBCC and counseling on behavioral change.

to the first 1000 days for poor and vulnerable families. **Component Three** will finance the day to day support to the implementation of the social registry, the cash transfer program and the coordination, monitoring and evaluation for the overall WB multi-sectoral nutrition convergence approach. The following is a detailed description of the components likely to directly impact the beneficiaries covered by this social assessment.

Component 1: Developing the building blocks of a social protection system (IDA Credit US$ 1 million)

The objective of this component is to develop some of the key building blocks of a social protection system. This includes project support to the creation of a social registry, leveraging the government's previous data collection from all households. This information system will provide a "gateway" for potential inclusion of intended populations into social programs. The social registry would be used as a basis for targeting for the project Cash Transfer program and other programs part of the nutrition convergence approach. At the same time this component will finance the set-up of an integrated beneficiary registry which will allow to monitor and coordinate "who receives what" across programs in the target area.

Component 2: Cash transfer program for pregnant women and/or mothers with children under two years old (IDA Credit: US$21.3 million). The objective of Component 2 is to support the Government of Lao in setting up and delivering a cash transfer program to support poor and vulnerable households in selected rural areas with pregnant women and/or children under two years old. The goal of the cash transfer program would be to incentivize nutrition-promoting behaviors such as improving dietary quality (in terms of diversity and amount), increasing utilization of essential health and nutrition services, as well as to contribute to poverty reduction in targeted areas. This component will finance the development and implementation of the key operational aspects of the cash transfer program. This component will finance the following sets of activities:

(a) **Building the delivery system for a cash transfer (CT) program.** This will include: (i) a management information system to support implementation and monitoring of the cash transfer program; (ii) an effective system to enroll eligible households; (iii) a system for delivery of secure and timely cash payments, and (iv) a system for grievance redress.

(b) **Cash transfers for eligible pregnant women and mothers of children 0-2.** This activity will finance cash transfers to pregnant women and children under two in the selected areas. Cash transfer amounts will be set at KIP 150, 000 per beneficiary household per month (around US$18), which is around 15 percent of household consumption for the poor. This will ensure, on the one hand, that transfers can have a sufficient impact on consumption and service utilization and, on the other hand, that they do not distort labor market incentives. The program is expected to target the bottom 50 percent of households, previously identified under Component 1[11]. The cash transfer will be conditioned on regularly attending monthly village level social and behavioral change communication (SBCC) sessions and conditionalities may progressively evolve as the supply of health services improves.

[11] Through this targeted approach the project would include approximately 88 percent of stunted children (based on simulations) in the selected districts.

(c) Innovations in social behavioral change communication. This activity will support community-based SBCC activities aimed at contributing to improvements in: (a) maternal nutrition and related caring practices; (b) infant and young child feeding and caring practices; (c) sanitation and personal as well as environment-related hygiene behaviors; (d) dietary diversification; and, (e) other determinants of nutrition at the village level. This will utilize, to the extent possible, the same community-based platform to deliver SBCC as other WB financed programs, that is, the monthly village SBCC sessions primarily targeted at pregnant women and women with young children. For select sessions, male heads of households and mothers-in-law might be invited to participate.

The project is expected to include the entire population of the selected areas of intervention (400,000) as part of the social registry (indirect beneficiaries) and for the cash transfer would cover approximately 35,000 pregnant women and young children under two years old from poor and vulnerable rural households in the target provinces (direct beneficiaries). Women and ethnic minorities represent the majority of the population in all Strategic Support for Food Security and Nutrition Project (SSFSNP) districts[12] and are likely to benefit the most from project activities. Other households in the target provinces as well as the public at large will also benefit from mass media and community-wide campaigns which would be part of the revamped SBCC.

Knowledge Attitudes and Practices (KAP)Survey design & data collection

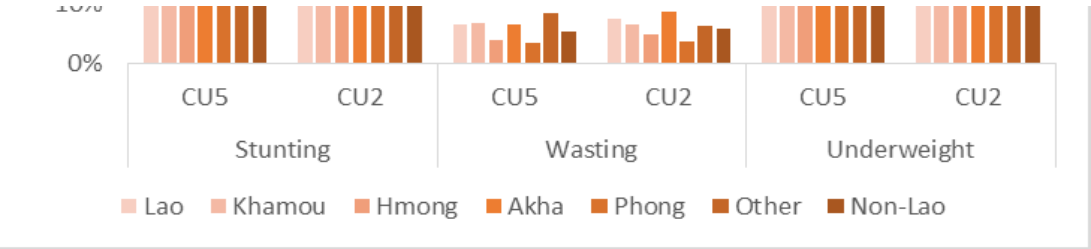
The findings of this social assessment are based on a KAP survey that was conducted to provide baseline information on key program indicators for the monitoring and evaluation of HGNDP and SSFSNP in Lao PDR. It was a two-stage cluster-based household survey of farming households with children under five (CU5) selected from the 12 target districts in Phongsaly, Oudomxay, Houaphan and Xiengkhuang Provinces. This household survey was conducted July to August 2017 for the Ministry of Health (MOH) by Indochina Research Ltd. (IRL). All of the villages in the survey are targeted to implement the WB financed multi sectoral nutrition convergence approach project. In the final sample of this survey, household ethnicity varied widely by population group and chi-square tests revealed significant differences in ethnic composition by village type, area of residence, income quintile, and province. Non-Lao ethnic groups together comprised the majority of survey respondents with the Khamou comprising 26.32% of the total sample, the Hmong, 26.92%, Akha, 14.96, Phong, 7.45%, Lao, 13.79 and other ethnic minority groups comprised 10.56% of the total sample.

Preliminary health and nutrition findings based on descriptive analysis

What follows is a preliminary descriptive analysis of the findings of the survey. This includes findings on child nutritional status, dietary diversity, pre and post-natal care, use and access to nutritional information and reports of experience of food insecurity. While the household survey data on which this is based speaks to the entire population in the target area, the findings presented in this report are focused on identifying the ethnically disaggregated findings on rural malnutrition and vulnerability.

[12] Key characteristics of the Lao target ethnic groups are summarised in Appendix 1

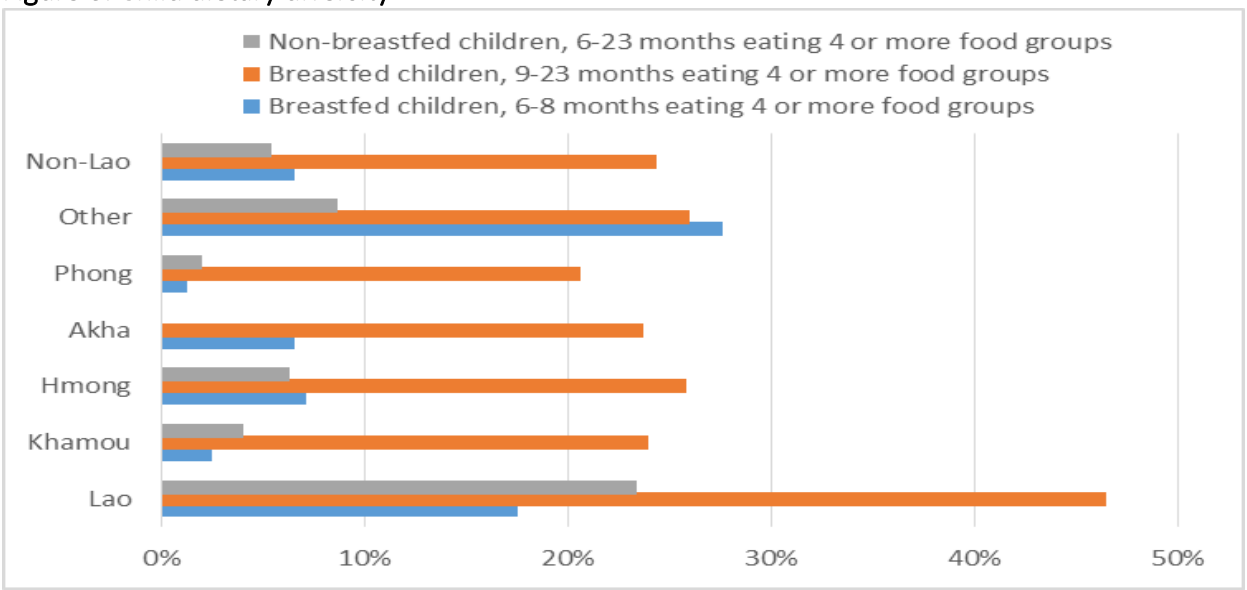
Figure 5: Child nutritional status by ethnicity



Childhood stunting is the most prominent nutritional problem in Laos with 43% of children under 5 years old and 30% of children under 2 years old reporting stunting. From the study sample and on average, ethnic minority groups had the higher rates of stunting amongst children under five years old compared with ethnic-Lao children. The rates of childhood stunting amongst Khamou children was 36.62%, amongst Hmong, 47.21%, Akha, 47.30, Phong, 59.27, other ethnic minority groups, 31.48% whereas amongst ethnic Lao children, the prevalence of stunting was 28.65%.

There was also a high prevalence of underweight children (21% of children under 5 years), and this was more prevalent among boys than girls (22% vs. 20%), and the poorest households having the highest prevalence (24%). Similar to stunting rates, the prevalence of underweight children was higher in non-Lao households, compared to Lao households, and highest among Phong and Akha households. Wasting was not as prevalent as stunting or underweight children under five years, and appeared to be more evenly distributed among households of different ethnicity.

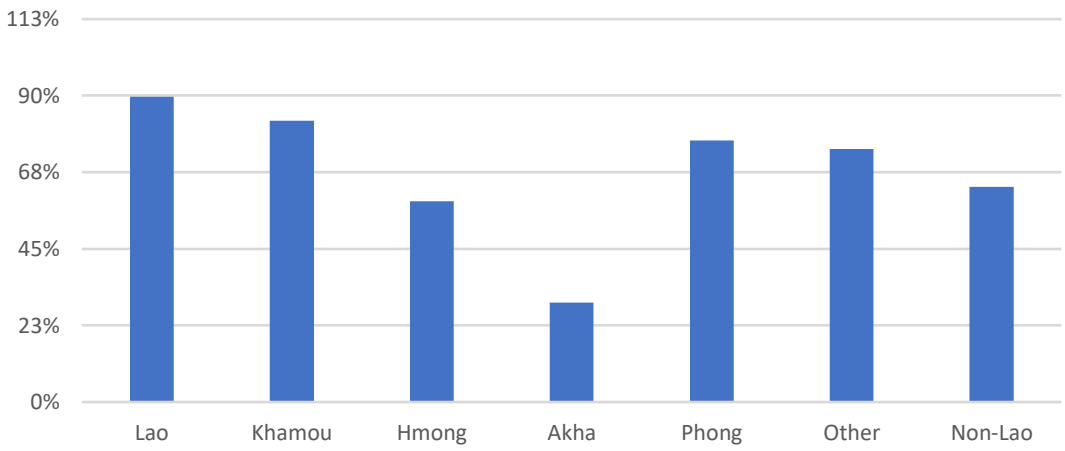
Figure 6: Child dietary diversity



Across all households, only a proportion of children 6-23 months received an adequately diverse diet, defined as having eaten from four or more of the seven food groups during the previous day. The number of children with an adequately diverse diet was generally lower among non-breastfed children (0% in Akha, 2% in Phong, etc.) in comparison to breastfed

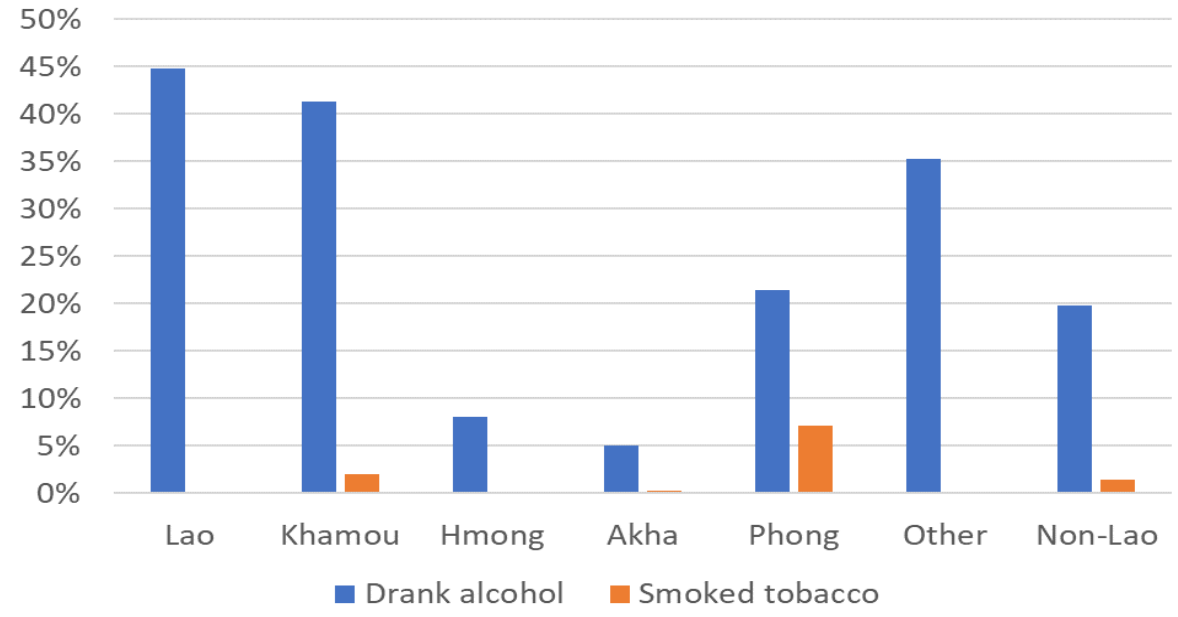
children. It is noteworthy that dietary diversity was highest among Lao households, compared to non-Lao households, with the lowest rates being reported among Phong and Akha households.

Figure 7: Received Ante Natal Care by Ethnicity



Most mothers received ANC for their child (67%) in the 3rd or 4th month of pregnancy (58%). However, the prevalence was much higher among mothers from Lao households (nearly 90%) compared to non-Lao (63%). It was the lowest among mothers from Akha households (less than 30%).

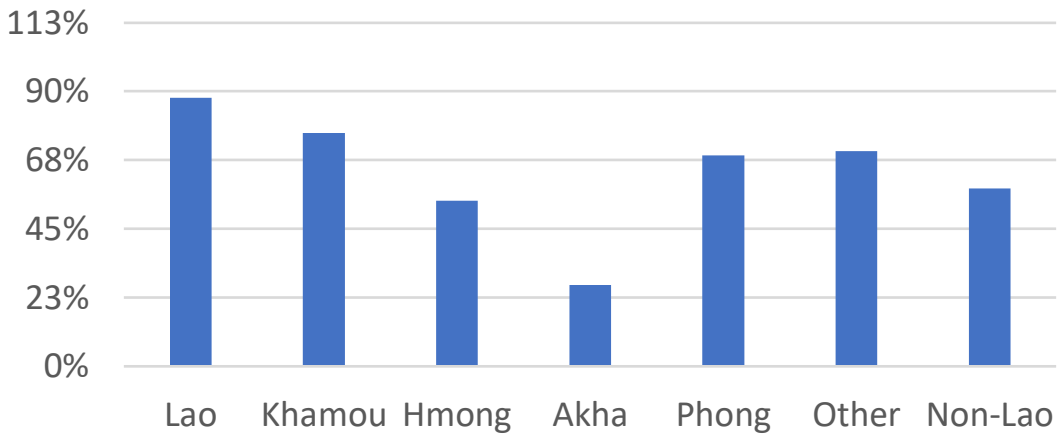
Figure 8: Behavior of mothers during pregnancy by ethnicity



In terms of the behavior of mothers during pregnancy, it is noticeable that the prevalence of alcohol consumption was high, especially among Lao women, but was comparatively low among

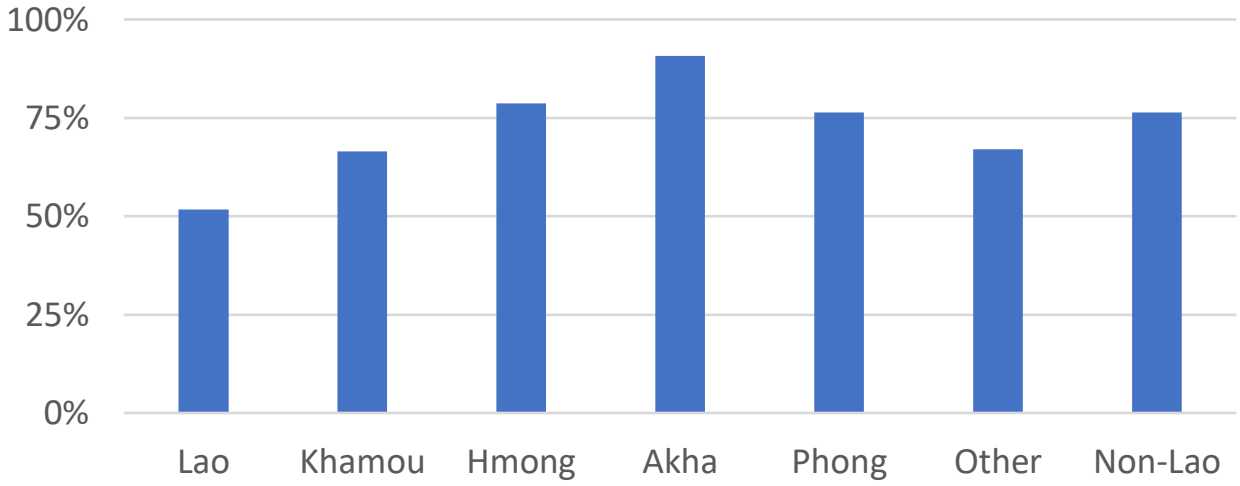
non-Lao households, especially the Hmong and Akha households.

Figure 9: Took folic Acid during pregnancy



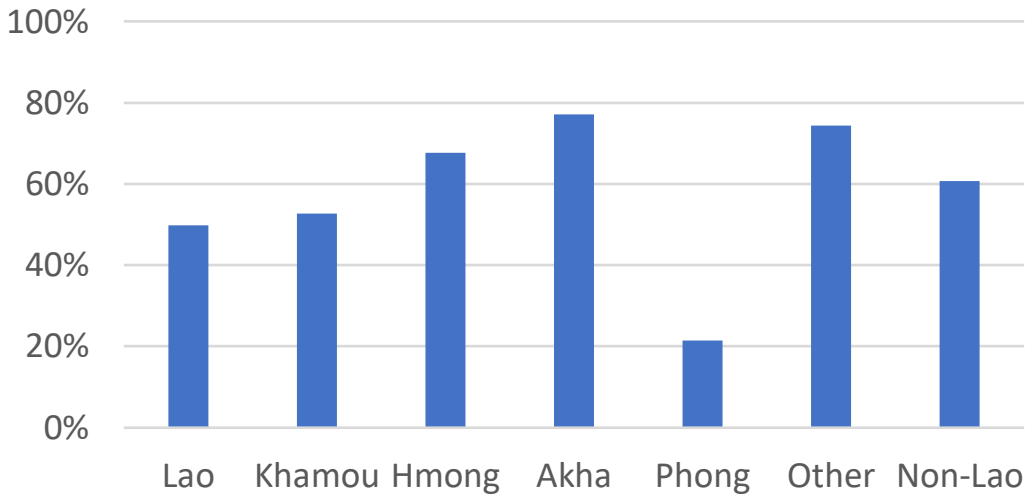
In terms of other behaviors during pregnancy, it was found that most mothers rested for at least two hours a day during their last pregnancy (77%), and that nearly half (49%) of women reported eating more during pregnancy. It was also found that the majority of mothers took folic acid (63%) during their last pregnancy However, there were large differences among ethnic groups, with less than 30% of Akha mothers taking folic acid, compared to over 70% of Khamou households and nearly 90% of Lao households. Only about a quarter of women received PNC within 48 hours after delivery.

Figure 10: Mothers not receiving post-natal care within 48 hours of delivery by ethnicity



It was found that only a quarter of women received post-natal care within 48 hours of giving birth, which increased to only 10% among Akha households, and just above 20% for Hmong households. About 8% of mothers received PNC over three visits within six weeks after delivery

Figure 11: Did <u>not</u> receive health and nutrition information in the past 6 months by ethnic group



In terms of access to health and nutrition information, over 40% of mothers received information about health and nutrition in the past 6 months. Most often this information was coming from the health center (22%), followed by the district hospital (18%), and the VHV (15%). Over 98% of mothers were satisfied with the information received.

However, access to health information varied significantly between ethnic groups, with close to 50% of Lao households receiving information, compared to 60% on non-Lao households (rising to over 75% among akha houeholds).

Table 12: Percentage of Households Reporting Food Insecurity by Ethnicity

Ethnicity	Lao	7.94%
	Khamou	19.00%
	Hmong	13.80%
	Akha	18.65%
	Phong	7.27%
	Other	12.86%
	Non-Lao	15.28%

Over 14% of all households reported that they did not have enough food at some point in the last 12 months. The percentage of households reporting food insecurity varies significantly by ethnicity, with

less than 8% of Lao-Lum households reporting food insecurity, increasing to over 15% for non-Lao households, and close to 19% for both Khamou and Akha households surveyed.

Conclusions and Recommendations

Overall, there is high prevalence of underweight and stunting among children under 5 years. The poorest households, and populations from the rural areas, and ethnic minorities consistently have worse economic and human development indicators compared to wealthier, urban and ethnic-Lao populations. It was also found that current knowledge on nutrition and health is relatively low, suggesting that mothers and their children could benefit from greater information and education about health and nutrition issues.

The prevalence of stunting and underweight children under 5 was higher among non-Lao households as were reported rates of food insecurity. This indicates that the project is appropriately targeted at communities where the majority of the population is made up of non-Lao ethnic groups. It also suggests that targeted cash transfers could have a positive impact on child stunting and food insecurity at the household level.

The KAP survey also found that behavioral indicators on dietary diversity, ante natal care, and post-natal care were significantly different among ethnic groups. It was found that non-Lao groups, especially the Hmong, Akha and Phong, were likely to have less dietary diversity, and less access to ante and post-natal care. The survey also found that the same population groups had relatively limited access to health and nutrition related information that other ethnic groups. This indicates that appropriately targeted social and behavioral change campaigns could have a positive impact the behavior of mothers from these ethnic groups. However, these activities will need to be targeted to the unique circumstances of those groups, with a stronger emphasis placed on certain types of knowledge and practices, depending on the ethnic group.

It is also the case that these social behavioral change and communication activities will need to be adapted to in order to be accessible to certain ethnic groups. It will be necessary to understand whether there are specific cultural prohibitions and sensitivities around specific practices, and whether the language and medium of communication would need to be adapted in order to maximize the chance of success. To this end, a complementary qualitative KAP study will be carried out in the same project and quantitative KAP survey communities. The qualitative study will seek to better understand the current knowledge, attitudes and practices (KAP) related to perceptions of malnutrition, food consumption of mothers during pregnancy and post-partum, infant and young child feeding which includes breastfeeding, women's workload, water and sanitation, and food production and expenditures. The study will produce data that will serve as; i) complementary data to the quantitative KAP baseline data for impact evaluation of the SBCC component of HGNDP and other convergence projects and that aims to improve nutrition outcome of the target population in the selected districts, ii) beneficiary analysis to understand their knowledge, attitudes, practices, social norms, facilitating factors, and barriers regarding the nutrition amongst the different ethnic communities.