THE MINISTRY OF HEALTH

ETHNIC MINORITY PLANNING FRAMEWORK

THE 'INVESTING AND INNOVATING FOR GRASSROOTS SERVICE DELIVERY REFORM' PROJECT

NOVEMBER 2018

Abbreviations

CPC	Commune's People's Committee
CPMU	Central Provincial Management Unit
DPC	District's People's Committee
EM	Ethnic minorities
EMPF	Ethnic Minority Planning Framework
EMDP	Ethnic Minority Development Plan
GRM	Grievance Redress Mechanism
HH	Household
HR	Human resources
ID	Identification
PPC	Provincial People's Committee
SA	Social assessment
WB	World Bank

Table of Contents

I. INTRODUCTION

1.1. The project background

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.[1] Between 1990 and 2015, the child mortality rate fell from 51 to 22 per 1,000 live births[2] and the maternal mortality ratio fell from 139 to 54 per 100,000 live births.[3] In 2014, the proportion of births assisted by a trained staff was 93.8%[4] and the proportion of pregnant women receiving 4 or more antenatal care visits was 73.7% [5]. In 2015, the nationwide full immunization rate was 97.1% and exceeded 95% in 53 out of Vietnam's 63 provinces[6]. In 2014, 7.5% of people (7.8% in rural and 6.7% in urban areas) had at least one inpatient visit, while 33.5% (32.9% in rural and 34.9% in urban) had an outpatient visit in the previous 12 months[7].

However, disadvantaged groups – and especially ethnic minorities (EMs) 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); child mortality rates in the remote mountainous provinces exceeded 50 but were less than 20 in the delta provinces.[8] Similarly, while the national under-five stunting prevalence was 24.6%, it reached over 35% in some remote mountainous provinces.[9] Full immunization rates fall to as low as 70% among disadvantaged groups, such as EM 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.%)[10]. The proportion of births assisted by a trained staff was 68.3% among EM women and 73.4% among the poorest quintile, compared to over 95% among women in the remaining quintiles. [11] The proportion of pregnant women having 4 or more prenatal care visits was only 32.7% among EMs and 38.6% among the poorest quintile, but rose to 67% in the second poorest quintile and to 96% in the richest quintile.[12]

---

1 World Development Indicators 2017.

2 UN Inter-Agency Group for Child Mortality. 2015. Estimation. Levels and Trends in Child Mortality Report 2015. New York. UNICEF.

3 Alkema, Leontine, et al. 2016. "Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group." The Lancet 387.10017 (2016): 462-474.

4 General Statistics Office and UNICEF. 2015. Viet Nam Multiple Indicator Cluster Survey 2014, Final Report. Ha Noi, Viet Nam.

5 General Statistics Office and UNICEF. 2015. Viet Nam Multiple Indicator Cluster Survey 2014, Final Report. Ha Noi, Viet Nam.

6 These estimates are from administrative data. By contrast, household survey data show a full immunization rate of 82.4% (Multiple Indicator Cluster Survey 2013/14)

7 General Statistics Office. Result of the Vietnam Household Living Standards Survey 2014. Hanoi: Statistical Publishing House. 2016.

8 General Statistics Office. 2016. Statistical Yearbook of Vietnam 2015. Hanoi: Statistical Publishing House. (Table 35).

9 National Institute of Nutrition. 2016. Statistical data on child malnutrition 2015. http://viendinhduong.vn/news/vi/106/61/0/a/so-lieu-thong-ke-ve-tinh-trang-dinh-duong-tre-em-qua-cac-nam.aspx.

10 General Statistics Office and UNICEF. 2015. Viet Nam Multiple Indicator Cluster Survey 2014, Final Report. Ha Noi, Viet Nam.

11 General Statistics Office and UNICEF. 2015. Viet Nam Multiple Indicator Cluster Survey 2014, Final Report. Ha Noi, Viet Nam

12 General Statistics Office and UNICEF. 2015. Viet Nam Multiple Indicator Cluster Survey 2014, Final Report. Ha Noi, Viet Nam

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. 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. In this context, the Ministry of Health (MoH) and the World Bank are preparing the *Investing and Innovating for Grassroots Service Delivery Reform Project* to improve the efficiency of the grassroots health system.

1.2. Higher Level Objectives to which the Project Contributes

The project will support the GoV in the strengthening and reform of PHC, which is a major strategic direction for the health sector. It will contribute to the realization of various of the government's PHC-related strategies and plans such as the Grassroots Masterplan, the Masterplan for Reducing Hospital Overcrowding, various disease-specific strategies (for example, for reproductive health and for NCDs), and on-going reforms related to the benefit package and health financing arrangements. Through investing in grassroots infrastructure as well as the scope and quality of CHS services, the project will help ensure readiness to shift service delivery from hospitals down to lower-cost facilities, increase the utilization of closer-to-home PHC services (especially for NCDs) on a timely basis and, thus, lower health care costs and increase the financial sustainability of the health system.

1.3. Project development objectives

In order to enhance overall health system efficiency, the project development objective is to improve the quality of the commune health system in the targeted provinces, including to take on a new role in the management of selected NCDs while maintaining historical strong performance in services related to maternal and child health (MCH) and infectious disease.

1.4. Project specific objectives

This project aims to strengthen the quality and efficiency of the grassroots (district and commune) health system in the project provinces. The grassroots system should be the foundation of the health care system, providing essential primary care (primary and secondary prevention) to the population. Right now, care provided at this level is often of inadequate quality and patients frequently bypass this level, resulting in an efficient service delivery structure that is overly hospital-centric**.** The project aims to improve the quality and efficiency of the grassroots system by enabling the CHS to take on a new role in managing non-communicable diseases (including hypertension, diabetes, and cervical cancer), while strengthening their existing role in managing infectious disease (including through immunization) and providing maternal and child health services.

Family medicine principles, which emphasise continuity of care and collaboration among different levels, will guide service delivery. Family medicine principles now form the basis of training for grassroots health professionals in Vietnam. In line with these principles, the project will seek to build stronger teamwork within facilities, horizontal integration across services, and vertical integration of service delivery across commune (health center) and district (hospital) levels. One example is having the commune level play a role in ensuring that children who are not born in facilities (hospitals) also get birth doses of vaccines. Another example is combatting the spread of drug-resistant TB by setting up a system whereby samples can be transported from commune-level to district hospital-level for MDR-TB testing.

1.5. Beneficiaries of the project

The project is pro-poor in terms of geographic scope. It will be implemented in 12 disadvantaged provinces, as well as 2 "frontrunner" provinces which were selected for their capacity to implement more ambitious reforms and innovations. Transparent, pro-poor criteria were used to identify the

project provinces. First, exclusion criteria eliminated (i) the provinces that will be covered by the Asian Development Bank's (ADB) grassroots health project and (ii) the five major municipalities/cities because they are economically better off. Second, inclusion criteria were applied, namely that (i) at least two-thirds of project provinces should be among the poorest provinces (using the multi-dimensional poverty indicator), (ii) the provinces should represent the three main regions of Vietnam, and (iii) the provinces should be willing and able to participate in the project (which includes accepting the on-lending ratios applied by the MOF and not have exceeded their provincial debt ceilings). The 12 disadvantaged provinces are Ha Giang, Bac Kan, Son La, Yen Bai, and Hoa Binh (in the north), Quang Binh, Quang Tri, Quang Ngai, and Ninh Thuan (in the central region), and Tra Vinh, Hau Giang and Bac Lieu (in the south). The 2 frontrunner provinces are XXXX (in the central region) and Long An (in the south). All but one of the project provinces have poverty rates above the national average, 5 of the project provinces have poverty rates exceeding 2.5 times the national average. Within the selected provinces, the project will prioritize investing in CHS located in rural, remote communes (zones 2 and zones 3) that have not met the national CHS benchmarks.

The project will benefit all population groups in the selected project provinces, but children, women, the elderly, the poor and ethnic minorities are expected to benefit more than others. This is both because of the nature of the project interventions and the geographic location of the project provinces. Looking across the life-cycle and by gender, the grassroots health system tends to be used mainly by women of child-bearing age and young children (because the CHS have historically focused on reproductive and child health services), and also by the elderly (because the CHS are located within the community and are convenient and inexpensive for older people with limited mobility and financial means to use). That said, by expanding the CHS's role to also include the management of NCDs, the project will likely also lead to increased utilization of CHS by men (and even more elderly people) than before, thus helping to reduce the gender gap in utilization of basic CHS-level primary care services. The project will also disproportionately benefit EM populations, both because the targeted project provinces have higher concentrations of EM populations than most other provinces and because ethnic minorities tend to use the CHS for a greater share of their outpatient health visits than do the majority Kinh or Hoa population. Finally, the criteria for selecting project provinces, for selecting communes within project provinces, and the fact that poor people are more likely to use CHS services than better off people ensures that the project will be strongly pro-poor. Evidence for the utilization patterns described can be found in household surveys of health service utilization.

1.6. Project components

The project is financed by a combination of an IDA loan, various grants (from multilateral development partners, bilateral development partners, and the private sector), and counterpart financing, with a total value of 118 million USD. The project will include three components:

Component 1: Ensure service availability through improving the CHS infrastructure: This component will improve the quality of CHS infrastructure in the project provinces so that the CHS meet the national standards for CHS infrastructure. Targeted CHSs will be upgraded through either new construction, expansion, or renovation to a level that is sufficient to reach the infrastructure standards of the "commune benchmarks"[13] set by the MOH in 2002[14]. Within each province, the specific CHS targeted for investment will be based on provincial plans and complemented by a set of criteria that will help to improve the efficiency and equity of project investments.

Component 2: Ensure that facilities are equipped to deliver the tracer conditions and improve the

[13] The commune benchmarks include items related to infrastructure, equipment, and investment. Consequently, the reason that a particular CHS has not reached the benchmarks could be due to inadequacies in infrastructure, or equipment, or human resources.

[14] If new standards are approved by CHS, then these will apply to the project sites.

quality of care provided: This component will support the equipment, training and other "soft activities" needed for the CHS, with the support of the DH/DHC, to manage the tracer conditions and improve the overall quality of care delivered. Essential equipment will be procured to enable the CHS and DHC to manage the tracer conditions. In addition, for child health (immunization), the component will also support improvements in the vaccine cold chain and, in so doing, leverage further support from GAVI. For tuberculosis (TB), the project will also help to combat the threat of Multi-Drug-Resistant (MDR)-TB by increasing the availability of GeneXpert testing at the district level. This component also seeks to improve the competencies of grassroots health workers to provide services associated with the tracer conditions, in line with the principles of family medicine. The project will support the implementation of quality scorecards as an intervention to monitor and improve quality of care.

Component 3: Creating an enabling policy environment, piloting innovations, evaluation and project coordination

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. The five tracer conditions which will be at the core of the project's activities include *hypertension* (new CHS role); *diabetes* (new CHS role); *cervical cancer* (new CHS and DHC role); *Immunization and other early childhood interventions* (existing CHS role); and *Tuberculosis* (existing CHS role). 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. All participating project provinces and their districts will implement activities related to strengthening their existing roles. All project provinces, but not necessarily all of their districts, will take on the new role of managing hypertension and diabetes (within the project period). At least a sub-set of the project provinces will take on activities related to cervical cancer screening.

1.7. The Objectives of an Ethnic Minority Planning Framework

Bank's OP 4.10 requires that when the project involves the preparation and implementation of annual investment programs or multiple subprojects, but the presence of EM in the subproject area could not be determined until the programs/subprojects are identified during project implementation, the project owner has to prepare an Ethnic Minority Planning Framework (EMPF).

This EMPF provides guidance on how an Ethnic Minority Development Plan (EMDP) for a program/subproject should be prepared. It helps, on the basis of consultation with affected EM in the subproject areas, ensure (a) affected EM peoples receive culturally appropriate social and economic benefits; (b) when there are potential adverse effects on EM, the impacts are identified, avoided, minimized, mitigated, or compensated for.

This EMPF is prepared by MoH in accordance with Bank's OP 4.10. It was developed on the basis of a) social assessment report (conducted during project preparation), b) consultation exercises conducted by MoH with the various project stakeholders, and ethnic minorities residing in the project area. This EMPF will be applied to all subprojects/investments identified during project implementation of the project.

II. ETHNIC MINORITIES IN VIETNAM AND IN PROJECT PROVINCES

2.1. General information on EM groups in Vietnam

Vietnam is a multi-ethnic country with 54 different ethnic groups who have formed the language, lifestyle and cultural characteristics of their nation for a long time. The Kinh people (also known as the Viet ethnic group) are the majority group, accounting for 85% of the population in the country. According to the survey data on 53 EMs in 2015, the total population of 53 EMs is about 13.3 million people, accounting for 15% of the population in the country. Among the EMs in Viet Nam, some live in deltas, such as Cham, Khmer, and Hoa, mainly in the South West and Southern Central Region. The remaining 50 EMs reside in the midland and high mountains in the North, Central and Central Highlands.

Some EM groups have a population of over one million people, such as Tay, Thai, Muong, Khmer, and Hmong. As many as 14 EM groups have a population of over 100,000 people; 34 EM groups have a population of less than 100,000, of which 16 EM groups have a population of less than 10,000 and five have less than 1,000 people, such as Si La, Pu Peo, Brau, Ro Mam, and O du.

One of the barriers to accessing health care services for EM groups is their customs and limited awareness of health care practices. On the other hand, the infrastructure and quality of primary care services at the grassroots level are poor. According to MoH's assessment of the quality of medical examination and treatment services at the grassroots level, although Viet Nam has gained some achievements in maternal and child health care after 30 years of the renovation process, the inequalities in the health outcomes in EM ethnic minorities areas are still very different from those of the majority population. Child mortality among EM groups is three times higher than that of Kinh/ Chinese children. The incidence of low birth weight, stunting, prevalence of antenatal clinic visits, or birth rates in health facilities varies between EM areas and urban ones. According to MoH's statistics in 2014, the grassroots health network in the northern mountains was facing many difficulties. Out of more than 2,560 CHSs, 78 are housed in temporary houses; over 2,200 CHSs have been degraded. The percentage of doctors working at CHSs was lower than that in the lowlands. To improve the quality of grassroots health services for mountainous areas to meet health care needs of EM communities is one of the key priorities of the sector health.

According to UN Women's Report on Gender Equality in Viet Nam in 2016, adolescent births were a concern as they posed a big threat to the health of young women and their babies. This issue is also linked to early marriage and child marriage, early dropouts, lack of services for adolescents and young people. According to the Viet Nam Assessment of Targets for Children and Women, the birth rate for women aged 15-19 was 45 births per 1,000 women, of which the proportion in rural areas doubled that in urban areas (56 births per 1,000 rural women, compared to 24 in urban areas). Adolescent pregnancies are also related to economic conditions, residence and ethnicity, with a higher proportion among the poorest quintile, and among women in the midland and Northern mountainous areas and Central Highlands, where EM groups are concentrated and where teenage births are about three times higher than in other regions due to the practice of early marriage and child marriage (GSO and UN women, 2016). The Mekong River Delta, the Red River Delta, and the North Central Coast and Central Coast had the highest rates of contraceptive use, while in the upland areas, such as in the Northern Midlands and Mountains and the Central Highlands, the contraceptive prevalence was much lower. The percentage of EM women using any contraceptive method (70.6%) was lower than that of Kinh and Chinese women (76.6%), but interestingly, EM women tended to use more modern contraceptives than Kinh and Chinese women (GSO and UN women, 2016).

Many studies have shown that there are many obstacles against EM women when it comes to reproductive health services, especially for EM groups residing in mountainous areas, such as Hmong, Ha Nhi, and Lo who have very difficult living conditions. The barriers include low education level, low income, limited awareness of individuals, families and communities, influence of customary factors on decision-making behavior and participation in using health services. But the most important barrier is constraints in service delivery, especially medical examination and treatment. The use of health insurance cards has made EM women less accessible to health insurance. It is becoming more difficult to have access to the services they should benefit from. Meanwhile, health care policies remain general

and no new efforts have been made to bring health care services, especially reproductive health care services, to EM women, especially those with extremely difficult regions. Some EM women in the northern mountainous areas still give birth at home with the help of relatives. This is a customary habit and difficult to change. Research results from the Institute of Ethnology and Dam Khai Hoan and associates (2013) show that almost all of H'mong women giving birth at home (98.9%). The proportion of mothers receiving antenatal care and vaccination is lower in the Hmong and Dao than in the Tay and Thai. According to this observation, Tran Mai Oanh et al. (2012) found that 81% of the poor attended CHSs, and 47% did not attend antenatal care during pregnancy, and the percentage of mothers giving birth at home is still high, with only 30% of births using clean delivery packages. Research results from the Center for Community Health Research and Development show that access to health services for reproductive health care among EM women has not been improved. Home delivery rates have dropped by only 6.9% while child and maternal malnutrition rates remain above 20%[15].

2.2. Ethnic minorities in project provinces

Some project provinces have high rates of EM populations. For example, Tra Vinh and Bac Lieu are inhabited by Khmer; Ninh Thuan by Cham and Raglai, Quang Tri and Quang Binh by Bru Van Kieu, Ta Oi, Co Tu and Chut groups. The northwestern provinces of Son La, Hoa Binh, and Yen Bai have Thai, Muong, Tay, Hmong, and Dao.

The EM people residing in the project provinces can represent 53 EM groups in Viet Nam, for example, the Khmer, Muong, and Thai representing EM groups with more than one million, and Chut representing EM groups with less than 10,000 people, and Ta Oi, Co Tu, and Chut representing EM groups with very difficult socio-economic conditions.

III. THE LEGAL AND POLICY FRAMEWORK

This section provides a framework for ensuring that the affected ethnic minorities (equivalent to the indigenous peoples as defined in OP 4.10) has equal opportunity to share the project benefits, that free, prior and informed consultation will be conducted to ensure their broad-based community access and support to the project are obtained, and that any potential negative impacts are properly mitigated and the framework will be applied to all the subprojects. It provides guidance on how to conduct preliminary screening of ethnic minorities, social assessments, and identification of mitigation measures given due consideration to consultation, grievance redress, gender-sensitivities, and monitoring. An outline of the EMDP report is provided in Annex 1.

In terms of consultation and participation of ethnic minorities, when the subprojects affect EMs, the affected EM peoples have to be consulted in a free, prior, and informed manner, to assure:

(a) EM and the community they belong to are consulted at each stage of subproject preparation and implementation,

(b) Socially and culturally appropriate consultation methods will be used when consulting EM communities. During the consultation, special attention will be given to the concerns of EM women, youth, and children and their access to development opportunities and benefits; and

[15] Center for Community Health Research and Development, Mid-Term Review of the Project to Improve Maternal and Child Health through Eradication of Health Behaviors, 2013

(c) Affected EM and their communities are provided, in a culturally appropriate manner at each stage of subproject preparation and implementation, with all relevant project information (including information on potential adverse effects that the project may have on them.

3.1. Key legislative documents relating to ethnic minorities

The existing legal framework has reflected that the Communist Party and the Government of Vietnam has always placed the issue of ethnicities and ethnic affairs at a position of strategic importance. Citizens from all ethnicities in Vietnam enjoy full citizenship and are protected through equally enforced provisions according to the Constitution and laws, as listed in the framework. The underlying principle of the framework is 'equality, unity, and mutual support for common development', with priorities given to 'ensuring sustainable development in ethnic minorities and mountainous areas'.

The Constitution strongly commits to equality for ethnic minorities. In particular, Article 5 proclaims all ethnicities to be equal, prohibits discrimination by ethnicity, asserts the right of ethnic minorities to use their own languages, and commits the state to implementing a policy of comprehensive development for ethnic minorities. Other parts of the Constitution specifically prioritize ethnic minorities in policies for health care and education.

The fundamental principle has been institutionalized in laws, Government decrees and resolutions and the Prime Minister's decisions, which can be divided into three following categories by: (i) ethnicities and ethnic groups; (ii) by geographical areas (for socio-economic development); and (iii) by sectors and industries (for socio-economic development), such as support for production, poverty reduction, vocational training and job creation, protection of the eco-environment, preservation and promotion of culture and tourism, communication, and awareness raising in legal issues and legal aid.

In terms of the national legal framework, equality and rights of ethnic people was stipulated clearly in the Vietnam Law. Article 5 in the Vietnam Constitution (1992) is as follows: the Socialist Republic of Vietnam is a united nation having many nationalities. The State implements a policy of equality and unity and supports the cultures of all nationalities and prohibits discrimination and separation. Each nationality has the right to use its own language and characters to preserve their culture and to improve its own traditions and customs. The State carries out a policy to develop thoroughly and gradually improve the quality of life of ethnic minorities in Vietnam physically and culturally.

Decree No. 05/2011/ND-CP (January 14th, 2011), provides the guidance for activities related to EMs which include support for the maintenance of language, culture, customs and identities of every Ethnic Minorities. Article 3 of that decree lays out general principles when working with EM peoples as follows:

- To implement the EM policy on the principles of equality, solidarity, respect and mutual assistance for development;
- To assure and implement the policy on comprehensive development and gradual improvement of material and spiritual life for EM people;
- To assure preservation of the language, scripts and identity, and promotion of fine customs, habits, traditions and culture, of each EM group; and
- An EM group shall respect customs and habits of other groups, contributing to building an advanced Vietnamese culture deeply imbued with the national identity.

The document of the Government on the local democracy and citizen participation is directly related to EMPF. Ordinance No. 34/2007/PL-UBTVQH11 dated April 20th, 2007 of the Standing Committee of the National Assembly, of the 11th National Assembly on exercise of democracy in communes, wards and townships had provided the basis for the participation of the community in preparing the development plans and the supervision of community in Vietnam. Decision No.80/2005/QD-TTg of the Prime Minister dated April 18th, 2005 on investment supervision by the community.

3.2. The policies relating to healthcare for poor and EM households:

The Government's Decision No.135/1998/QD-TTg, dated July 31st, 1998 approved "*The socio-economic development programme for the extremely difficult mountainous and remote communes*". Accordingly, those people who live in the extremely difficult area in mountainous and remote areas will receive adequate support in health examination and treatment.

Resolution No. 18/2008/QH12, issued by the National Assembly, stipulated the acceleration of the performance of socialization policies and laws to promote the quality of health care service for the people. The National Assembly made a directive to increase the rate of annual budget expenses for health care, ensuring that the rate of increase of expenses for health care is higher than the average expense increase of the national budget. At least 30% of the health budget should be spent on preventive health. It also includes a budget line for health care for the poor, farmers, EM groups and the people in the regions with difficult and extremely difficult socio-economic conditions.

On October 15th, 2002, the Government enacted Decision No.139/QD-TTg on "*health check-up and treatment for the poor*" applicable to all people who are the poor and who live in extremely difficult regions under Program 135, and EM groups. They will be entitled to free health check-up and treatment. The fund of this program will come from national and local budgets (accounting for 75%) and organizations and individuals's contributions.

Thank to enforcement of Decision 139, health care for the poor and EM peoples has been greatly improved. Relevant provinces established funds for check-up and treatment for the poor. In extremely difficult provinces in the North Central Region, due to a high rate of EM people and people living in the areas under Program 135, the number of beneficiaries of Policy 139 is high. As the performance of health check-up and treatment for the poor has improved, the number of patients visiting health facilities has been increasing significantly. This becomes a great challenge for poor provinces in the North Central Region because of limited state budgets in the context of increasing demand for health check-up and treatment from the poor in the region.

Decision 139 has significantly improved healthcare conditions for the poor, especially those in mountainous areas and from EM groups. However, access to health care services of the poor and EM groups in the Northern Central Region is still difficult. The poor cannot go to health care facilities because they cannot afford transport costs or caring costs for patient, or they cannot access modern health care services at central and provincial health care establishments. Meanwhile, at the district level, medical equipment and facilities are inadequate, and human resources are not satisfactory in both quantity and quality to provide adequate examination and treatment for local people in general, and for the poor and EM people in particular.

The Vietnamese Government has made considerable efforts to improve access to health care services for poor EMs and people in EM areas. Health care policies have been comprehensive, covering health care infrastructure, human resources, education, and communication (to raise awareness of preventive health), and provision of insurance cards.

Decree 39/2015/NĐ-CP, dated April 27, 2015, stipulated support for women from poor EM households who follow the national population policy on the number of children.

In his Decision No. 122/QĐ-TTg, dated January 10, 2013, the Prime Minister approved the National Strategy for Protection, Care and Improvement of Public Health for the 2011- 2020 Period, with Vision to 2030. The Strategy states the objective to "ensure that all people, especially the poor, EMs, under-six children, people entitled to preferential treatment, people living in disadvantaged and remote areas and vulnerable groups can access to quality basic healthcare services".

Resolution No. 20/NQ-TW, dated October 25, 2017, issued by the Central Party Committee, 12th tenure, stipulated the strengthening of the protection, care and improvement of public health in the new situation. Under this resolution, one of the tasks to renovate grassroots healthcare service is to

deliver activities to prevent and combat non-communicable diseases (NCDs), with due attention to preventive healthcare and capacity building for screening and early detection and control of diseases as well as strengthened management and treatment of NCDs, chronic diseases and long-term care at the grassroots level.

3.3. The World bank's policy toward the ethnic minorities (OP 4.10)

The WB's Operational Policy 4.10 (Indigenous Peoples) requires engagement in a process of free, prior, and informed consultation[16]. The Bank provides project financing only where free, prior, and informed consultation results in broad-based community access and support to the project by the affected Indigenous Peoples. Such Bank-financed projects include measures to (a) avoid potentially adverse effects on the Indigenous Peoples' communities; or (b) when avoidance is not feasible, minimize, mitigate, or compensate for such effects. Bank-financed projects are also designed to ensure that the Indigenous Peoples receive social and economic benefits that are culturally appropriate and gender inclusive.

The Policy defines that EM peoples can be identified in particular geographical areas by the presence in varying degrees of 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 are separate from those of the dominant society and culture; and
d) an indigenous language, often different from the official language of the country or region.

As a prerequisite for an investment project approval, OP 4.10 requires the borrower to conduct free, prior and informed consultations with potentially affected EM peoples and to establish their broad-based community access and support to the project objectives and activities. It is important to note that the OP 4.10 refers to social groups and communities, and not to individuals.

3.4. Consultation and participation of EMs people at each stage of the project

This section provides a framework for ensuring that the affected EMs (equivalent to the indigenous peoples as defined in OP 4.10) has equal opportunity to share the project benefits, that free, prior and informed consultation will be conducted to ensure their broad-based community access and support to the project are obtained, and that any potential negative impacts are properly mitigated and the framework will be applied to all the subprojects. It provides guidance on how to conduct preliminary screening of EMs, and identification of mitigation measures given due consideration to consultation, grievance redress, gender-sensitivities, and monitoring. An outline of the EMPF is provided in Annex One.

In terms of consultation and participation of ethnic minorities, when the subprojects affect EMs, the affected EMs peoples have to be consulted in a free, prior, and informed manner, to assure:

(a) EM and the community they belong to are consulted at each stage of subproject preparation and implementation,

[16]Free, prior, and informed consultation with the affected Indigenous Peoples' communities" refers to a culturally appropriate and collective decisionmaking process subsequent to meaningful and good faith consultation and informed participation regarding the preparation and implementation of the project. It does not constitute a veto right for individuals or groups.

(b) Socially and culturally appropriate consultation methods will be used when consulting EM communities. During the consultation, special attention will be given to the concerns of EM women, youth, and children and their access to development opportunities and benefits; and

(c) Affected EM and their communities are provided, in a culturally appropriate manner at each stage of subproject preparation and implementation, with all relevant project information (including information on potential adverse effects that the project may have on them.

During project implementation, as a principle of ensuring inclusion, participation and cultural suitability, the project should hold continuous consultations including soliciting feedback from all communities so that remedial actions can be taken to support improved participation and provision of benefits to households including those of EMs. The consultation methods to be used are appropriate to social and cultural traits of EM groups that the consultations target, with particular attention given to land administrators, household land users, village leaders and other service providers related. The methods should also be gender and inter-generationally inclusive, voluntary, free of interference and non-manipulative.

The process of consultation should be two-way, i.e. both informing and discussing as well as both listening and responding. All consultations should be conducted in good faith and in an atmosphere free of intimidation or coercion, i.e. without the presence of those people who may be intimidating to respondents. It should also be implemented with gender inclusive and responsive approaches, tailored to the needs of disadvantaged and vulnerable groups, enabling incorporation of all relevant views of affected people and other stakeholders into decision making.

IV. PREPARATION OF AN EMDP

An EMDP should be developed on the basis of consultation with EMs in the project areas. Consultation is important to preparation of an EMDP since it provides EMs groups (both potentially affected and not affected by subprojects) with opportunities to participate in planning and implementation of subprojects. More importantly, it helps identify potential adverse impacts, if any, as a result of subproject, on EMs groups, thereby enabling devising of appropriate measures as to how adverse impacts could be avoided, minimized, and mitigated. Consultation also aims to ensure EMs people have opportunities to articulate, on the basis of their understanding of subprojects/ project objectives, their needs for support from the project in relation to the project goal/project activities. The whole exercise of developing an EMDP is grounded on a study that is referred to, in the Bank-funded projects, as a Social Assessment (SA).

4.1. Social assessment

Objectives of the SA. In the context of the Bank's OP 4.10, is a study that aims to explore how planned project activities under a Bank financed subproject would affect the life of EMs present in the subproject areas. The purpose of the SA is to ensure if there is any potential adverse impact as a result of the subproject, appropriate measures are in place (in advance of subproject implementation) to avoid, mitigate, minimize such potential adverse impacts, or to compensate for affected population, if unavoidable. The SA also aims to explore, based on the understanding of EM's cultural, socio-economic characteristics of the EM communities, possible development activities that the project can implement (in relation to the project goal/objectives) to ensure EMs peoples in the subproject area receives socio-economic benefits that are culturally appropriate to them.

Relevant information has been collected regarding demographics of EM communities, socio-economic status and primary health services and barriers in accessing grassroots health services (mainly from CHSs) of the general population and EMs groups in five districts and five communes of Tra Vinh, Quang Tri and Yen Bai provinces. The SA also includes information consultation with ethnic minorities who have used or using commune and district level health services and providers of grassroots health

services (district and commune) to determine whether there are any risks that may prevent the EMs communities from accessing and benefiting from the investment project at the grassroots level.

Consultations were carried out in December 2017 and March and April 2018. Apart from community consultations, including those with various EM groups, meetings were held with representatives from the health authorities at the national, provincial, district and commune levels. The SA reviews have confirmed a general interest amongst the stakeholders in the objectives of the project. The SA also identified a potential risk that the poor and remote areas could be excluded from project activities and benefits. To address this, the project would undertake targeted activities to reach out and ensure participation of/consultation with poorer communities, women, EM communities and other vulnerable groups to ensure that they will be well-informed and can have access to the project benefits.

Main findings of the SA. The SA was conducted between January and March 2018 in Son La, Quang Tri and Tra Vinh provinces to understand gaps between various EM groups and other populations in the project sites with regard to access to health services, and measures to address these gaps. Generally, the project will bring positive benefits in health care to local people in the project sites, especially poor people in remote areas. The SA demonstrates the broad support to the project benefits from various stakeholders and communities, including those from the EM groups of H'mong, Thai, Paco, Bru Van Kieu, and Khmer. Respondents value the important role of CHS in the care of their health due to more convenient and cost-efficient location, more timely service, and closer familiarity with local health staff. However, in some communities, local people prefer a district hospital for check-ups, treatment and birth deliveries, especially when the hospital is not too far away from their communities. They said that they have stronger trust in the hospital's treatment capacity and can have better prescriptions. In addition, district hospitals are preferred for birth deliveries for certain reasons, including a lack of delivery facilities and female delivery assistants in CHS.

The SA also provides a better understanding of the gaps in access to health services between the EM groups and other populations in the visited sites. Gynecological diseases and malnutrition are frequently cited as two common diseases among the EM groups, caused by a lack of knowledge of hygienic practices and poor working conditions. Meanwhile, the common causes of child malnutrition, some of which are related to cultural norms, include early marriage, premature delivery, mothers' mal-nutrition, lack of breastfeeding due to mothers' early labor after delivery, inadequate feeding practices, and poor sanitation. Hypertension and diabetes are described as emerging diseases as a result of changing lifestyles but have not received due attention among many rural people. Local respondents attributed the situation to their lack of awareness of health risks and unavailability of monitoring and treatment services in CHS which they can access in a more convenient manner. The SA has made some recommendations to address those gaps, as described in the section on the proposed measures for an EMDP.

As the SA indicated, while progress has been made at a national level, there are still gaps in ending preventable maternal mortality and improving child nutrition, most importantly among poor and EM populations. As contributions to gender outcomes, the project is expected to make the following interventions:

The project will finance activities to overcome supply-side barriers to accessing key evidence-based reproductive, maternal, and child health interventions that have demonstrated effectiveness in improving these outcomes. Though the project will target entire populations, the focus on commune health services in poor and rural areas will be expected to have disproportionate impacts on poor and EM women and children.[17] Because essential interventions for prevention of maternal mortality and improvement in child nutrition are provided across the continuum of reproductive, maternal,

[17] The rationale for this assumption is two-fold: 1) The targeted provinces were selected based on poverty rates and have disproportionately high prevalence of EM; and 2) CHS are more commonly utilized by mothers, infants, and children relative to those at other stages of the life course, as well as by the poor and ethnic minorities (whereas the rich are more likely to utilize higher level and private facilities).

newborn, and child health contact points, the 'child health' tracer condition will provide the opportunity to strengthen delivery of these interventions at commune health stations.[18]

Increasing utilization of essential services for poor and EM populations will contribute to improvements in health status, but recent evidence highlights that it is not only the availability, but also the quality of services that is needed to accelerate reductions on maternal mortality and improvements in child stunting. The project's infrastructure investments provided under Component 1 will ensure that basic physical quality standards are met for health services and set the foundation for adequate service delivery; Component 2 investments in equipment, training, and quality monitoring will strengthen the focus on adherence to clinical guidelines for priority MCHN services. The results indicators will monitor multiple steps across the theory of change, from outputs (facilities upgraded to standards relevant for delivery of tracer condition services and providers trained in delivery of these interventions) to outcomes (increased utilization of evidence-based maternal and child health and immunization services with known effectiveness in reducing maternal mortality and child stunting).

4.2. Methodology for preparing an EMDP

To prepare an EMDP, consultations will be conducted with various stakeholders at the national level and at sub-national ones in the project provinces. A number of conventional qualitative research instruments are employed, including focus group discussions, in-depth interviews, note-taking, and photographing, and non-participant observation.

- **Focus group discussions (FGDs)**: Each FGD includes 6-8 participants who are recommended and invited by local guides following the requirements of the research team. Gender-disaggregated data are paid attention through the establishment of gender sensitive FGDs. Local guides are the chiefs of the selected residential units who have a very good understanding of the community. In order to understand likely different impacts and their responses to the project, a variety of respondent groups are selected, including administrators from Local and MoH at the national and subnational levels, users of health insurance services, and social assistance beneficiaries, including local poor/near-poor and representatives from local EM groups.
- **In-depth interviews**: The study team may plan to explore some case studies with more in-depth information. The informants for such in-depth interviews may be selected from the FGDs (researchers may find some discussants who have more interesting details to provide so have him/her for a separate in-depth interview). Also, the interviewees may be recommended directly by local guides after researchers have fully explained the assessment objectives.
- **Consultation with local managers:** The study team may organize consultations with local managers on health and health care. The management team is selected in two respects: the team carried out professional activities in health and health care; state management staffs

[18] Antenatal care (ANC) provides a platform for important interventions, including health and nutrition promotion, screening for and diagnosis of pregnancy risks, and disease prevention. Through timely and appropriate evidence-based practices, evidence has shown that ANC can save maternal and newborn lives.[18] ANC also provides the opportunity to communicate with and support women in a critical time in their own life and in the life of their fetus. Furthermore, ensuring access to skilled birth attendance, facility-based maternity services, and essential obstetric care that is effective and of good quality can help reduce maternal and newborn mortality.[18] Regardless of delivery in facility or in the community with postnatal care contacts with women and children provides the opportunity for early identification of post-partum issues and the provision of preventive and promotive interventions for the mother and child. Routine immunization can reduce child morbidity and mortality, and also serves as the contact point for essential nutrition and child health interventions.

involved in the planning and implementation of local socio-economic development tasks, including government, and mass organizations.

- **Gathering available information**: Collecting and distilling from existing research results on issues related to investment in basic health care, collecting secondary data and information in survey areas.

4.3. Suggestive steps in developing an EMDP

The following steps should be followed by the Central Project Unit (CPU), Provincial Project Management Units (PPMUs) and their consultants, to prepare an EMDP for a subproject. The CPU, PPMUs or their consultants should comply with the suggestion steps for preparing an EMDP for the project.

Step	Implementation plan	Monitoring the implementation
1	***EMDP*** objectives For ensuring: (1) Avoiding, minimizing, mitigating potential negative impacts (if yes) and (2) Receiving the benefits for EM groups that are suitable to their cultures.	Monitor whether public consultation is organized or not.
2	***Developing the data collection plan*** The data to be collected can be both quantitative and qualitative regarding: • Natural conditions; • Socio-economic conditions: the population of the selected project sites, the EM populations (broken down by each ethnicity group, by household and individuals); economic structures, growth rates, etc. • Project beneficiaries of using services, providing health care services to minority groups. • EM groups' perceptions on the legislation, accessibility to information, and both positive and negative potential impacts. These qualitative data come from local consultations. Secondary data can be collected from organizations and individuals involved: Department of Health, District Hospital, District Health Center, Commune People's Committee, Commune Health Station. They can collect qualitative data through conventional qualitative methods, such as group discussions, in-depth interviews, observation and photographing. Such direct consultations with representatives from the related MOH administrators as well as individual service users and beneficiaries, including those from EM groups. The team leaders should communicate regularly with a focal point at the central level to report emerging issues, consult necessary issues and report the progress to make the study to	Factors to monitor (whether they are in accordance with the plan) The data both quantitative and qualitative) collected (whether they are relevant and reliable; any discrepancies found) Methods used to collect the data (whether they are relevant and effective)

	be followed. The focal point would provide adequate supervision and guidance to the teams as needed. ***Review and analysis the data:*** • Compilation and aggregation of the data from the focus group meetings and participant groups in each location; • Based on this type of aggregation it is possible to begin analyzing patterns in the data according to the frequency with which certain responses occur. This is where triangulation of the responses and recommendations made by different participant groups becomes important. The purpose of this is to identify areas of commonality in which there is a high degree of consensus and also areas in which there are major differences of opinion between one or more groups; • Iterative analysis of the data and in-depth knowledge of the local situation is required to interpret and assess the relevance and implications of this type of information; and • It is important to verify the findings and the main conclusions with participants and other stakeholders to ensure that the analysis has not somehow drifted away from what people were trying to say. Some data should be tabulated properly and placed either in the main text or annexes, whichever is more relevant depending on the specific report structure of each province.	The approaches employed to analyse the collected data (whether they are relevant and effective; identify any constraints)
3	Based on the data collected and findings from public consultation, the study team should determine: (a) The factors from the project activities that may cause potential positive and negative impact (if any) and (b) Assess the needs of the related EMs groups (with clear targets and priority strategy). It is important to prioritize their needs based on the sources (human resources, technology, finance, and institutions) available to the project. On a basis of the identified factors, the team should discuss and propose what specific measures the project can do to avoid, minimise and mitigate the negative impacts, specifying who should do what and how given the available resources.	Check whether beneficiaries and impacts on them have been identified appropriately. Check whether all the existing resources have been sought to address to maximise positive impacts and minimise potential negative impacts. The expectation of beneficiaries and whether the project objectives can be met.
4	***Writing up an EMDP*** An EMDP should be structured to address the important social safeguards issues relating to the EM groups in the project sites	Determining the implementation plan can be successful or not, and how the CPU perceive the

	• Background information on the project sites and a profile of the related EM groups in the project sites (the related socio-economic and political conditions as well ethnic cultures and customs); • Key activities/mitigation measures that should be implemented locally, as identified on a basis of the assessment of specific needs from the public consultation with the related EM groups in each study site; • Key stakeholders who will implement these activities; • Resources needed (finance and human resources) for these key stakeholders to implement these activities. • A timeframe (frequency) to implement these activities; • An GRM mechanism (in addition to the existing government structure); • An institutional arrangement for implementing the identified activities; • Disclosure of EMDP; • An indicated budget estimates.	effectiveness of this plan. The implementation and monitoring plan should be developed with the CPU to make it easier to them to adopt it.

4.4. The proposed measures for an EMDP

Based on the results of community consultations with users of CHSs and health service providers, some measures proposed in the EMDP, or integrated into the EMDP may include:

a) Develop a communication strategy to raise awareness among EM communities in general and women in particular about primary care and reproductive health care:

- Implement communication activities to raise awareness of EM communities about the needs for health examination and treatment. The proposed communication activities are based on assessments in some areas where people's perceptions of treatment are limited. EM people often buy medicine and pray for patients without bringing them to clinics for medical treatment. They only go to CHSs or other health services when diseases become severe and difficult to cure. Many women are not yet aware of the importance of adequate antenatal, prenatal and postnatal care.
- It is important to use spoken languages that are close and relevant to the culture and cognitive ability of EM communities and people; avoid the use of many documents and documents on paper. In addition, communication activities should be conducted in places that people visit on certain occasions, such as village community culture houses, and village markets. Communication activities should also be utilized and integrated in local cultural events.
- Involving senior village elders in health care talks will increase the effectiveness of the media.
- Mass communication should be combined with presentations by physicians in residential areas, especially regarding dissemination of knowledge to women about antenatal care. maternity care, nutrition care for children and mothers after childbirth, and consultations with regular pediatric health workers.

b) Organize short courses for mothers and village midwives regarding delivery and management of situations that may be encountered when giving birth at home.

- Many EMs women often deliver at home because of their customs. Some, for other reasons such as living far away from a clinic, when the pain comes, may not have time to come to commune clinics. Midwives, village midwives or some women who provide birth support for their children at home should be trained in basic knowledge about delivery and management of some common situations to avoid unfortunate accidents in delivery.

- Training may take 2-3 days. The training should combine both theory and practice, avoiding just providing theoretical knowledge as the ability of village midwives is limited, they need to receive hands-on training. It is necessary to invite doctors from the provincial and district levels to participate in the training courses. Examination is required at the end of the course and the certificate of attendance provided for village midwives.
- It is possible to learn more about the model of training EM women to become village midwives who have provided good support in Ninh Thuan province. Training activities for midwives and village mothers will be carried out to improve gender sensitivity in training.

c) Organize awareness campaigns to promote gender equality in EM groups. There should be a plan to talk periodically and persistently because changing habits and perceptions is not a day-to-day change. In addition, it is necessary to engage EM men and women in the talks and discussions on the issue of family sharing and joint decision-making for their work, including selection of health services when someone in the family is sick.

- A majority of northern EM groups are patriarchal. Pregnant women who have to work hard until delivery without antenatal care may encounter serious consequences during delivery. As husbands and fathers in the family, men need to be aware of sharing their hard work with their wives so that their wives can have antenatal care. Men who ride motorbikes can take pregnant women for regular antenatal care.
- It is essential to engage women, especially those form the EM groups in the project sites, in various project activities and interventions.
- Reproductive health care needs for EM women should be tailored to their cultural and ethnic characteristics. Efforts should be made to arrange appropriate venues and times for women's participation, and also to promote complementary activities to maximize the participation of women-headed households. The provision of training to local managers and project staff should be gender sensitive.
- Women from various EM groups should be consulted in good faith throughout the project cycle, from the design to the evaluation steps to ensure their voices to be heard and paid due attention to. There is a risk that female attendance at information workshops and meetings may be low. Specific measures may therefore be necessary to enhance women's current access to information and their benefits from the project's activities.
- During the monitoring of the EMDP implementation, the key indicators of gender actions will be monitored and reflected in monitoring reports.

d) The grievance redress mechanism (GRM): Many EM respondents preferred direct communication, rather than through a help-line service. They trust the role of the village management boards in settling grievances. Meanwhile, some administrators argued that grievances can be redressed through annual meetings with voters and annual community meetings with local people.

4.5. Procedure for review and approval of an EMDP

Once an EMDP for a subproject is completed by the PMU, or its consultants, the EMDP needs to be submitted to the World Bank for prior review and comments before implementation of the subprojects for which the EMDP is associated. The Bank may request revision of the EMDP, based on the quality of the EMDP. When there is doubt or need for technical support in preparing an EMDP, the Bank's task team should be contacted for timely support.

V. IMPLEMENTATION OF AN EMDP

5.1. Implementation arrangements

The PCU is in charge of the overall implementation of all EMDPs prepared under the project. The PCU will make sure all PPMUs understand the objectives of the EMPF and know how to apply it to develop EMDP for relevant subprojects.

At the central level - The PCU is responsible for providing technical support to PPMUs in preparing EMDPs for relevant subprojects. The PMU will assign a qualified member of staff to work on social safeguards in the project. S/he will support local and stakeholders with preparing materials in implementing EMPF and in monitoring progress. S/he will ensure that EMDP is implemented and delivered as per work plan and quality. At the outset of the project implementation, PCU will provide training to its social staff – at central and provincial levels, to enable them to undertake screening (of EM present in the influence area of the subprojects) to determine when an EMDP is needed, and on the basis of the screening result, conduct social impact assessment, and prepare EMDP. Where local capacity is insufficient to prepare an EMDP, qualified consultants may be mobilized to assist PPMUs in development an EMDP for a subproject in accordance with the EMPF.

At provincial level - The PPMUs and local governments are responsible for implementing the EMDPs. Appropriate staff and budget – sufficient to achieve the objective of an EMDP, need to be included in the EMDP for Bank's prior review and approval. and comments before implementation of the subprojects for which the EMDP is associated. The Bank may request revision of the EMDP, based on the quality of the EMDP. When there is doubt or need for technical support in preparing an EMDP, the Bank's task team should be contacted for timely support.

The PCU would coordinate with provincial and other stakeholders which would provide support in the implementation and monitoring the implementation process of EMDP. Provincial and other stakeholders would provide guidance to district and other stakeholders in the implementation and monitoring the implementation of EMDP.

5.2. Disclosure of EMDPs

Once preparation of an EMDP is completed, it needs to be disclosed to affected EM people and their communities. The EMDP needs to be disclosed in an appropriate manner to ensure affected EM people and their community can conveniently access and can fully understand. In addition to public disclosure of the EMDP, meetings need to be given at the community where EM people are affected by the subproject. Where needed, meetings should be conducted using the language of the EM affected to ensure they fully understand the EMDP objective and can provide feedback.

Please note that all EMDPs prepared during project implementation must be disclosed locally in a timely manner, before appraisal/approval of these subprojects. The EMDPs need to be disclosed in an accessible place and in a form and language understandable to affected EMs as well as key stakeholders, including the Bank's Portal.

5.3. Grievance Redress Mechanism (GRM).

GRM will be applied to persons or groups that are directly or indirectly affected by the project, as well as those that may have interests in a project and/or have the ability to influence its outcome -- either positively or negatively. At the commune level, MOH representatives regularly organize meetings with local people. Therefore, grievances can be redressed through annual meetings with voters and PMU's annual meetings with local people.

If the affected EM people are not satisfied with the process, resolutions, or any other issues, the EM themselves or village leaders can lodge their complaints to the CPC or to the PMU following GRM

described in the EMDP. All grievances will be addressed promptly, and in a way that is culturally appropriate to the affected EM peoples. All costs associated with EM's complaints are exempt to EM complainants. The PMU is responsible for monitoring the progress of resolution of EMs' complaints. All cases of complaints must be recorded in the PMU's project files.

To ensure that the grievance mechanism is practical and acceptable by EMs affected by the project, this will be consulted with local authorities and local communities taking into account of specific cultural attributes as well as traditional, cultural mechanisms for raising and resolving complaints/conflicts. If the EM objects, efforts will be made to identify and determine ways to resolve that are culturally acceptable to them. The information on GRM will be included in the Project Operation Manual (POM). Local administrators and people in the project sites will be informed of this GRM.

All costs associated with EM's complaints are exempt to EM complainants. The PPMU is responsible for monitoring the progress of resolution of EMs' complaints. All cases of complaints must be recorded in the PPMU's project files.

All costs associated with EM's complaints are exempt to EM complainants. The PPMU is responsible for monitoring the progress of resolution of EMs' complaints. All cases of complaints must be recorded in the PPMU's project files.

VI. MONITORING AND EVALUATION

The responsibility for overall monitoring and implementing the EMDPs rests with the PMU. In case of necessity, the PMU may hire a qualified consultant for external monitoring of the implementation of EMDP. During monitoring of EMDP implementation, the key indicators, including those of gender actions, will be monitored and reflected in monitoring reports.

VII. BUDGET

The budget for the implementation of EMDP comes from the counterpart funds. MOH will allocate and provide funds sufficiently and timely to ensure that EMDP will be implemented successfully. The implementation budget for EMDP will be estimated on a basis of activities proposed in EMDPs.

VIII. ANNEX ONE: Elements for an EMDP

Executive Summary

This section describes briefly the *critical facts*, *significant findings* from the social assessment, and *recommended actions to manage adverse impact (if any)* and *proposed development intervention activities* on the basis on the social assessment results.

I. Description of the Project

This section provides a general description of the *project goal*, *project component*s, *potential adverse impact (if any) at the project and subproject levels.* Make clear the identified adverse impact at two levels – project and subproject.

II. Legal and institutional framework applicable to EM peoples

III. Description of the sub-project population

- Baseline information on the demographic, social, cultural, and political characteristics of the potentially affected EM population, or EM's communities.
- Production, livelihood systems, tenure systems that EM may rely on, including natural resources on which they depend (including common property resources, if any).
- Types of income generation activities, including income sources, disaggregated by their household member, work season;
- Annual natural hazards that may affect their livelihood and income earning capacity;
- Community relationship (social capital, kinship, social network…)

IV. Social Impact Assessment

This section describes:

- ***Methods of consultation*** already used to ensure free, prior and informed consultation with affected EM population in the sub-project area.
- ***Summary of results of free, prior and informed consultation*** with affected EM population. Results includes two areas:
    - Potential impact of subprojects (positive and adverse) on their livelihoods of EM in the project area (both directly and indirectly);
    - Action plan of measures to avoid, minimize, mitigate, or compensate for these adverse effects;
    - Preferences of EM for support (from the project) in development activities intended for them (explored through needs assessment exercise conducted during the social assessment);
    - An action plan of measures to ensure EM in the subproject area receive social and economic benefits culturally appropriate to them, including, where necessary, measures to enhance the capacity of the local project implementing agencies;
    - Gender issues: to ensure the engagement of both men and women in project activities.

V. Information Disclosure, Consultation and Participation:

This section will:

a) describe information disclosure, consultation and participation process with the affected EM peoples that was carried out during project preparation in free, prior, and informed consultation with them;
b) summarizes their comments on the results of the social impact assessment and identifies concerns raised during consultation and how these have been addressed in project design;
c) in the case of project activities requiring broad-based community access and support, document the process and outcome of consultations with affected EM communities and any agreement resulting from such consultations for the project activities and safeguard measures addressing the impacts of such activities;
d) describe consultation and participation mechanisms to be used during implementation to ensure EM peoples' participation during implementation; and
e) confirm disclosure of the draft and final EMDP to the affected EM communities.

VI. Capacity Building: This section provides measures to strengthen the social, legal, and technical capabilities of (a) local government in addressing EM peoples' issues in the project area; and (b) EM organizations in the project area to enable them to represent affected EM peoples more effectively.

VII. GRM: This section describes the procedures to redress grievances by affected EM peoples. It also explains how the procedures are accessible on a participatory manner to EM peoples and culturally appropriate and gender sensitive. While designing GRM procedures, the borrower should pay attention to the support of the existing legislation as well as dispute settlement mechanisms in EM communities;

VIII. Institutional Arrangement: This section describes institutional arrangement responsibilities and mechanisms for carrying out the various measures of the EMDP. It also describes the process of including relevant local organizations and NGOs in carrying out the measures of the EMDP;

IX. M&E: This section describes the mechanisms and benchmarks appropriate to the project for monitoring and evaluating the implementation of the EMDP. It also specifies arrangements for free, prior and informed consultation and participation of affected EM peoples in the preparation and validation of monitoring, and evaluation reports.

X. Budget and Financing: This section provides an itemized budget for all activities described in the EMDP