Ethnic Minority Plan

May, 2010
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ABBREVIATIONS

CPC Commune People’s Committee
CPMU Central Project Management Unit
CSWs Commercial Sex Workers
DFID Department for International Development
EMP Ethnic Minority Plan
IDA International Development Association
IDU Intravenous Drug Users
IBBS Integrated Biological and Behavioral Surveillance
Gov Government of Vietnam
HC Health Center
HD Health Department
HI Health Insurance
HS Health services
MoH Ministry of Health
GoV Government of Vietnam
PC People’s Committee
PH Preventive Health
PHC Preventive Health Center
PMU Project Management Unit
PPMU Provincial Project Management Unit
SWs Sex Workers
WB World Bank

Executive Summary

I. Project Introduction
II. Socio-Economic Situation of Ethnic Minorities in Project Locations

2.1. General view

2.2. Socio-economic features and population structure in project areas
The 32 project provinces stretch along the country with complicated topography and harsh climate. Total population of the provinces is approximately 40 million people. Basics economic activities are agriculture and husbandry. Poverty rate are different within provinces with highest rate in north upland provinces and lowest rate in urban and lowland provinces.

2.3. Ethnic minorities in project areas:
There are about 49 ethnic groups living in the project areas. With the exception of the Cham, Khmer and the Chinese, most of remaining ethnic minority groups live in upland areas.

2.4. Basics socio-economic features of some major ethnic minority groups in the Project areas
Though having been benefited from various development projects implemented by both Vietnam government and International agencies, most of ethnic minorities in the project areas hold high poverty rate, with high dependence on agricultural production.

III. Policy Framework

3.1. WB’s policies toward ethnic minorities
The WB has its own policy toward the indigenous/ethnic minority people (OP4.10). It calls upon projects to invest into ethnic minority areas, and to fully respect the preferential rights of the affected ethnic minorities. At the same time, it is expected to mitigate the adverse impacts on the ethnic minorities and promote those activities that aim at bringing benefits and preserving their traditional cultural values. The WB requests that the local people should be sufficiently informed and freely participated in the Project, and the Project should receive the support from most of the affected ethnic minority people. The designed Project must ensure that the ethnic minority people receive the social and economic benefits are culturally appropriate, and gender and inter-generationally inclusive.

3.2. GoV’s policies
During the last ten years, GoV has implemented number of projects aiming to provide better health care service for the people, especially ethnic minority people. Relating to HIV/AIDS prevention, the GoV has designed and implemented a national action plan with 8 strategies aiming to bring about better HIV/AIDS intervention program.

IV. Constraints that cause Limited Access to HIV/AIDS prevention for Ethnic Minorities

4.1. Geographical and transportation
4.2. Customary practices

4.3. Poverty

4.4. Language and educational background

4.5. Migration

4.6. Urbanization

4.7. Cross border issues

4.8. Tourism

V. Community Consultation

*Activity principles*

Ensuring the participation of the ethnic minorities in the project in order to speed up the smooth project implementation. Disclosure of project information for ethnic minority people is an important part of project preparation and implementation. Making consultation with them, and ascertaining their active participation in the project. These will mitigate the risk of conflicts and project delays. They will also enable the Project to design the resettlement and rehabilitation program as a comprehensive development one, which meets the needs and priorities of the displaced, and thereby maximizing the economic and social benefits of the investments.

*Methods of community participation and consultation*

The project implementation activities must be consulted with the ethnic minority specialist, especially the one who has experience in project activity areas (healthcare, insurance, etc.)
- The CPMU must have close cooperation with the PPMUs, especially those with high and diversified concentration of ethnic minorities.
- The PPMUs will monitor the implementation process in order to make sure that equal healthcare services will be provided for ethnic minorities, and financial and legal support will be made available for districts in their provinces.
- The DPC must establish the efficient cooperation with other departments/programs in the district, especially those related to ethnic minority development activities.

VI. Ethnic Minority Plan (EMP)
The goal of this EMP is to ensure better HIV/AIDS preventions for people in the project areas, especially ethnic minorities. This EMP is prepared with careful consideration of the cultural practices of the ethnic minorities, and the constraints that prevent the effective implementation of HIV/AIDS prevention activities in each region.

VII. Organization and Implementation

As for the performance of the ethnic minority development plan, the CPMU and PPMUs will start up the implementation of project components and carry out the supervision exercise in order to make sure that the project activities are kept on right track.

- With regard to those districts which have high concentration of ethnic minority population, documents in their languages should be published, and the engagement of people who have the knowledge of local ethnic minority languages should be made in order to make sure that the communication and consultation with local people will be done during their check-up and treatment exercises in the health facilities.

- Qualified doctors will be sent to organize training activities and capacity building for ethnic minority medial workers working in district-level hospitals where there is a high need for the transfer of medical techniques, especially in those districts where there is a high concentration of ethnic minority population.

VIII. Monitoring and Evaluation

- Monitoring the implementation of the ethnic minority development plan is a part of monitoring activities within all project components.

- An independent supervision agency with qualified and experienced specialists must be in place in order to provide monitoring and evaluation of project activities related to social and ethnic minority development aspects.

The CPMU and PPMUs will undertake monitoring and evaluation of project components. As for provinces which have districts with more than 50% of its population as ethnic minorities, the cooperation should be done in order to provide the monitoring of ethnic minority-related activities.

IX. Cost Estimation

- The costs of EMP activities are estimated and embedded within project activities.

- The costs of training activities will be calculated in detail when these activities are conducted.

- In order to make cost savings, EMP-related training and communication activities will be incorporated into other project training and communication activities.

I. INTRODUCTION
1.1. Project Introduction
**Project Background**

(i). The number of people in Vietnam living with HIV/AIDS has rapidly increased in recent years, and reached an estimated 254,387 by the end of 2009. HIV/AIDS has been founded in all 63 provinces/cities, from urban to rural and upland areas. High rate of HIV/AIDS is present in northern provinces which lye along border line with Laos and have high population of numerous ethnic minority groups. In these provinces, drug uses and prostitution are two main causes of HIV/AIDS increas. IDUs comprise 52 percents of registered HIV cases, highlighting the concentrated nature of Vietnam’s epidemic.

(ii). A study of 7 provinces found that 90 percent of IDUs had had no access to sterile injection equipment in the previous six months; behavioral surveillance has found that as much as 44% of IDUs reported sharing injecting equipment at the last injection. HIV/AIDS transmission through unprotected sex is increasing annually and a low rate of condom use during intercourse persists. In addition to that, an increase in IDUs among female sex workers constitutes an emerging challenge.

(iii). For this reason, harm reduction as a prevention strategy is considered a key tool in the fight against HIV. The 2005-2006 Integrated Biological and Behavioral Surveillance (IBBS) reveals that HIV prevalence is highest among IDUs, ranging from 23% to 66%, with significant variation by province. SWs also exhibit high HIV prevalence, ranging from 4% to 10%, with HIV prevalence up to three times higher among sex workers who reported injecting drug use. IDU and SWs, particularly SW-IDUs, are ‘core transmitters’ and driving forces in the current HIV epidemic. Populations with high prevalence and large degrees of social mixing such as IDUs and sex workers require greater coverage than low prevalence, low mixing communities. Despite the significant increase in the number of needles and syringes as well as free condoms distributed in Vietnam in the last few years, coverage remains poor at best.

(iv). This project is the continuation of a HIV/AIDS prevention project which started since 2005 with extension from 20 provinces to 32 provinces after receiving financial support from DFID.

(v). IDA Credit for the Vietnam HIV/AIDS Prevention Project, in an amount of US$ 35 million equivalent, was approved by the Executive Directors on March 29, 2005 and became effective on October 17, 2005. The grant is financed in full by DFID and channeled through the Trust Fund arrangement of the World Bank. IDA project cover 20 Project provinces and cities. The 20 provinces covered by the project include: Lai Chơu, S−n La, Y¨n B.i, Cao Bông, Th.i Nguyơn, B¾c Giang, H¶i Phßng, Th.i B×nh, Nam §Pnh, Thanh Ho., NghØ An, Kh„h Hou., §ång Nai, TP. Hå ChÝ Minh, An Giang, BÕn Tre, Kि�n Giang, HÉu Giang, TiØn Giang, VỮnh Long

(vi). DFID had previously supported government HIV/AIDS program through bi-lateral project (GBP 17.3 million, from 2003-2008) for Behavior Change Communication (BCC), Harm
Reduction (HR), Sexually Transmitted Infections (STI), and Capacity Building in 21 provinces, of which 8 coincided with WB-supported provinces (but covered different communes).

(vii). For the second phase of DFID support (GBP18 million, from 2009-2012), DFID and the Bank teams discussed and agreed to have a joint project. The proposed arrangement was strongly appreciated and supported by the government. The joint project will maintain the original IDA Grant funded project’s Development Objectives and implementation arrangements. The joint project coverage will be extended to additional districts within the original IDA covered provinces and 12 additional provinces which were under the first phase of the DFID project. The 12 additional provinces are: Lạng Sơn, Quảng Ninh, Hà Nội, Hậu Giang, Tuyên Quang, Bến Tre, Đồng Nai, Bà Rịa-Vũng Tàu, Cần Thơ, Sông Hậu, Sóc Trăng.

(viii). With these resources, the total project provinces will be 32 out of 63 provinces of Vietnam. The proposed activities are fully consistent with the existing project development objective, which is to halt the transmission of HIV/AIDS among vulnerable populations and between these groups and the general population. The additional financing would complement ongoing activities by mitigating the social and health-related consequences of drug injecting, particularly the risk of contracting HIV/AIDS for vulnerable groups.

(ix). The joint project will create opportunities to strengthen the successful implementation of the original project in 12 new provinces; promoting a coherent and streamlined response to scale up coverage, quality and impact of harm reduction services; streamline coordination at the national and provincial level; move to one program approach with a more coherent administrative arrangement for VAAC; and create a joint program arrangement with which other agencies can align in future.

The joint project consists of three components with some modifications as below:

**Component 1: Implementation of provincial HIV/AIDS Action Plans (USD 12.34 million).**

Support will be provided to the 20 provinces and cities currently covered, and will be expanded to an additional 12 provinces. The provinces will be allocated block grants based on specific criteria to determine the size of each year's base allocation. Proposed activities are expected to reflect the diversity of provincial needs as well as the different responses needed in each location.

**Component 2: National HIV/AIDS Policy and Program (USD 5.6 million).**

This component will strengthen capacity at the national and provincial levels, and promote the development of innovative, effective prevention through condoms promotion and needle

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1 Vulnerable populations are defined as people living with HIV/AIDS (PLWHA), intravenous drug users (IDUs), commercial sex workers (CSWs) and their clients/sexual partners.
exchange programs. Opiate substitution therapy in the form of methadone maintenance therapy will also be scaled up with the technical support of WHO.

**Component 3: Project Management (USD 7.0 million).** This component will provide support to establish 12 provincial Project Management Units (PPMUs) in the 12 additional project provinces. It will also provide support to the institutions that will manage and implement the project, such as the Central Project Management Unit (in the Ministry of Health), Provincial AIDS Steering Committees and other implementing agencies.

**Project objectives**

Objective of the Project is to assist Vietnam in establishing and maintaining national, provincial and local policies and capacity to design, implement and evaluate information and service delivery programs designed to halt the transmission of HIV/AIDS among vulnerable populations and between vulnerable populations and the general population, thereby assisting Vietnam in the implementation of its National Strategy on HIV/AIDS Prevention and Control.

The project also aims to reduce stigma and discrimination towards vulnerable groups such as PLWA, IDU, SWs, and to increase access to HIV/AIDS care and support for vulnerable populations resident in rehabilitation centers

**Project Direct Beneficiaries**

The project beneficiaries will include the following three groups:

(i). Support programs designed to halt transmission of HIV/AIDS among vulnerable populations (PLWHA, IDU, CSW, and their clients and sexual partners) and between these vulnerable populations and the general population

(ii). Healthcare service providers: Staffs from provincial- and district-level healthcare service providers, especially district hospitals and DPHCs, will be provided necessary training on HIV/AIDS prevention and related professional knowledge. 32 participating project provinces, with supports from the project, is expected to have the policies and capacities to utilize block grants to design, implement and monitor HIV/AIDS programs which promote harm reduction (increased opiate substitution, clean needle-syringe and condom use) to reduce HIV transmission among vulnerable populations (IDU, CSW, their clients and families)

(iii). Administrative agencies: Funding will be provided for administrative organizations (Provincial Health Departments, District Health Centers, Rehabilitation centers) to help them manage better HIV/AIDS related activities.
II. SOCIO-ECONOMIC SITUATION OF ETHNIC MINORITIES IN PROJECT LOCATIONS

2.1. General review

(i). There are around 49 ethnic groups living in the project areas. Most of the groups live in upland areas.

(ii). Ethnic minority groups are concentrated mainly in two mountainous geographical regions. They can be found in the 11 north mountain provinces (Northern East and North West) that encompass 31 ethnic groups. They are also in the Central Coastal and Central Highlands, covering 19 provinces with 18 ethnic groups. The Central Highlands also host many newly settled ethnic minority groups. The Hoa, Khme, and Cham, who reside in the coastal and lowland areas, mix with the Kinh group in the South Coastal and Mekong River Delta provinces.

(iii). Population growth in the mountainous regions is higher than the national population growth rate, which is 2.1 percent. In the Northern region, the population growth rate is 2.3 percent and in the Central Highlands it is 3 percent. For several ethnic groups, the population growth rate is much higher than the national average.

(iv). There is great diversity among the ethnic minority groups in terms of their size, language, lifestyle, customs and beliefs, social organization.

(v). Literacy is lower among ethnic minorities comparing to that of the Kinh. The literacy ratio for ethnic minorities is estimated to be 73 percent compared to 90 percent for the total population. Primary education is available for 90 percent of the total population while for ethnic and poor it is much more limited. At secondary and higher education levels, gender disparities still exist due to cost, fees, and sociocultural barriers.

(vi). Among ethnic minority communities. Women are assigned the traditional “women’s work” such as taking care of domestic chores, reproductive and family care and activities related to hygiene and sanitation.

(vii). Vietnam is a success story for poverty reduction and development. The country has made great strides in reducing the overall poverty rate, from nearly 60 percent of the population in 1993 to 16 percent in 2006 (based on Vietnam Household Living Standards Survey (VHLSS) data). However, despite the impressive overall gains, ethnic minorities have experienced lower rates of poverty reduction than the general population. In 2006, ethnic minorities accounted for only 14.5 percent of the total population, but they made up 44.7 percent of the poor and 59 percent of the hungry. In that year, ethnic Vietnamese and Chinese households experienced a poverty rate of only 10 percent, while all other minority groups averaged a 52 percent poverty rate (VHLSS 2006). These figures, based on national survey data, may not show the real depth
and severity of poverty among some especially vulnerable minority groups. More localized qualitative studies indicate an income gap between ethnic groups, with entrenched and serious poverty among some populations.

(viii). Financial constraints are significant factors on the health care seeking behavior among many ethnic minorities. In 1998, the government enacted Decision 135 focused specifically on poverty alleviation for ethnic minorities. Under this policy, health cards were distributed to the ethnic minorities, entitling them to specific free health services. In spite of this, ethnic minorities continued to suffer inequity in health care. To correct this and to provide cover for the other poor citizens, the government implemented the Decision 139 (Health Care for the Poor Initiative) in 2002, where the poor and disadvantaged, including the ethnic minority groups, received a more extensive health coverage through a fund created from contributions from the central government (75%) and the provincial government (25%). Beneficiaries are either provided with a health insurance card or a health card that entitles them to free health services at all levels. Since its introduction, there has been an increase in health service utilization by ethnic minorities.

(ix). A UNODC (United Nation Office on Drugs and Crime) study on drug use among ethnic minorities in the provinces of Son La, Lai Chau and Lao Cai reveals that “the traditional means of consumption of the mountainous regions are gradually being transformed and replaced by a drugs scene closer to the urban realities of Vietnam. Drug users tend to be younger; heroin and, to a lesser degree, amphetamines are fast supplanting opium.”

(x). The above study points to the preference by drug users to access treatment and rehabilitation within the community. However, there are several obstacles to this: primarily, cost (investment in terms of infrastructure), the availability of skills (training of local medical staff and availability of outside expertise)) and the effectiveness itself of on-site treatment regimen.

(xi). The UNODC and the FGDs (Focus Group Discussions) also have similar findings when it comes to sources of information about HIV, its modes of transmission and prevention. The primary source was television, followed in order by radio, newspapers, commune officials, family, friends, and commune broadcasting. The UNODC study notes that Vietnamese is the language of national and local mass media (TV, radio, newspaper); that many commune households own a television set, a radio or both; that almost all communes have a communal television set; that newspapers, all owned and published by government agencies, are circulated within the commune. It further stated that while ethnic minority groups can understand Vietnamese, majority have limited fluency, leading to information breakdown and distortion.

(xii). Women and minors from ethnic minority groups residing in border
provinces are subject to cross-border trafficking. While some do it voluntarily, many are forced into it. They usually end up in foreign countries as sex workers while others are exploited as work slaves in factories and sweat shops.

### 2.2. Socio-economic features and population structure in project locations

The Project area stretches alongside the country, from northernmost to southernmost provinces with complicated topography and different climate features consists of 32 provinces. Basics socio-economic database of the project provinces is shown in table 2.1.

#### Table 2.2a. Situation of the Project area’s population by location

<table>
<thead>
<tr>
<th>STT</th>
<th>Province</th>
<th>Total area (Km²)</th>
<th>Total population</th>
<th>Ethnicity rate</th>
<th>Poverty rate (%)</th>
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<tr>
<td>1.</td>
<td>Lai Chau</td>
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<td>4.</td>
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</tr>
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<td>1149.1</td>
<td>24.5</td>
<td>13.99</td>
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<td>6.</td>
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<td>1628.4</td>
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<td>14.05</td>
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<td>7.</td>
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<td>31.</td>
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<td>32.</td>
<td>Tay Ninh</td>
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<td>1058.5</td>
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<td>7.76</td>
</tr>
</tbody>
</table>

Source: General Statistics Office, Annual Statistics Book 2007

With the exception of some big cities such as Hanoi, Ho Chi Minh, Hai Phong, Da Nang, most of the project provinces are located in rural areas where income from agriculture is still the most important sources.

Basically, the 32 provinces could be classified into following groups:
Urban areas: including: Ha Noi, Hai Phong, Ho Chi Minh, Hue, Da Nang

Peril urban areas: Thai Nguyen, Nam Dinh, Quang Ninh, Ba ria- Vung Tau, Can Tho


Upland areas: Lai Chau, Son La, Yen Bai, Cao Bang, Bac Giang, Lang Son

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<tr>
<td>all of Vietnam</td>
<td>58</td>
<td>37</td>
<td>29</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>northern Mountains</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>north east</td>
<td>X</td>
<td>62</td>
<td>38</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>north west</td>
<td>X</td>
<td>73</td>
<td>68</td>
<td>59</td>
<td>49</td>
</tr>
<tr>
<td>red river Delta</td>
<td>63</td>
<td>29</td>
<td>22</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>north Central Coast</td>
<td>75</td>
<td>48</td>
<td>44</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>South Central Coast</td>
<td>47</td>
<td>35</td>
<td>25</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>Central Highlands</td>
<td>70</td>
<td>52</td>
<td>52</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>South east</td>
<td>37</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Mekong Delta</td>
<td>47</td>
<td>37</td>
<td>23</td>
<td>16</td>
<td>10</td>
</tr>
</tbody>
</table>

Within the 32 project provinces, there are about 49 ethnic minority groups. Most of ethnic minorities live in upland areas (including provinces classified in previous section) with the exception of the Cham, Khmer and the Chinese. However, high presence of ethnic minority groups is seen in 15 provinces only, including: Lai Chau, Son La, Yen Bai, Cao Bang, Thai Nguyen, Bac Giang, Thanh Hoa, Nghe An, LangSon, Quang Ninh, Binh Thuan, Dong Nai, An Giang, Kien Giang, Soc Trang

Table below shows basic data on population and location of major ethnic minority groups who live in the project areas and have **total population more than 100,000 peoples only**:

**Table 2.2c: Ethnic minorities and population distribution in the project areas**

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Language family</th>
<th>Provinces</th>
<th>Total population (in the country)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tay</td>
<td>Tai- Kadai</td>
<td>Lai Chau, Son La, Dien Bien, Yen Bai, Cao Bang, Lang Son, Thai Nguyen</td>
<td>1,477,514</td>
<td>1.9</td>
</tr>
<tr>
<td>Thai</td>
<td>Tai- Kadai</td>
<td>Lai Chau, Son La, Dien Bien, Yen Bai</td>
<td>1,328,725</td>
<td>1.7</td>
</tr>
<tr>
<td>Muong</td>
<td>Viet-Muong</td>
<td>Thanh Hoa, Ha Noi, Ha Tinh</td>
<td>1,150,000</td>
<td>1.5</td>
</tr>
</tbody>
</table>
Vietnam HIV/AIDS Prevention Project

**Ethnic Minority Plan (EMP)**

<table>
<thead>
<tr>
<th>Nung</th>
<th>Tai- Kadai</th>
<th>Lang Son, Cao Bang</th>
<th>856,412</th>
<th>1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dzao</td>
<td>Miao- Yao</td>
<td>Lai Chau, Son La, Dien Bien, Yen Bai, Cao Bang, Lang Son, Thai Nguyen, Quang Ninh</td>
<td>620,538</td>
<td>0.8</td>
</tr>
<tr>
<td>San Chay</td>
<td>Tai Kadai</td>
<td>Lai Chau, Son La, Quang Ninh</td>
<td>147,315</td>
<td>0.2</td>
</tr>
<tr>
<td>Hmong</td>
<td>Miao- Yao</td>
<td>Lai Chau, Son La, Dien Bien, Yen Bai, Thanh Hoa, Nghe An</td>
<td>787,604</td>
<td>1.0</td>
</tr>
<tr>
<td>Cham</td>
<td>Austronesian</td>
<td>Binh Thuan, An Giang, Soc Trang, Dong Thap</td>
<td>132,873</td>
<td>0.2</td>
</tr>
<tr>
<td>Chinese</td>
<td>Sinitic</td>
<td>Ho Chi Minh, An Giang, Soc Trang, Dong Thap, Can Tho, DongNai</td>
<td>862,371</td>
<td>1.1</td>
</tr>
<tr>
<td>Khmer</td>
<td></td>
<td>An Giang, Soc Trang, Dong Thap, Hau Giang, Tien Giang, Can Tho</td>
<td>1,055,174</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Source: VALSS 1999

Data from some selected project sites investigation show that poverty rate of local ethnic minorities are much higher than national average rate.

**Table 2.2b. Ethnicity rate and poverty rate in the visited sites**

<table>
<thead>
<tr>
<th>STT</th>
<th>Province</th>
<th>Ethnicity rate (%)</th>
<th>Poverty rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>An Hao Commune, An Giang Province</td>
<td>100</td>
<td>23</td>
</tr>
<tr>
<td>2.</td>
<td>Tham Don Commune, Mi Xuyen District, Soc Trang Province</td>
<td>93</td>
<td>27</td>
</tr>
<tr>
<td>3.</td>
<td>Luu Tu Commune, Long Phuc District, Soc Trang Province</td>
<td>97</td>
<td>21</td>
</tr>
<tr>
<td>4.</td>
<td>Van Ho, Moc Chau District, Son La Province</td>
<td>&gt;95.0*</td>
<td>30.62</td>
</tr>
<tr>
<td>5.</td>
<td>Xa Chieng Son, Moc Chau District, Son La Province</td>
<td>48.4</td>
<td>19.1</td>
</tr>
<tr>
<td>6.</td>
<td>Hop Thanh Commune, Cao Loc District, Lang Son Province</td>
<td>93.6</td>
<td>9.3</td>
</tr>
</tbody>
</table>

Data from national scale at different periods of time also shows that ethnic minorities are much poorer comparing with the Kinh (with exception of the Chinese)
Figure 2.2. General poverty trends between the Kinh- Chinese and ethnic minority in two sample region in Vietnam

Source: VHLSS: 2006

2.4. Basics socio-economic features of some major ethnic minority groups in the Project areas

Though having presence of around 49 different ethnic groups in the project areas, there are only around 10 ethnic groups whose population exceed 100,000 people. This section provides brief descriptions of 12 ethnic groups, who have quite distinctive socio-economic and cultural features.

(i). The Hmong

- Location: The Hmong group in Viet Nam consists of four sub-groups of white Hmong (Hmong đôn), black Hmong (Hmong düz), flowery Hmong (Hmong lênhz) and blue Hmong (Hmong sauj). Hmong people often live in the high mountains and remote communes. In Thanh Hoa and Nghe An provinces, Hmong people live close to the border areas between Viet Nam and Laos (Muong Lat, Quan Son, Ky Son, Que Phong and Tuong Duong districts).

- Economic activities: The main economic activity of the Hmong in Central North region is upland cultivation. The main plants are maize and one-crop rice. Therefore, their living is still
in difficult situation. The income is rather low and unstable because of their heavy dependence on the natural and climate conditions.

- **Community relations:** Each Hmong village consists of several dozens of houses built on the mountain’s sloppy sides. The Hmong kinship system is very well-organized and supportive. Each kinship has its own worship rituals. Their houses are often not permanent with thatch roof and wooden walls. There is high humidity and darkness inside houses.

- **Family and marriage system:** The Hmongs rarely marry people from other ethnic groups. Men have more decision power, especially in community interactions. Women are responsible for housework.

- **Language:** The Hmong language belongs to Tibet-Chinese linguistic family. The writing system has been Latinized and widely used by the whole community. Most of Hmong women do not speak Vietnamese, and this brings barriers to social services in general and healthcare in particular.

- **Education:** Living in the upland and rather remote areas, the educational level of the Hmong is still very low. Given the language barriers and burden of farming activities and housework, many of Hmong women and girls are illiterate. Children often start their schooling very late with high drop-out rate. Very few of them are able to complete high schools.

(ii). The Thai

- **Location:** The Thai people live in north west provinces such as Lai Chau, Son La, Yen Bai, and in the Central North concentrate in upland districts of Thanh Hoa and Nghe An provinces.

- **Economic activities:** Traditional economic activities include upland farming and wet rice cultivation. Recently, they have planted some other long-term crops such as bamboo and rubber. Food security is maintained.

- **Community interactions:** Thai villages are often located in valley areas close to rivers or streams where there is production land available. Each Thai village consists of a hundred of houses divided into kinships. Most of Thai villages have limited access to district and provincial healthcare centers due to the difficulties in transportation.

- **Family and marriage system:** Thai people live in extended patriarchal families. Under each Thai house-on-stilt roof, there are often a few couples. Each couple is allocated a separate bedroom, and the distribution of bedrooms among couples follows age-based principles.

- **Language:** The Thai people are more fluent in Vietnamese language than other ethnic minority groups.

- **Education:** Given better transportation system (as compared with the Hmong, for instance) and stable economic conditions, the education level of the Thai is high with low illiterate rate.
(iii). The Muong

- **Location**: Muong people concentrate in lowland areas in Thanh Hoa Province.

- **Economic activities**: Besides wet rice, the Muong also have some other industrial crops such as sugarcane, rubber, and ground nuts. In general, they have medium living standards.

- **Community interactions**: Muong villages are often located in the midlands with a small part in mountainous areas. Each Muong village consists of a hundred of houses divided into kinships. The kinships are very well-integrated and help maintain a community cooperative network.

- **Family and marriage systems**: Muong people are free to make their marriage decisions. Though Muong families follow patriarchal system, men and women are quite equal in all terms.

- **Language**: Muong language is very similar to the Vietnamese language. Therefore, Muong people can easily speak Vietnamese. Most of them are bilingual.

- **Education**: Given the advantage of transportation system, the Muong people have better access to educational and other social services. There is very low illiterate rate.

(iv). The Khmu

- **Location**: Khmu people concentrate in Lai Chau, Son La, Nghe An and Thanh Hoa province. These are the border area between Vietnam and Laos with traveling difficulties. Khmu people often live scattered on the hillsides, and each Khmu hamlet often consists of tens of households.

- **Economic production**: The Khmu people are heavily dependent on the upland crops such as dry rice, maize and cassava. Their income is very low though they also have, besides farming, some additional revenues from gathering activities of non-timber resources. The average income of the Khmu household is the lowest among the ethnic minority groups in the region. According to the survey data collected by the Institute of Ethnology in 2007, the percentage of Khmu hunger households in Nghe An province accounted for over 80% with the average income of only VND 120,000 per month (Nguyen Quang Tan et all, Ethnology Newspaper, 2008).

- **Community interaction**: Khmu villages are often scattered in upland area. Each village consists of several dozens of households, so the relationship within a village is quite integrated.

- **Family and marriage system**: The Khmu have early marriages, and the proportion of exogamous marriages is pretty high. Men have more power than women.

- **Language**: The Khmu language belongs to Mon-Khmer family. It does not have writing system. Speaking fluent Vietnamese is still a constraint for many Khmu people, especially for women and children.
- **Education:** Given economic difficulty, very few Kho Mu people are able send their children to schools. There is high drop-out rate at primary level.

**(v). The Tho**

- **Location:** The Tho group mostly lives in lowland areas in Thanh Hoa and Nghe An provinces, where transportation condition is pretty good.

- **Economic production:** The main crops are wet rice and maize. In Nghia Dan district (Nghe An province) and Nhu Xuan district (Thanh Hoa province), the Tho have some other cash crops such as rubber, sugarcane, etc.

- **Community interactions:** marriage and neighbor relationships are the foundation of the Tho community interactions.

- **Family and marriage system:** The Tho group follows patriarchal system, but women have their voices in decision-making.

- **Language:** The Tho language belongs to Viet-Muong group. Therefore, Tho people have no difficulty in speaking fluent Vietnamese.

- **Education:** The education level of the Tho is quite high. Most of children complete general education, and there is a high rate participating in further education.

**(vi). The O Du**

- **Location:** The O Du only lives in Tuong Duong district, Nghe An province with very small population.

- **Economic production:** There is combination between lowland and upland cultivation. The income from this activity is low with roughly 200 kg of rice per individual per year.

- **Community relations:** Because of small population and scattered distribution, O Du village’s integration is very loose; some live with the Thai.

- **Family and marriage:** The O Du people often marry people from other ethnic groups, especially the Thai.

- **Language:** The O Du language belongs to the Mon-Khmer. Therefore they have more difficulty in learning Vietnamese. However, most of them can speak Thai language.

- **Education:** Given economic difficulty, a few O Du children go to schools. There is high illiterate rate.

**(vii). The Chut**
- **Location**: Being one of the ethnic minority groups with small population, Chut people live concentratedly in the mountainous areas in western Quang Binh province, close to the border of Vietnam and Laos. The Chut group has many sub-groups such as: Sach, May, Ruc, A rem, Ma Lieng, etc, and lives in Minh Hoa, Tuyen Hoa, Le Thuy and Quang Trach districts, Quang Binh province.

- **Economic production**: Upland farming and non-timber production are the two main activities. The household income is not stable and highly dependent on forest resources.

- **Community relations**: In the past, the Chut people had mobile life, moving from forest/cave to forest/cave. At present, they settle in Government-built villages. The old people and village leader are highly respected in Chut community.

- **Family and marriage**: Chut people live in nuclear families. Marriages are allowed for people in their own group, except for siblings.

- **Language**: Chut language belongs to Viet-Muong linguistic family. Therefore, Chut people can speak Vietnamese quite fluently.

- **Education**: The education level of the Chut is very low. Very few people have completed high schools, especially females.

**(viii). Bru – Van Kieu**

- **Location**: Bru – Van kieu group has quite large population who concentrates in the Central North with different sub-groups such as Bru, Ma Cong and Khua in Tuyen Hoa, Minh Hoa and Bo Trach districts (Quang Binh province), and Gio Linh, Vinh Linh and Hung Hoa districts (Quang Tri province). The Bru-Van kieu language is quite similar to those of Co Tu and Ta Oi groups.

- **Economic production**: There is combination of upland and wet rice farming. The main crops are rice, maize, cassava, coffee and pepper. The income level is average and close to the poverty line.

- **Community relations**: Each Bru-Van Kieu village has strong ties of Mu (the kinship on father’s side). Neighboring relations are important. The head of each family name is respected, and the village leader is responsible for village management.

- **Family and marriage**: The Bru-Van Kieu group follows the patriarchal system with nuclear families. When the young people reach their marriage age, they often stay overnight in the village house. They can make friends there.

- **Language**: The Bru-Van Kieu language belongs to the Mon-Khmer linguistic family, and is quite similar the Co Tu and Ta Oi languages. It does not have a writing system. Speaking fluent Vietnamese is still a problem for some Bru-Van Kieu people.
- **Education:** Attendance rate among Bru- Van Kieu students is pretty high with low drop-out rate.

(ix). **The Ta oï**

- **Location:** Ta Oi people concentrate in the western mountainous areas of Quang Tri and Thua Thien Hue provinces with the local sub-groups of Pa Koh, Ba Hi and Ta Oi. Their language belongs to Mon – Khmer linguistic family.

- **Community relation:** The Ta Oi village is arranged in a circle, with a Rong - the community cultural house - at the center. The Ta Oi’s house has long floor on stilt (usually 100m long), and is the living place of many couples within one extended family. Teeth cutting, and body/face tattoos are also the traditional customs of Ta Oi people. In each hamlet, there is a distinction of residence and forest areas, and Rong house is a common place for the community’s activities.

- **Family and marriage:** The Ta Oi’s marriage relation is quite similar to the Co tu’s and Bru-Van Kieu’s. Ta Oi people believe in traditional belief with the system of Yang (gods) and souls. They believe that each person has his/her soul, and their health and sickness depend on the soul (The soul of a family member is represented by a bowl which is considered as a sacred object and used for ritual activities).

- **Language:** The Ta Oi language belongs to the Mon-Khmer linguistic family and does not have writing system. Speaking fluent Vietnamese is still a problem for some Ta Oi people.

- **Education:** The drop-out rate of Ta Oi children is high because they live in remote areas. The number of illiterate Ta Oi people has significantly reduced in recently years.

10. **The Co Tu**

- **Location:** Co Tu people concentrate in Quang Nam and Da Nang. In the Central North, they live in Phu Loc and A Luoi districts (Thua Thien - Hue province).

- **Economy activities:** Similar to other ethnic minority communities on Truong Son mountain range, the Co Tu people live on upland cultivation. In the past, they had shifting cultivation, leading to very poverty condition. At present, they settle down in villages along the Ho Chi Minh Road.

- **Community relation:** The Co Tu’s living place is normally on highly dangerous mountains. Co Tu village is arranged in a circle, with the community cultural house (Guol) at the center with a pillar used for binding animals for village ritual activities. There are 50 houses in each village which is surrounded by a fence. The house type is with a round roof. Tooth cutting is quite common among the Co Tu people, and buffalo stabbing festival is held with the participation of the whole community. According to customs, the Co Tu people have a lot of taboos, especially women and children.

- **Language:** The Co Tu language belongs to the Mon-Khmer linguistic family without a writing system. Speaking fluent Vietnamese is still a problem for some Co Tu people. However, Co Tu’s language is more popular, and used for broadcasting purposes in the area.
- *Education:* The drop-out rate of Co Tu children is high because they live in remote areas. And the number of illiterate Co Tu people is still high.

(xi) **The Khmer**

*Location:* The Khmer live mainly in the Mekong delta region with high concentration in An Giang, Soc Trang Provinces.

*Economy activities:* Living in the biggest delta of the country, wet rice is main crop of the Khmer. Fishery also takes role as important income sources. Income from business trends to increase in recent years due to the development of the region.

*Community relation:* The Khmer’s traditional residential unit is Phum/Soc (village). Community relation is quite tight with Buddhism taking role as integration cod among the people.

- *Language:* The Khmer language belongs to the Mon-Khmer linguistic family with a quite developed writing system though at the present very few people could write and read their own language. Speaking fluently Vietnamese is still a problem for many people.

- *Education:* The drop-out rate of the Khmer children is getting much lower comparing with the past years due to many reason of which economic growth and government education promotion programs take important role. However, illiterate rate in the elderly is still high.

(vii) **The Cham**

*Location:* The Cham live mainly in Binh Thuan province.

*Economy activities:* Wet rice and fishery are the two most important income sources. Industrial crops are also popular. Income from business trends to increase in recent years due to the development of the region.

*Community relation:* The Cham’s traditional residential unit is village. Community relation is quite tight with Islam taking role as integration cod among the people.

- *Language:* The Cham’s language belongs to the Malayo-Polynesian with a quite developed writing system though at the present very few people could write and read their own language. Speaking fluently Vietnamese is still a problem for many people.

- *Education:* The drop-out rate of Cham children is lower than that of many other ethnic minority groups since because they live in lowland areas. Number of Cham people who have university education is increasing.
III. POLICY FRAMEWORK

3.1. World Bank’s Policy toward Ethnic Minorities (OP 4.10)

The WB has its own policy toward the indigenous/ethnic minority people (OP4.10; 7.2005). It calls upon projects to invest into ethnic minority areas, and to fully respect the preferential rights of the affected ethnic minorities. At the same time, it is expected to mitigate the adverse impacts on the ethnic minorities and promote those activities that aim at bringing benefits and preserving their traditional cultural values. The WB requests that the local people should be sufficiently informed and freely participated in the Project, and the Project should receive the support from most of the affected ethnic minority people. The designed Project must ensure that the ethnic minority people receive the social and economic benefits are culturally appropriate, and gender and multi-generationally inclusive.

The WB’s objective on ethnic minorities is to ensure that the development process will foster a full respect for their dignity, human rights, and cultural characteristics. The focus of the planning framework is to ensure that ethnic minorities will not be affected during the development process, especially under projects using the WB’s loan. At the same time, it is also to make sure that the ethnic minorities will receive their corresponding socio-economic benefits.

The WB’s strategy for addressing the issues pertaining to ethnic minorities must be based on the participation and informed consultation of the ethnic minority people themselves. Thus, identifying local preferences through direct consultation, incorporation of indigenous knowledge into project approaches, and appropriate early use of experienced specialists are core activities for any project that affects ethnic minority people and their rights to natural resources.

3.2. GoV’s Policy

The GoV made its Decision No.135/1998/QD-TTg dated 31 July 1998 on the approval of the “socio-economic development program for the extremely difficult mountainous and remote communes”. Accordingly, those people who live in the extremely difficult mountainous and remote areas will be entitled to preferential health examination and treatment.

The National Assembly’s Resolution No. 18/2008/QH12 stipulates the accelerated performance of socialization policies and laws to promote the quality of healthcare services. The National Assembly approves the directions to increase the share of annual health budget expenses, and to ensure that the increased health expenses are higher than the average increased expenses of the national budget. It is planned to spend at least 30% of health budget for the preventive health. The attention will also be paid to the budget line allocation for the healthcare for the poor, farmers, ethnic minorities and those living in difficult and extremely difficult socio-economic situation.

On 15 October 2002, the Government promulgated the Decision No.139/QD-TTg on "medical check-up and treatment for the poor", which states that all people
who are the poor, live in extremely difficult areas under Program 135, and ethnic minorities will receive free medical check-up and treatment. The budget of this program will be allocated from the national and local budgets (accounting for 75%), and mobilized from various organizations and individuals. The payment levels will be in accordance with the regulations.

Thanks to the enforcement of Decision 139, the healthcare for the poor and ethnic minorities has been significantly improved. Provincial governments have issued regulations on the fulfillment of medical check-up and treatment for the poor, and established their funds for medical check-up and treatment for the poor. In extremely difficult provinces in the Central North, the number of beneficiaries who are entitled to preferential treatment as indicated in Decision 139 is quite large due to the high proportions of ethnic minorities and those living in Program 135 areas. Since the implementation of health check-up and treatment for the poor, the number of patients visiting health facilities has significantly increased. This also is a great challenge to the extremely difficult provinces in the Central North due to their limited public budget in the context of the poor’s increasing demands for health check-up and treatment.

Especially, Decision 139 also stipulates the provision that eligible people will be granted with Health Insurance Cards, benefits of non-advance payment medical examination and treatment, and refundable medical examination and treatment in the healthcare establishments which are not the originally registered ones. The eligible people include are those living under the poverty line, those living in extremely difficult communes (under Program 135), and ethnic minorities.

The preferential medical examination and treatment given to the poor as stipulated in the Government’s Decision 139 has significantly contributed to the improved healthcare for the poor, especially those living in mountainous areas and ethnic minorities. However, the access to healthcare services by the poor and ethnic minorities in the Central North is still difficult. The poor cannot go to healthcare units because they cannot afford the transport or the patients’ caring costs, or access to modern healthcare services at provincial and central healthcare establishments. Meanwhile, the district-level medical equipment and facilities are inadequate, and the personnel are not satisfactory in both quantitative and qualitative terms in order to provide ensured examination and treatment for local people in general and for the poor and ethnic minorities in particular.

The Vietnam government has designed a national program for HIV/AIDS prevention with 8 Action Plans as below

<table>
<thead>
<tr>
<th>Action plan</th>
<th>Main activities/channels</th>
<th>Targets/programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Information sharing, education</td>
<td>- To change behavior and practices of HIV vulnerable groups such as prostitutes, drug users.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| 2 | Mitigation and intervention | - Injectors free provision  
- Condom free provision  
- Medical treatment for drug users |
| 3 | Support and treatment | - Better basics medical treatment improvement  
- General TB/HIV reduction  
- Orphan and vulnerable children living with HIV/AIDS |
| 4 | Evaluation and Monitoring | - HIV test free consultation  
- To supports for test centers  
- To develop evaluation and monitoring system |
| 5 | HIV/AIDS treatment provision | - HIV/AIDS medicine provision |
| 6 | HIV transmission from Mother | - To reduce transmission from pregnant mother to new born child |
| 7 | Treatment and management for people having HIV via sexual relations | - To organize HIV test and treatment for people having HIV via sexual relations, and other vulnerable groups.  
- To provide condom and other prevention plans. |
| 8 | Strengthening HIV/AIDS prevention capacity and international cooperation for domestic | - To strengthen professional capacity for involves staffs.  
- To provide supports for proposed activities for HIV/AIDS prevention. |

Directive N06-CT/TW issued in 2002 by Central Committe of the Communist Party of Vietnam directs the MOH to formulate policies with priorities for people in remote and
mountainous areas, especially the ethnic minority groups, in order to significantly improve the equity of health care and contributing to the improvement of the people’s living standards.

Decision 139 or the Health Care for the Poor from 2002 enabled the poor and disadvantaged, including ethnic minority groups, to receive more extensive health coverage through a fund created from contributions from the central government (75%) and the provincial government (25%). Beneficiaries are either provided with a health insurance card or a health card that entitles them to free health services at all levels.

IV. CONSTRAINTS AND THREATS FOR HIV/AIDS PREVENTION IN ETHNIC MINORITY AREAS

General constraints:

Constraints that may prevent the development of ethnic minority people have been investigated by number of previous studies. Terry (2001) from various case studies identifies some major obstacles including: poverty, population growth, natural resource degradation, migration, marginalization. A study conducted by a multi-discipline team directed by World Bank (2009) conclude that there are 7 obstacles that ethnic minority people are confronting: high poverty rate, low education background, mobile migration, limited access to credit and financial services, limited access to land, agriculture and forestry, market, trading, and off-farm employment and misconception and stereotyping.

While most of ethnic minority live in upland and mountain region, where there is rugged conditions and slow development, its population is more disadvantaged in terms of living conditions. Its people also lag behind in economic and social progress. A 1998 study by Phan Thanh Xuan presented the three categories of the mountainous areas in terms of socio-economic development.

- The 1st category covers 931 communes (21.4 percent) with 6 million people and various ethnic minority groups. The minority groups typically reside along the main roads, industrial centers, and agricultural enterprises close to basic infrastructure services (health stations, communications, schools, and markets). Many ethnic minority groups grow rice, develop animal husbandry or cultivate commercial products. Most of the ethnic minority population are settled and have developed a household based economy with an income per capita approaching the national average.

- The 2nd category includes 1854 communes (42.5 percent) with about 8.5 million people, where most of the ethnic minority groups have settled but have not achieved a stable life. Many ethnic minority households exist on a
subsistence based economy and have access to limited basic services. They are often at risk of living in poverty and need support to develop a sustainable lifestyle.

- The 3rd category, consists of the poorest and most difficult conditions with 1568 communes (36 percent), with about 4.5 million people including 90 percent ethnic minority who live in remote areas. These groups are most vulnerable and highly dependent on natural resources.

On the other hand, literacy is lower among ethnic minorities, especially ethnic minority women. The literacy ratio for ethnic minorities is estimated to be 73 percent compared to 90 percent for the total population. Primary education is available for 90 percent of the total population while for ethnic and poor it is much more limited. At secondary and higher education levels, gender disparities still exist due to cost, fees, and sociocultural barriers.

Gender gaps are more marked and complex among certain ethnic minority groups. Some ethnic minority groups maintain strong matrilineal traditions where women's status is higher than men's. This is found among the Ede and Hmong groups. Men are still considered the representative head and main decision maker in the household and community. Generally, women have a limited role and representation in the public community sphere. This situation is accentuated by the language barrier which is typically more pronounced for women than for men. In ethnic minority communities the role and power of village elders is strong.

In terms of health care, women in many ethnic minority groups practice traditional birth control methods and are reluctant to use modern methods. The use of modern methods is low among the illiterate women in many ethnic minority groups in the mountainous regions. The number of children and family size of ethnic minorities are higher than that of national average.

Financial constraints are significant factors on the health care seeking behavior among many ethnic minorities. In 1998, the government enacted Decision 135 focused specifically on poverty alleviation for ethnic minorities. Under this policy, health cards were distributed to the ethnic minorities, entitling them to specific free health services. In spite of this, ethnic minorities continued to suffer inequity in health care. To correct this and to provide cover for the other poor citizens, the government implemented the Decision 139 (Health Care for the Poor Initiative) in 2002, where the poor and disadvantaged, including the ethnic minority groups, received a more extensive health coverage through a fund.
created from contributions from the central government (75%) and the provincial government (25%). Beneficiaries are either provided with a health insurance card or a health card that entitles them to free health services at all levels. Since its introduction, there has been an increase in health service utilization by ethnic minorities. This could be higher if more ethnic minority groups fully understand the benefits accruing to them under these 2 policies.

Gynecological diseases make ethnic minority women more vulnerable to HIV/AID infection. They suffer frequently from a number of reproductive tract infections such as sexually transmitted diseases (STDs). The percentage of women reported suffering from gynecological diseases is high (70 to 80 percent) in rural and ethnic minority areas. These conditions make women feel weak; their health status aggravated by bad working conditions, lack of clean water and sanitation, improper care and treatment. The national average for gynecological check ups at health clinics is a high 80.0 percent. However, the rate for ethnic minority women in mountainous areas is much lower than for the Kinh women. The lowest rate of health check ups was for ethnic minority women in the southern area (56 percent) and in the Central Highlands (63 percent). Most poor women indicated that they had never had a gynecological check up.

Specific constraints:

4.1. Geographical and transportation:

Currently, infrastructure and transportation in rural areas of the 32 project provinces are not in very good condition, especially the ones in north upland region. The distance between villages and district centers is, in some cases, about 50-70 km, while roads are not available or under bad condition, especially during rainy season. Means of transportation is mainly by bike or on foot. This constraint prevents both periodical HIV awareness raising campaign and people’s willingness to visit medical centers for HIV test. For ethnic minority groups such as the Hmong, Dzao, Kho Mu, who live in Northern provinces, it may take a day for them to go to district medical center from their village. Low population density is also another factor that creates difficulties for getting people involved in any prevention/awareness raising activities.

4.2. Customary practices

As the modern healthcare services are uneasily accessible in various areas, many ethnic minority groups preserve their traditional medical knowledge. Their healthcare relies on indigenous prevention and treatment knowledge/experience. Spiritual belief-based treatment also plays an important role and even drives the decision on the selection of treatment methods. The role of local medical men and of ritual ceremonies in health care remains significant. This belief and practice makes medical centers become the ultimately destination, but not the primary one. Taking this into consideration, it could be seen a potential threat of HIV increase
since HIV is alien from traditional medical knowledge of the Hmong (and many other ethnic minority groups).

4.3. Poverty

Given the reality of unstable and low income, healthcare is not the first spending priority of ethnic minorities in the project areas. High poverty rate is one of the most significant causes that force many young ethnic minority peoples: (i) to seasonally leave their village for off farm jobs; (ii) to be not able to access to mass media; (iii); and to be unable to participate in community meeting. These are factors that have marginalized many poor ethnic minority peoples from learning necessary and update information related to health care, including HIV.

4.4. Language and educational background

Among 49 ethnic minority groups in the project areas, many of them are not fluent enough at Vietnamese, especially when the language is written, spoken in medical perspective (with possible exception of the Hoa, Thai, Muong, Tay). During field investigation, it was observed that many Hmong, Dzao, or Khmer people did not clearly understand the conservation if without interpreter/or could not fluently speak out what they want to say. Having been determined by numerous reasons (poverty, transportation, languages, etc), there is considerable low rate of ethnic minority students who finish high school. Consequently, there are very few ethnic minority peoples who are qualified enough to enter medical schools, and become physical doctors. Language weakness and limited educational background also create self-stigma among ethnic minority peoples, or create discrimination from the Kinh people. This situation may maintain a gap between the Kinh and other ethnic minority people, prevents full integration of the later into a larger network.

4.5. Migration

Poverty, land scarcity, rapid population growth and some other factors have made more and more: (i) ethnic minority people leave their land to other regions/countries for jobs/ production resources; (ii) lowlanders immigrate into ethnic minority people regions. These two trends (i) maintain mobile demography, and make HIV prevention activities less accessible in many communities; and (ii) may lead to high risk of HIV transmission among different ethnic groups.

This potential threat could be a future problem given the fact that seasonal migration/immigration, from field investigation, has not been fully controlled and taken into consideration.

4.6. Urbanization
Urbanization is increasing in most of project provinces. This process is always associated with migration/immigration, population growth/prostitution/drug use, and many other practices that may increase HIV transmission.

4.7. Cross-border issues

Provinces such as Lai Chau, Son La, Lao Cai, Cao Bang, Lang Son, Quang Ninh, Thanh Hoa, Nghe An and An Giang have long border line with China, Laos and Cambodia. Cross border migration, trans-national prostitution and drug smuggling are potential channels bridging HIV transmission.

4.8. Tourism

Tourism is good for economic growth, but at the same time could increase social problems such as prostitution and drug use. This could make ethnic minority people more vulnerable to HIV.

V. COMMUNITY CONSULTATION

5.1. Activity principles

Participation of ethnic minorities in the project could help to speed up smooth project implementation. Disclosure of project information for ethnic minority people is an important part of project preparation and implementation since it will mitigate the risk of conflicts and project delays.

The objectives of the public information and consultation program for ethnic minority people are as follows:

a) To ensure that local authorities, as well as representatives of ethnic minorities, will be included in the planning and decision-making processes.
b) To fully share information about the proposed project components and activities with the ethnic minority.
c) To obtain information about the needs and priorities of the ethnic minorities, as well as their reactions to the proposed policies and activities.
d) To ensure that ethnic minorities are able to make fully informed decisions that will directly affect their incomes and living standards, and that they will have the opportunity to participate in activities and decision-making on the issues that will directly affect them.
e) To establish the cooperation and participation of ethnic minority people and communities in various activities necessary for future project implementation.

5.2. Methods of community participation and consultation
The main method to encourage community participation and community consultation is community based that include:

- Public disclosure: through the communication campaigns associated with the public media such as television, commune-based radio, posters, leaflets.
- Community meetings at project sites
- Formation of groups/group discussion in order to establish the information channel to facilitate the participation of ethnic minorities in project planning and implementation.
- Face-to-face interviews of household representatives to reach agreements on their benefits/interests.
- Diversifying the involvement of typical social organizations that have high influences on local people. Selection of these organizations should be based on each province and ethnic minority community. For instance, in Son La province, in Hmong and Dzao community, kinship and various village social organizations should take part in community consultation initiatives, while in Khmer community, Buddhism pagoda is

In the process of strengthened consultation and community/stakeholder participation, the following should be considered:

- Identification and participation of all stakeholders, including beneficiaries and affected people.
- Development of a strategy for community–based project planning, implementation, and monitoring and evaluation.
- A complete and comprehensive list of requests for communication campaigns and information disclosure, the establishment of steps to provide better access to project goals for ethnic minority people.
- Development of a timeframe for the completion of activities/items such as information campaign, compensation levels, solutions and conditions, and resettlement areas and plans.
- Seeking for the assistance from public organizations (e.g. women association, farmer’s association, veteran’s organization, Fatherland Font, etc.) to address various issues related to community consultation and participation.
- The project implementation activities must be consulted with ethnic minority specialists, especially the ones who have experience in project activity areas (healthcare, insurance, etc.).
- CPMU must have close cooperation with PPMUs, especially those with high and diversified concentration of ethnic minorities.
- PPMUs will monitor the implementation process in order to make sure that equal healthcare services will be provided for ethnic minorities, and financial and legal support will be made available for districts in their provinces.
- DPC must establish the efficient cooperation with other departments/programs in the district, especially those related to ethnic minority development activities.

VI. ETHNIC MINORITY PLAN

4.1. Activities in the previous 20 project provinces in previous years

There are 11/20 provinces have carry out intervention for EM (Laichau, Sonla, Yenbai, Caobang, Thainguyen, Bacgiang, Thanhhoa, Nghean, Dongnai, Angiang, Kiengiang). However, all of 20 provinces have implemented IEC/BCC activities including developing IEC materials for this group (testing and printing).

HIV/AIDS investigations have been initiated in number of project provinces in Lai Chau and Son La province since 2006. The investigation results show that within the drug addicted group, approximately 75% are from ethnic minority groups, and 40.6% of them are HIV positive. Regarding to sex worker group, this ratio is 4.5%.

In other investigation that is “HIV rate and high risk in some ethnic minority groups in 11 provinces” conducted in 2006 and supported by the “Vietnam HIV prevention project”, HIV rate in some ethnic minority groups is recorded rather high: 6.03% in the Thai in Thanh Hoa province; 0.6% in the Hmong in Lai Chau province.

From HIV information sharing accessibility perspective, in Yen Bai province, number of ethnic minority people who do not have frequent access to HIV information takes up 22.9%; 14.4% and 13.7% in An Giang and Kien Giang province respectively.

Another important figure that has been recorded in the 11 provinces is the low rate of using condom when having sex with strange partners, which is roughly 30%. Lai Chau, Son La, Yen Bai, An Giang are some typical provinces where (i) access to HIV information is limited; (ii) awareness of HIV prevention is weak; (iii) high presence of poverty rate; and (iv) high rate of illiteracy is popular.

In terms of intervention activities, in these provinces the following activities have been initiated and implemented:

(a). Communication for behavior changes

(1). Provide primary training on HIV, HIV prevention for local village elderly; village leaders; local medical servants; local peer educators, etc.

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2 These provinces include: Lai Chau, Yen Bai, Cao Bang, Thai Nguyen, Bac Giang, Thanh Hoa, Khanh Hoa, Dong Nai, An Giang, Kien Giang, and Hau Giang
(2). Organize public consultation/public communication to reduce discrimination on HIV/AIDS people.

(3). Organize public communication about safe sex; condom use for young ethnic minority people. This activity is initiated via village periodically meetings.

(4). Distribute flyers and brochures about HIV in local languages with taking local cultures into consideration.

(5). Establish mobile communication teams in order to periodically implement communication activities for ethnic minority people living in remote areas through various activities (film broadcasting for instance). Through these activities, HIV related information is introduced to the people.

(b). Intervention to mitigate HIV increase

(1). In remote areas where transportation is not very well accessible, village medical staff network has been established and supported by the project. This network is responsible to provide daily HIV communication sharing to local people.

(2). In remote areas where there is high rate of drug use/prostitution/or poor transportation systems, mobile HIV test is provide periodically with participation of local medical staff. This intervention activity, as recorded by most of province, is highly supported by local people.

©. Capacity strengthen

(1). Provide and update HIV information for village and commune medical staffs

(2). Village cooperators are invited to attend periodical training programs on HIV.

(3). Village elderly and village leaders are also active in HIV training programs.

(d). Monitoring and evaluation

(1). Update data on HIV in relation to ethnic minority people is maintained by involved organizations at different levels.

(2). Maintain the participation of different organizations/agencies related to ethnic minority people in activity designing period, training activities, implementation activities and other meetings.

Field investigation in April, 2010 in 4 provinces: An Giang, Soc Trang, Son La and Lang Son show that these activities have been implemented, and still ongoing. They do have positive impact on raising HIV awareness and HIV prevention strategies.
4.2. Proposed activities

It is suggested that the ongoing activities mentioned in section 4.1 should be continued in developed in the provinces where there is high presence of ethnic minority people.

This Plan is proposed for 15 provinces, where there is high population of ethnic minority people. In the other 17 provinces, ethnic minority population is not significant so as EMP is not applicable.

From the consultations with local authorities, ethnic minority patients and relevant agencies/bodies, the evaluation indicators of project activities for ethnic minority development will be as follows:

1. **Increasing knowledge of ethnic minority groups on HIV transmission prevention and harm reduction for high risk group and community based care and support;**
   To organize direct communications for EM groups and integrated with regular meeting in the villages (hotspot sites). Collaborators and Peer educators will implement these activities in each village (1 time/quarter). This is far under demand given vast area, poor transportation condition and low population density in ethnic minority people regions.

2. **Increasing number of medical workers who are ethnic minority** and selecting young ethnic minority people for professional training. Besides lack of human resources, most of the provincial centers do not have enough representation of ethnic minority people in the office. This situation may prevent the effectiveness and level of accessibility to ethnic minority people given language constraint, and cultural barriers between medical workers and the people. This situation is serious in some ethnic communities whose Vietnamese is not good enough such as the Hmong, Dzao, Khmer.

3. **Carry out counseling and communication activities** in order to raise more awareness on HIV prevention. These activities should be carried often via appropriate channels depending on each ethnic group socio-economic and cultural features. For instance, Buddhism pagoda should be a good channel in Khmer community or kin leader could be a good collaborator in Hmong villages.

4. **Improving equipments, IEC material, and providing technology transfer** for HIV prevention centers in each province in order to meet the needs of HIV test and treatment, particularly ethnic minorities in remote areas.
5. **Promoting verbal communication**: most of ethnic minority group in Vietnam has low literacy rate with estimated 73% illiterate. This rate is higher in female than it is in male. In northern mountain region, while 17.8% of ethnic minority men are illiterate, this figure is 35.3% with women. In Khmer and Cham ethnic in the south, though there have been no official record of illiterate rate, it is estimated that the rate is rather high. From field investigation, every focus group discussion, and individual interview could not proceed without assistance of an interpreters. Field observation also proves that the Khmer women do not speak Vietnamese as fluently as men. This situation may prevent the effectiveness of flyer distribution, or any other kind of publication. It is suggested that in communities where Vietnamese is not well understood, there should be more indigenous people trained about HIV knowledge and then provide verbal communication to local people via community meeting/village meeting. It is also important to take into consideration that most of ethnic minority peoples do not have capacity to read their scripts (such as Cham, Khmer, Thai, Dzao, Hmong, etc) so as bi-lingual distributed publications could not assure that people would understand. In brief, **verbal communication is highly recommended, and should be the most effective way.**

6. **Increasing accessibility to mass media/communication program related to HIV**: With the exception of the Chinese ethnic (who hold poverty rate similar to that of the Kinh-10%), all other ethnic minority groups hold much higher poverty rate than the Kinh ethnic, averagely 52% (VHLSS, 2006). This means nearly 10 million people classified as ethnic minorities (around 14 percent of the population) have been living in poverty. Poverty brings to many consequences: (i). not often accessible to mass media (since they do not have TV, radio, or access to newspapers, internet). This obstacle prevents people from having frequent, necessary, proper and update information about HIV (prevention, treatment, etc). Field investigation in An Giang, Soc Trang, Son La and Lang Son show that people learn about HIV via informal channels (community sharing for instance) more often given the fact that not everyone could participate in seldom communication programs of local clinics/ or could not fully understand the distributed flyers, banners; (ii). Spending more time in the field/off village for off-farm job. While most of information/communication campaign (if any) brought to villages during day time (working time of government officials), very few people (especially young people) stay in the village so as the effectiveness of previous campaigns was not as much as expected (communal clinics in the 4 visits provinces admitted this fact); (iii) limited accessibility to medical centers including communal clinic. Records from interview with both medical staffs at communal level and villagers reveal that the poor are afraid to go to clinic because: (a) they think it would cost them a lot of money; (b) they do not have self confidence.

7. **Designing proper condom distribution channel**: At some provinces, condoms are still distributed free to people. However, distribution mechanism seems inappropriate. In some communes in the four visited provinces, condoms are delivered to village level
via an assigned person. This person is often a staff of communal clinic. Target for condom provision is all villagers. Overall, this policy is highly appreciated by local people. However, many of the interviewed people admit that they never come to ask for condom regardless of free provision, and thus number of condom distributed to each village is rarely completely taken. After spending time talking with villagers, it turns out that this situation comes from people conception of condom. Until recently, condom is not yet familiar with most of ethnic minority people. They are shy to go to pharmacy buying it, or going to ask condom distributor. Many people still hold incorrect understanding of condom’s role since they think one “must have some problems so as s/he has to use condom”, or “it is such a weir practice using condom when having sex with your wife”. Another place where people could come and ask for free condom is commune clinic. However, in many cases, distance between a village and the clinic is too far that takes hours on foot (not everyone have motorcycle). To improve these two obstacles, it is suggested that condom distribution should be done at village level in collaboration with two social organizations: Women union and farmer union. The involvement of these two organizations is necessary since it make both men and women feel comfortable and less shy when they want to ask for condom (women may prefer to come to women union, why men may prefer to come to farmer union). On the other the hand, people’s misconception of condom should be changed.

8. **Mobile VCT for mountainous districts of following provinces: Nghe An, Thanh Hoa, Son La, Lai Chau, Yen Bai, Thai Nguyen, Bac Giang, Cao Bang.** The reason for establishing mobile VCT in these areas is low population density, poor transportation and limited access to medical centers for EM, especially in rainy season.

9. **Reducing HIV discrimination**: Most of ethnic minority peoples believe that HIV is a “dead sentence”. This perception, to a certain extend comes from HIV prevention programmers. People think one’s life will end upon HIV suffering, and HIV patient could do nothing but wait for death. For instance, many Khmer people in An Giang think HIV patients should be given any favor food and should not be asked to do any think because the Death is coming to them shortly. This misconception is clearly a fire wall that burns down HIV people’s desire to live healthy. It may also prevent people to go for HIV test, and reduce community sharing and support to HIV people.

**VII. ORGANIZATION AND IMPLEMENTATION**

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3 HIV discrimination reduction framework/mechanism is being constructed and will be finalized soon by the author of this report. If World Bank, CPMU and PCMU approve this activity, a detail action plan related to HIV discrimination reduction strategy could be developed in a separate research paper and separate contract.
As for the performance of the ethnic minority development plan, CPMU and PPMUs will start up the implementation of project components and carry out the supervision exercise in order to make sure that the project activities are kept on right track.

- With regard to those provinces/districts which have high concentration of ethnic minority population, documents in their languages should be published, and the engagement of people who have the knowledge of local ethnic minority languages should be made in order to make sure that the communication and consultation with local people will be done during their check-up and treatment exercises in the health facilities. However, it should be taken into consideration that not every ethnic minority group are literacy at their mother languages such as the Hmong, Thai, Tay, Dzao or Khmer. In these cases, verbal communication and direct community consultation should be the first priority.

- Qualified doctors will be sent to organize training activities and capacity building for ethnic minority medial workers working in district-level hospitals where there is a high need for the transfer of medical techniques, especially in those districts where there is a high concentration of ethnic minority population.

- PPMUs should take into consideration of getting related legal and traditional institutions to participate in the project implementation. Legal institutions should be organizations such as: Ethnic minority committee, Department of Culture, Sports and Tourism, Department of Home Security. Traditional institutions should be kinship, village community, or Buddhism pagoda.

**VIII. MONITORING AND EVALUATION**

- Monitoring the implementation of the ethnic minority development plan is a part of monitoring activities within all project components. Detail implementation schedule should be available at the initial of the project.

- An independent supervision agency with qualified and experienced specialists must be in place in order to provide monitoring and evaluation of project activities related to social and ethnic minority development aspects.

- The external monitoring agency should have strong competencies on ethnic minority studies, and development projects related to ethnic minority people. The selected evaluation and monitor agency should not be government organization to ensure independent and objective involvement.

CPMU and PPMUs will make final supervisions and undertake monitoring and evaluation of project components. As for provinces which have more than 30% of its population as ethnic minorities, the cooperation should be done in order to provide the monitoring of ethnic minority-related activities.

The evaluation should be made periodically, and should be distributed to every project participated partner for comments before finalization.
IX. COST ESTIMATION
- The costs of EMP activities are estimated and embedded within project activities.
- The costs of training activities will be calculated in detail when these activities are conducted.
- In order to make cost savings, EMP-related training and communication activities will be incorporated into other project training and communication activities.
Table 6: EMP’s Estimated Budget

(Unit: USD)
(for only 15 provinces where EM living*)

<table>
<thead>
<tr>
<th>No.</th>
<th>Items</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increasing knowledge of ethnic minority groups on HIV transmission prevention and harm reduction for high risk group and community based care and support; To organize direct communications for EM groups and integrated with regular meeting in the villages (hotspot sites). Collaborators and Peer educators will implement these activities in each village (1 time/quarter),</td>
<td>150,000</td>
<td>150,000</td>
<td>150,000</td>
<td>450,000</td>
</tr>
<tr>
<td>2</td>
<td>Communication reducing stigma and discrimination on HIV/AIDS (TV, Video, Radio…)</td>
<td>80,000</td>
<td>80,000</td>
<td>80,000</td>
<td>240,000</td>
</tr>
<tr>
<td>3</td>
<td>Providing equipments and IEC materials for communication.</td>
<td>75,000</td>
<td>50,000</td>
<td></td>
<td>125,000</td>
</tr>
<tr>
<td>4</td>
<td>Training for Collaborators and Peer educators on knowledge and skills of communication, harm reduction and care-support.</td>
<td>45,000</td>
<td>45,000</td>
<td>45,000</td>
<td>135,000</td>
</tr>
<tr>
<td>5</td>
<td>Training for CHWs and VHWs on knowledge and skills of communication, harm reduction and care-support.</td>
<td>50,000</td>
<td>50,000</td>
<td>50,000</td>
<td>150,000</td>
</tr>
<tr>
<td>6</td>
<td>Training for head of villages on knowledge and skills of communication and harm reduction.</td>
<td>45,000</td>
<td>45,000</td>
<td>45,000</td>
<td>135,000</td>
</tr>
<tr>
<td>7</td>
<td>Printing communication documents for the ethnic minorities</td>
<td>30,000</td>
<td>30,000</td>
<td>30,000</td>
<td>90,000</td>
</tr>
<tr>
<td>8</td>
<td>Mobile VCT for mountainous districts of Nghean, Thanhhoa, Sonla, Laichau, Yenbai, Thainguyen, Bacgiang, Caobang</td>
<td>250,000</td>
<td>250,000</td>
<td>250,000</td>
<td>750,000</td>
</tr>
<tr>
<td>9</td>
<td>Providing equipments for mobile VCT</td>
<td>50,000</td>
<td>50,000</td>
<td>50,000</td>
<td>150,000</td>
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<tr>
<td>10</td>
<td>Providing syringes and needles</td>
<td>450,000</td>
<td>450,000</td>
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<td>11</td>
<td>Procure safe boxes and destroy used needles &amp; syringes</td>
<td>20,000</td>
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<td>20,000</td>
<td>60,000</td>
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<td>12</td>
<td>Providing condoms</td>
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<td>150,000</td>
<td>150,000</td>
<td>450,000</td>
</tr>
<tr>
<td>13</td>
<td>Training on data collection, data use and reporting; Providing M&amp;E equipments for ethnic minority districts</td>
<td>30,000</td>
<td>30,000</td>
<td>30,000</td>
<td>90,000</td>
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<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>1,425,000</strong></td>
<td><strong>1,400,000</strong></td>
<td><strong>1,350,000</strong></td>
<td><strong>4,175,000</strong></td>
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</table>

4 15/32 provinces: Laichau, Sonla, Yenbai, Caobang, Thainguyen, Bacgiang, Thanhhoa, Nghean, Langson, Quangninh, Binhthuan, Dongnai, Angiang, Kiengiang, Soctrang.