Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 01-Feb-2019 | Report No: PIDISDSA23444

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Vietnam	P161283	Investing and Innovating for Grassroots Service Delivery Reform	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	18-Feb-2019	15-May-2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Socialist Republic of Vietnam	Ministry of Health	

Proposed Development Objective(s)

The project development objective is to improve the quality and efficiency of the grassroots health system in the project provinces, with a focus on the management of select tracer conditions.

Components

Component 1: Improving the quality of commune health station infrastructure
Component 2: Improving the readiness of commune health stations to manage select tracer conditions
Component 3: Creating an enabling policy environment, piloting innovations, evaluation and project coordination

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	96.00
Total Financing	96.00
of which IBRD/IDA	80.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	80.00

IDA Credit	80.00
Non-World Bank Group Financing	
Counterpart Funding	8.00
Borrower/Recipient	8.00
Trust Funds	8.00
Integrating Donor-Financed Health Programs	5.00
Pharmaceutical Governance Fund	3.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

1. **Vietnam has achieved tremendous poverty reduction over the last decade through distributing the gains of strong economic growth equitably.** In 2014, the incidence of poverty was 13.5% (national General Statistics Office – World Bank poverty line), down from close to 60% 20 years earlier (in 1993), effectively lifting 40 million people out of poverty. Over the same period, the average consumption level of the bottom 40% grew by 6.8% annually. Inequality remained largely unchanged, with the Gini coefficient growing only slightly, from 32.6 to 34.8 over the same period. Vietnam's success in reducing poverty has been largely the result of rapid economic growth and restructuring that was also accompanied by job growth and government investments to improve public infrastructure and service delivery. The economy has transformed from a largely closed and centrally planned one to a dynamic and market oriented one, integrated and connected to the global economy. Economic growth has also been fairly resilient to a challenging global environment, with recent annual growth in excess of 6% and only moderate inflation. Vietnam reached middle income status in 2009.

2. **Poverty reduction has also been accompanied by broader welfare gains and improved living standards.** This is evidenced by the fact that Vietnam achieved most of the Millennium Development Goals (MDGs) including many of them well ahead of the 2015 MDG deadline. From 1993 to 2015, the infant mortality rate decreased from 33 to 14.7 (per 1,000 live births), while stunting fell from 61% to 24.6%. The net enrollment rate for primary school increased from 78% in 1992-93 to 93% in 2014. Access to household infrastructure has improved dramatically: by 2014, 99.2% of the population used electricity as their main source of lighting (up from 48.6% in 1993), 74% of the *rural* population had access to improved sanitation facilities (compared to 33.8% in 1993), and 89% of the *rural* population had access to clean water (compared to 62.9% in 1996). Access to these services in urban areas is well above 90%. Vietnam has also closed gender gaps along a wide range of social and economic measures (including bringing female labor force

participation within 10 percentage points of that of men). In 2015, the Human Development Index ranked Vietnam in the "medium" category with a score of 0.683.

3. **Looking ahead, Vietnam is expected to go through further social transformation, that will affect its outlook over the next 20 years, as well as potentially face economic and environmental pressures**. First, Vietnam is one of the most rapidly aging countries and the 65+ age group is expected to increase by 2.5 times by 2050. Second, while the population still largely lives in rural areas (66.1% in 2015), it has been steadily urbanizing (at about 1 percentage point a year). Expectations of the population in terms of equity in access to quality public services are also changing due to increasing incomes, access to information, and more spatial integration (global and urban-rural). Risks to development include the fragility of poverty gains, as well as the concentration of poverty in ethnic minority communities and rural, mountainous areas; environmental sources of vulnerability (such climate change, natural disasters and unsustainable exploitation of natural resources); rising fiscal pressures, including a growing fiscal deficit and a debt-to-GDP ratio that, at 62% is 15 percentage points higher than its 2015 level, and fast-approaching the 65% debt ceiling; structural constraints in the growth model, including an over-reliance on factor accumulation (compared to productivity growth); and limited private sector development. Balancing economic prosperity with environmental sustainability, promoting equity and social inclusion, and strengthening state capacity and accountability – all within a constantly evolving global and domestic context – will be challenging.

Health outcomes, access to services, and emerging health challenges

4. **Vietnam has made remarkable progress in health outcomes over the past 20 years and access to basic health services is good**. Life expectancy increased from 72.1 to 75.8 years, and is the highest in the region for countries at a similar income level. Between 1990 and 2015, the child mortality rate fell from 51 to 22 per 1,000 live births and the maternal mortality ratio fell from 139 to 54 per 100,000 live births.

5. **However, disadvantaged groups – and especially ethnic minorities and those living in poor, remote and mountainous provinces – have substantially worse access and outcomes.** In 2014, child mortality rates in rural areas (26.5 per 1,000 live births) was more than double those in urban areas (12.9) Full immunization rates are lower among disadvantaged groups, such as ethnic minority children (69.4%), the poorest quintile (72.2%), and those in mountainous provinces (such as the Central Highlands, 70.5%, and Northern Midlands and Mountains, 71.%). The proportion of births assisted by a trained staff was 68.3% among ethnic minority women and 73.4% among the poorest quintile, compared to over 95% among women in the remaining quintiles. The proportion of pregnant women having 4 or more prenatal care visits was only 32.7% among ethnic minorities and 38.6% among the poorest quintile, but rose to 67% in the second poorest quintile and to 96% in the richest quintile.

6. **Population ageing, a disease burden increasingly dominated by non-communicable diseases (NCDs), and a growing middle class will present a new set of challenges to the health system.** As previously indicated, Vietnam's population is ageing faster than most other Asian countries. This is contributing to a rapid shift in Vietnam's burden of disease towards NCDs, which increased from 46% of the disease burden (measured in DALYs) in 1990 to 74% in 2016. In 2015, cervical cancer accounted for 8.5 times more deaths than maternal causes. The single leading contributor to the disease burden is stroke, accounting for 14% of all DALYs. Leading risk factors associated with stroke (as well as with other major contributors to the disease burden) are uncontrolled hypertension, high cholesterol, diabetes, smoking, and an unhealthy diet. As Vietnam grapples with the shifting disease burden, it will also face the challenge of the rising expectations of a growing middle class which will demand better quality and more technological sophistication in health care (typically with a preference for hospital and specialist care).

Health financing and financial protection from health costs

7. **Government health spending in Vietnam is high and has been increasing over time.** The Government of Vietnam (GoV) has committed to keep the annual rate of increase of government health spending higher than the rate of increase of the general government budget (National Assembly Resolution 18/2008/NQ-QH12), with the result that health spending grew from 7.9% of government budget in 2008 to 14.2% in 2014. As a share of the budget, government spending on health in Vietnam is higher than any other low-to-middle income country in the region except China. Combined with increasing out-of-pocket health spending (see below), rising public spending means that overall health spending has also increased steeply: between 1995 and 2014, total per capita health expenditure increased more than five-fold, from 73 PPP$ to 390 PPP$. As a share of GDP, total health expenditure rose from 5.2% to 7.1% over the same period; this share is higher than all other low-to-middle income countries in the region.

8. **Out-of-pocket health spending has been rising, but increased incomes and expansions in health insurance coverage have mitigated the financial impact on households.** From 1995 to 2014, real per capita out-of-pocket health spending tripled, from US$46 to US$144 in PPP terms, but as a share of total health expenditure, out-of-pocket spending declined from 63% to 37%. GDP per capita rose almost as rapidly as out-of-pocket health spending, increasing 2.5 times in this period, with the result that out-of-pocket spending as a share of GDP declined from 3.3% in 1995 to 2.6% in 2014. Health insurance coverage also grew rapidly during this period, from 13.4% in 2000 to 87% by 2017, through a series of legal decrees to fully subsidize the health insurance coverage of the poor (2002), children (2006) and other vulnerable or meritorious groups (e.g. social assistance beneficiaries or people who had participated in the revolution) and provincial decisions to partially or fully subsidize the near-poor. Consequently, financial protection from health spending has been improving: the incidence of catastrophic health spending declined from 20.2% in 1992 to 9.8% in 2014 (when measured with a 20% threshold defined in terms of total household spending), while impoverishment due to health spending fell from 2.2% to 1.4% when using the US$3.10 per day poverty line (and 4.6% to 0.35% when using the US$1.90 per day poverty line). With these improvements, Vietnam now has similar levels of financial protection to other middle income countries.

9. **The country is no longer highly dependent on external assistance for the health sector.** In 1995, 3.5% of total health expenditure came from external assistance; this had fallen to 1.8% in 2013, but was back up to 2.7% in 2014. As Vietnam has achieved middle income country status, a number of major development partners – including GTZ, EU, the Global Alliance for Vaccines Initiative (GAVI), and the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GF) – have completed, or are busy, phasing out their assistance and working with the government to shift previously externally financed programs to government budget or health insurance. There is a need to ensure and sustain the gains made with development assistance, particularly for vertical programs (like immunization, tuberculosis, HIV/AIDS and others), especially as the country transitions away from supply-side subsidies and toward more demand-side financing through social health insurance.

10. **Fiscal pressures are driving a shift away from the use of government budget for health care, resulting in fee increases which threaten the financial sustainability of the health insurance fund and the financial protection of uninsured patients**. In 2012-2013 and again in 2016, following the introduction of the roadmap to phase in full cost recovery for government health services (Decree No. 85/2012/ND-CP), government-administered fees for health services were raised dramatically. As a result, consumer prices for medical services and pharmaceuticals rose by 45% in 2012. In 2013, they rose by a further 19%; in 2016, by 56%; and, in the first 5 months of 2017, by another 18%. These high price increases constitute a shift in the responsibility to pay for government health services from the government budget (through reduced provider subsidies) to the health insurance fund and uninsured patients. For the 13% of the population that was still not covered by health insurance by 2017, these policies present a financial risk. For the health insurance fund, the combination of price increases and a largely fee-for-service payment mechanism pose a threat to

financial sustainability. Premiums have not been raised to cover the price increases and Vietnam Social Security, which is currently in deficit, has few instruments at its disposal to effectively curb inefficient service provision and cost escalation.

Service delivery

11. **Over-reliance on hospital-centered care and over-servicing are major sources of health system inefficiency.** Vietnam's rate of hospital admissions and average length of stay are higher than regional averages and total inpatient spending is 1.42 times higher than outpatient spending. Bypassing lower levels of care is common because people generally do not have a primary provider who acts as a care coordinator to guide them through the system to get effective and appropriate care in line with their needs. Despite higher co-payment rates at higher-level hospitals to discourage bypassing, the deterrent effect has not been very strong because service prices have been substantially subsidized. With user fees now increasingly aimed at full cost-recovery, disincentives to bypassing are likely to be stronger than in the past. Public hospitals are also encouraged to raise capital from the private sector (including from their own staff) to invest in new medical technologies, and are allowed to charge higher fees for the use of the private equipment. In addition, the financial autonomy policy allows hospitals to top-up staff incomes from operating surplus, encouraging over-servicing. These factors create powerful incentives for hospitals to offer expensive, high-tech services, some of which may be medically unnecessary, but are also interpreted by patients as a signal of quality, further exacerbating bypassing and overcrowding.

12. **While relatively well-utilized in the more disadvantaged parts of the country, the grassroots health system (including commune health stations [CHSs]) is not yet sufficiently equipped or enabled to tackle the shift in the disease burden, while health financing arrangements fail to incentivize effective and coordinated care.** On average, only 23% of outpatient contacts are at the CHS or regional polyclinic, but this share reaches well over 50% in most mountainous provinces. However, the basic infrastructure, equipment and competencies are lacking in many communes. In 2016, only 69.76% of *rural* communes met the 2014 national commune health benchmarks. Moreover, those largely structural benchmarks do not provide any assurance that the CHSs are capable of appropriately dealing with specific medical condition in line with diagnostic and treatment guidelines for those conditions and in close coordination with higher-level facilities. Capacity to prevent, detect and manage chronic NCDs, identify pregnancy risks during antenatal care, and provide timely response and transport in case of obstetric emergency, for example, is weak. Creating a stronger primary care function based on a strong health professional team - patient relationship is needed to ensure continuity of care and better patient case management, while also encouraging more patients to seek care at this level rather than bypassing. Another challenge is that current provider payment arrangements do not provide the appropriate incentives to CHS health workers to make more effort to keep patients healthy or manage their diseases effectively. Staff are paid by salary, drugs are provided in-kind from the district hospital, and health insurance reimbursement at the CHS level is only for a small set of medical services and paid on a fee-for-service basis.

13. **The multiple transitions – demographic, epidemiological, health financing – through which Vietnam is going, coupled with a shift towards more horizontal integration of care, could pose some risks to the sustainability of essential public health services.** The epidemiological transition towards a disease burden dominated by NCDs, spurred by a rapidly aging population, will demand more resources for combatting conditions such as cancers, hypertension, and diabetes. This may limit further expansion of public health programs in this area of health care where success is perceived to be largely achieved. The domestic financing transition, whereby government is quickly shifting from supply-side subsidies to demand-side financing (through the expansion of health insurance coverage and through moving different "cost components" of care from government budgets to health insurance) will increase resources provided for curative care, possibly reducing the incentivize for providers to focus on preventive services. Finally, while solid

transition plans are generally in place, there remains a risk that the reduction in external financing may be challenging for those conditions/services that have traditionally been very reliant on donor support (for example, immunization where, in 2016, only 64% of financing was sourced domestically). The sustainability question is not only fiscal, i.e. whether domestic resources can fill the gap without jeopardizing access to care), but also programmatic (i.e., related to the integration and harmonization of the systems used by the donor-financed programs), which often have different procurement, financial management, human resources, and reporting arrangements.

Government strategies and plans

14. **Recent government strategies and masterplans, as well as on-going policy development, reflect an increasing awareness of these challenges and an emphasis on strengthening the grassroots health system**. The Ministry of Health (MOH) and development partners' recent Joint Annual Health Reviews (JAHR) have focused on the challenges related to the NCD burden (2014), strengthening primary health care (2015) and healthy ageing (2016). The five-year health sector plan for the period 2016-2020 includes a significant focus on strengthening of the grassroots health system (MOH Plan 139/KH-BYT of 2016). The Government's Masterplan for easing hospital overcrowding includes actions at the primary care level, including developing a family practice model, bolstering preventive medicine, and strengthening CHSs (Prime Ministerial Decision 92/QĐ-TTg of 2013). Both the National Strategy to prevent and control cancer, cardiovascular disease, diabetes, chronic obstetric pulmonary disease, asthma and other NCDs for the period 2015-2025 (Prime Ministerial Decision No. 376/QD-TTg of 2015) and the National Strategy for Population and Reproductive Health for the period 2010-2020 (Prime Ministerial Decision 2013/QD-TTg of 2011) emphasize the importance of strengthening the grassroots-level to prevent and manage NCDs and improving maternal and child health outcomes. Most importantly, in December 2016, the Government approved the Masterplan for building and developing the grassroots healthcare network in the new situation (Prime Ministerial Decision 2348/QĐ-TTg of 2016) which includes plans for both concrete (infrastructure and equipment) investment and reforms to address the above-mentioned problems, and also includes overseas development assistance (ODA) as one of the potential sources of financing for its implementation. In 2018, the new ten-year Central Party Resolution on Health Care (Resolution No. 20 NQ/TW, Oct 25 2018) underscored the emphasis on the strengthening of the grassroots health system, also referring specifically to the role of the CHS in managing NCDs. A new basic essential service package for health insurance reimbursement at the commune level, intended to expand the scope of services to include NCD interventions, is currently under development. Principles of family medicine are being promoted for CHSs and private primary care facilities. As reforms in the organization and financing of service delivery proceed, and the system attempts to address new challenges related to NCDs, care will also need to be undertaken that coverage of basic health services (such as immunization and maternal care) is sustained – and further improved.

C. Proposed Development Objective(s)

The project development objective is to improve the quality and efficiency of the grassroots health system in the project provinces, with a focus on the management of select tracer conditions.

D. Project Description

15. **The project's objectives will be achieved by investing in the grassroots health system infrastructure, ensuring the readiness of facilities to deliver services related to the tracer conditions, and implementing associated reforms and innovations.** Specifically, the project will:

a) Upgrade the CHS infrastructure by new construction, expansion, or renovation to help targeted CHS meet national standards related to facility infrastructure (Component 1),
b) Provide equipment, training, and quality management tools to strengthen the CHS' capacities in the management of tracer conditions (Component 2), and
c) Support policy reforms to improve the financial sustainability and technical quality of CHS services, pilot innovations in primary care delivery, and undertake monitoring, evaluation and implementation research activities (Component 3).

The project will organize its support around select "tracer conditions". These "tracer conditions" represent priority diseases or conditions that can be detected and treated at the commune level in line with the principles of family medicine, while also providing selective support to the district level to improve the vertical integration of care. They include:

a) *Hypertension* (new CHS role): Scope includes early detection, diagnosis, development of a treatment plan, and continuous management of uncomplicated primary hypertension.
b) *Diabetes* (new CHS role): Scope includes identification of suspected cases, referral to the District Health Center (DHC) for diagnostic confirmation and treatment plan, and continuous management and glucose monitoring of non-insulin dependent (type 2) diabetes based on the treatment plan developed by the DH/DHC.
c) *Cervical cancer* (new CHS and DHC role): Scope includes both opportunistic and population screening of eligible female (population aged 30 to age 50) for cervical cancer using visual inspection with acetic acid (VIA) method and referral to appropriate facility for cervical cancer diagnostic confirmation and treatment.
d) *Immunization and other early childhood interventions* (existing CHS role): Scope includes CHS services related to immunization, improved nutrition, and appropriate primary care for children with fever, respiratory infections, or diarrhea.
e) *Tuberculosis* (existing CHS role): Scope includes identification of suspected cases, referral of these cases to DH/DHC for X-ray, GeneXpert testing and development of treatment plan, followed by directly observed treatment, short course (DOTS) management by the CHS in line with the treatment plan.

The project will operationalize interventions related to the tracer conditions in all project provinces, but not all provinces and districts will necessarily implement all tracer conditions related to the new role of the CHS. The list of tracer conditions supported by the project may expand during project implementation.

E. Implementation

16. **A Financing Agreement and Grant Agreement will be signed between the World Bank and the Government of Vietnam for the IDA loan and grants, respectively**. For the IDA credit, a Financing Agreement will be signed by the World Bank and the Socialist Republic of Vietnam. The participating project provinces will be the project owners of the share of the loan assigned to them. For the grants, there will be one Grant Agreement that includes all grant resources, viz. grant resources from the Global Financing Facility (GFF), the Integrating Donor-Financed Health Programs Multi-Donor Trust Fund, and the Pharmaceutical Governance Fund. The MOH will be the project owner of the grants. The GFF grant, which is used to soften the interest rate, will be transferred directly from the GFF to the World Bank Treasury.

17. **The roles and responsibilities of the provinces, who will be responsible for most of project implementation and the (partial) repayment of the loan to the central government will be outlined in two sets of agreements within the GoV**. First, there will be a set of Sub-Loan Agreements, signed by the Ministry of Finance (MOF) and the respective Provincial Peoples' Committees (PPCs), specifying the amount of the IDA loan that will be on-lent to the provinces for Components 1 (infrastructure) and 2 (equipment). Second, there will be a set of Implementation Agreements, signed by the MOH and the PPCs, to cover grant-financed activities that will be carried out by the provinces under Component 2 (such as training and the quality scorecard) and Component 3.

18. **A number of bodies will be established and/or mobilized to coordinate and conduct the implementation of the project.** The MOH will have a Central Project Management Unit (CPMU) to provide overall coordination of project activities. The CPMU will be accountable to a Steering Committee chaired by the Minister or Vice-Minister of Health and consisting of senior officials in the MOF, MOH, and participating provinces. In each of the provinces, a Provincial Project Management Unit (PPMU) or a dedicated project team will be assigned to implement all the project. This PPMU/team will have staff/consultants with the expertise needed to implement project activities at the provincial level.

19. **The funds for "hard" investment (components 1 and 2a) will be transferred directly to the project provinces and implemented by the PPMU/project team**. The MOH's CPMU will be responsible for implementing Components 2b, 2c and 3 and will transfer a share of the grant resources, and provide technical assistance, to the provinces for this purpose as needed. The CPMU will also have overall responsibility for monitoring and reporting related to on project implementation progress, M&E, safeguards, and audits at both central and provincial levels.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

While the project provinces have been agreed upon, the identification of project sites districts and communes within each provinces is still underway and will only be finalized during project implementation. The fact that the project targets poorer provinces means that there will likely be a relatively high concentration of ethnic minority groups in the project provinces. Health facilities are typically located in populated areas (e.g. close to the center of a village or a town).

G. Environmental and Social Safeguards Specialists on the Team

Giang Tam Nguyen, Social Specialist
Khang Van Pham, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project involves the construction, upgrading, and operation of commune health stations (CHSs) which has the potential for adverse environmental impacts.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	The project does not have potential for any significant conversion or degradation of critical natural habitats, forests or other natural habitats.
Forests OP/BP 4.36	No	Given the location and the nature of activities, the project will not affect forests.
Pest Management OP 4.09	No	The project will not involve the production, procurement, storage, handling, or transportation of any pesticide, nor will it result in an increased use of pesticides.
Physical Cultural Resources OP/BP 4.11	No	It is not expected that the project will require relocation of physical cultural resources (PCRs) such as monuments, temples, churches, religious/spiritual and cultural sites. However, there is a chance that civil works might result in chance finds. A chance find procedure has been included in the ECOP which will be included in the bidding documents and civil works contracts.
Indigenous Peoples OP/BP 4.10	Yes	Some of the project provinces have a high concentration of ethnic minority groups.
Involuntary Resettlement OP/BP 4.12	No	The construction and renovation of CHSs will not require new land acquisition, land clearance, or resettlement; they will be constructed within the existing land of the CHSs or communes. CHS sites will be screened for any land acquisition or resettlement impacts as part of the E&S screening process included in the ESMF.
Safety of Dams OP/BP 4.37	No	The project will not involve the construction or rehabilitation of dams nor would it affect or depend on the safety of any existing dam.
Projects on International Waterways OP/BP 7.50	No	The project will not be implemented in any international waterways.
Projects in Disputed Areas OP/BP 7.60	No	No part of the project will be implemented in a disputed area.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The project is classified Category B and triggers the policy on Environmental Assessment (OP/BP 4.01). While the project's overall impact will be positive, it may have adverse environmental and social impacts related to the construction and operation of commune health stations (CHSs). The civil works associated with the construction and renovation of commune health stations (CHSs) may involve dust, noise, vibration, wastes, traffic disturbance, communicable diseases transmission, and accident and incident risks. In addition, construction activities may also cause a temporary interruption of local people's access to health care services. Given the small scale and simplicity of the CHS civil works financed by the project, construction-related impacts are considered small, temporary, localized, and can be mitigated. Regarding the operation of the CHSs, some adverse impacts are also anticipated, such as the generation of healthcare waste (HCW). According to MOH's surveys, the amount of healthcare waste generated from a CHS is small, approximately 0.5 kg of solid hazardous HCW and 1-2 cubic meter of wastewater per day with characteristics similar to domestic wastewater. Nevertheless, environmental risk related to CHS operation is considered moderate given the hazards of solid hazardous HCW and exposure to infection and diseases.

From a social safeguard perspective, the project is expected to bring positive health benefits to local people in the project sites, especially ethnic minority people in disadvantaged and remote areas. The Social Assessment (SA) shows that generally respondents valued the CHSs, especially thanks to the convenience, cost and timeliness of their services. Familiarity with CHSs health staff was another important factor (fewer language barriers and a greater degree of comfort when being seen by the healthcare providers). The SA also confirmed that the tracer conditions prioritized by the project are aligned with the communities' perceptions of the disease patterns in the project sites. Gynecological diseases and child malnutrition were cited as common diseases among the ethnic minority groups, while home delivery remains common and hypertension and diabetes are emerging concerns.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

The operation of CHSs is envisaged to generate healthcare waste (HCW).

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

None.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

An Environmental and Social Management Framework (ESMF) has been prepared by the Ministry of Health (MOH) in accordance with OP 4.01. This approach is used because the project involves a series of subprojects whose details will not have been identified at project appraisal. The ESMF sets out the principles, rules, guidelines and procedures to assess the environmental and social impacts. It also contains measures and plans to mitigate such impacts with provisions for estimating and budgeting the costs of such measures, and information on the agencies responsible for addressing project impacts.

The ESMF includes an Environmental Code of Practice (ECOP) that provides a set of generic mitigation measures to address generic construction-related impacts associated with upgrading and construction of CHSs given the small scale and simplicity of civil works supported under the project. The ESMF also describes the process of identification of site-specific impacts associated with civil works of CHSs and designing corresponding mitigation measures (which will be carried out during technical preparation of the subprojects). The ESMF mandates that if a subproject has potential moderate adverse impacts, an Environmental and Social Management Plan (ESMP) must be developed to manage such impacts. The ESMP is subject to the Bank's review and clearance and must be publicly disclosed prior to the subproject appraisal. ESMP/ECOP and site-specific mitigation measures must be incorporated into bidding documents and construction contracts. Construction contractors are required to comply with the contract provisions and ESHS requirements set out in the Standard Procurement Document (SPD). Particularly, measures to mitigate a temporary interruption of the provision of care during construction must be developed, based on consultations with CHS manager, project technicians, and local authorities.

During operation, health care facilities should establish, operate and maintain a healthcare waste management system (HWMS) adequate to the scale and type of activities and identified hazards. Planning and budgeting for HCW management activities should be done for each project CHS. Medical staff of CHS should be trained regularly in accordance with Decision No. 43/2007/QD-BYT and Joint Circular No. 58/2015/TTLT-BYT-BTNMT on healthcare waste management. CHSs need to carry out healthcare waste and health risk management, such as waste minimization, reuse, and recycling; on-site waste handling and segregation; waste collection, transport and storage; treatment and disposal options; exposure to infections/diseases; exposure to hazardous materials and waste.

Based on the findings of the SA and public consultations, an Ethnic Minority Planning Framework (EMPF) has been developed to provide guidance for the preparation of Ethnic Minority Development Plans (EMDPs) in project provinces with ethnic minority groups. The EMPF will help to ensure that: (i) affected ethnic minority peoples receive culturally appropriate social and economic benefits; and (ii) where there are potential adverse effects on ethnic minority peoples, the impacts are identified, avoided, minimized, mitigated, or compensated for. The EMPF will be disclosed locally in Vietnam and the Bank's internal and external websites prior to appraisal. The EMPF and EMDPs will be disclosed in the same places after having been cleared by the Bank.

Borrower capacity and capacity building: The MOH has implemented many Bank-financed projects and it is familiar with the Bank safeguard policy requirements. However, the individual staff assigned (or hired) into the Central Project Management Unit (CPMU) of the MOH may not be. In addition, it is unlikely that the personnel of all Provincial Project Management Units (PPMUs) will be familiar with the Bank safeguard policy requirements. Thus, safeguards training will be provided by the Bank team to designated CPMU and PPMU safeguard staff at an early stage of project implementation and repeated annually as necessary. Safeguards training covers the following aspects (i) the scope of application and objectives of the Bank safeguard policies applicable to the Project, (ii) safeguard instruments preparation and implementation, (iii) specific training on EMDP and implementation including the application of Grievance Redress Mechanism (GRM), (iv) Environmental, Social, Health and Safety (ESHS) requirements in Standard Procurement Document (SPD), Contractor's Environmental and Social Management Plan (C-ESMP) preparation and ESHS compliance, and (v) safeguard performance monitoring and reporting expertise.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

During project preparation, consultations with key stakeholders at central and provincial levels, including MOH's

Health Environment Management Agency (HEMA) and the Departments of Health (DOH) of representative project provinces of Son La, Quang Binh and Bac Lieu, on the ESMF, were carried out by the MOH. In addition, public consultations with the central and provincial health authorities and local people, including those from ethnic minority groups, were carried out during preparation of the SA in Son La, Quang Tri, and Tra Vinh, and will be continued throughout the project cycle. All comments and recommendations from key stakeholders have been taken into account in project design and finalization of the ESMF and EMPF. The draft ESMF and EMPF in English were publicly disclosed on the Bank's external website on 28th February 2018 and MOH's website in Vietnamese language on March 5th, 2018. During project implementation, at the subproject level, consultations with key stakeholders including CHS operators and staff, patients, locally-affected people, members from local ethnic minority groups, and local NGOs will be conducted at an early stage. The PPMUs will ensure that the subprojects' information, environmental and social risks, and mitigation measures will be provided to consulted groups prior to consultations in language that is easy to understand. Comments and recommendations received during consultations will be taken into account in subproject design. Consultations with such groups will continue to be conducted as needed during subproject implementation.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
28-Feb-2018	28-Feb-2018	

"In country" Disclosure

Vietnam
05-Mar-2018

Comments

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure
28-Feb-2018	28-Feb-2018

"In country" Disclosure

Vietnam
05-Mar-2018

Comments

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
Yes
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?
Yes
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?
Yes

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?
Yes
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?
Yes
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?
NA

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes

Have costs related to safeguard policy measures been included in the project cost?
Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

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APPROVAL

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